

Maryland Hospital Community Benefits Narrative Reports FY 2009

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Narrative Report FY09

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

301 licensed beds and 24,545 admissions.

2. Describe the community your organization serves.

The community of Anne Arundel County has a current population of 512, 790 residents. It is a very diverse community, with a continuously evolving blend of age groups, ethnic groups, occupations, and social and economic conditions. Residents live in settings that range from urban to agricultural. Ethnicity breaks down as follows: white 79.5%; black 15.4%, Asian 3.1%; American Indian .3%; and Hispanic 4.2%. The Non-English speaking population in the County is expected to experience significant growth over the next decade. The population expected to experience the greatest growth (38%) over the next decade is among those age 65 and over. Clearly, community health initiatives over the next decade will need to focus on prevention and management of chronic diseases among the aged as well as those that disproportionately affect the growing minority populations.

The median household income of the community is \$80,158.00. Data shows that 2.6% of families, and 5.0% of individuals, are living below poverty level. The unemployment rate of January 2009 was 5.9%, and percentage of uninsured residents (age 18-64) was 11.2. The number of uninsured residents in Anne Arundel County is growing as the economy continues to struggle through 2009.

The geography of Anne Arundel County creates somewhat of a challenge in accessing healthcare. Parts of the county consist of a series of peninsulas making a comprehensive public transportation system too expensive to maintain.

Lastly, the county is considered a high risk area for bioterrorism as its geography contains the national Security Agency, the US Naval Academy, the Baltimore-Washington Thurgood International Airport, and Fort Meade.

3. Identification of community needs.

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

The hospital's community benefits initiatives reflect the evidence-based needs of our community. Community needs are also determined by county-specific assessments and research.

Determining the health status and needs of community members is done in a variety of ways. One of the best ways to understand community needs is by giving our community members a voice, and then listening to them.

For example: The hospital currently sponsors 33 monthly support groups to meet a variety of community needs. The groups offer support to those dealing with acute illness such as cancer, as well as chronic disease such as diabetes and hypertension. The hospital also sponsors a weekly support group to meet the unique needs of Hispanic women in the community.

Evidence-based community needs are also elicited by customer satisfaction surveys, customer call center inquiries, evaluations from community classes, and community outreach and educational presentations. The hospital's ongoing work with community groups and participation in advisory committees and councils create a continuous communications process, bringing new ideas from Anne Arundel County residents and organizations into the hospital's community benefits planning process.

Additionally, the hospital website, and email magazine: "Neighbor News," offers our community the opportunity to make inquiries or provide the hospital with feedback via the Internet. Additional community access is always available through the hospital's Ask-a-Nurse program. The Ask-a-Nurse program provides the community around the clock telephone access to registered nurses.

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

Yes. AAMC Physicians and nurses work weekly with members of the Anne Arundel County Department of Health to plan for and to provide collaborative services such as colorectal screenings, prenatal care clinics, and cancer education and screenings. Members of AAMC's Department of Community Health and Wellness meet monthly with members of the Health Department to plan and implement community health initiatives. In addition, AAMC staff, designated as participants in the County's Emergency Preparedness Program, meet with Health Department representatives on a quarterly basis.

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

Anne Arundel County Health Department established five areas of top priority for fiscal year 2009. The five priorities are: Elimination of Disparities in Health Status and Health Care Access; Emergency Preparedness; Healthy Children and Families; Prevention and Management of Communicable Disease and Chronic Illness; and, Environmental Safety and Health.

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

The community benefits span an increasing number of activities and initiatives performed by many different individuals and departments. Hospital staff, management staff, and/or executive leadership may all be involved in the community benefits planning process, depending on the purpose and scope of the initiative.

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

The hospital has activities and initiatives in each of the five areas identified by the County Health Department. Here are several examples.

The hospital has run a free medical clinic for our underserved and uninsured community for the past 14 years. The Annapolis Outreach Center, located in the historic Stanton Center in Annapolis' Clay Street Community, sees thousands of individuals each year in its medical and specialty clinics. This year 62 physician volunteers staffed approximately 250 medical or specialty clinics at the Annapolis Outreach Center. Another 175 physicians accepted referrals from the Outreach Center and saw the referred patients at no cost, up to and including laboratory testing, diagnostic testing, and surgical procedures. The Outreach Center holds monthly Pediatric clinics and weekly Mental Health clinics. In addition, the

Outreach Center provides a free adult dental clinic. Sixty dentist volunteers have provided free dental care for hundreds of community members in this (09) fiscal year.

The hospital has doctor on-call rotations in every specialty for which there may be an emergency or inpatient need. On-call coverage is provided to all patients regardless of insurance status. There are no gaps in availability of any specialty for uninsured or underserved patients. In addition, the hospital has Hospitalist programs in Medicine, Pediatrics, General Surgery, Obstetrics and an Intensivist program. These physicians provide 24-hour in-house coverage for each of these areas for all patients regardless of insurance status.

The hospital and many of its physicians support the Anne Arundel County Health Department's REACH Program (Residents Access to a Coalition of Health), which offers access to affordable health services for low-income uninsured individuals in Anne Arundel County.

The hospital collaborates with the County Health Department on the Health Smart Church program. This grant-funded program provides health education and blood pressure monitoring at minority churches throughout the county.

The hospital collaborates with the County Health Department on the Learn to Live program. This grant-funded program provides in-person point-of-purchase nutrition education at health department-targeted grocery stores throughout the county.

The hospital has a Disaster Preparedness Coordinator that is responsible to provide staff training, coordinate disaster drills, and keep the hospital's disaster preparedness supply inventory up to date. In FY09, nine additional hospital employees completed FEMA Emergency preparation courses to better collaborate with other county service providers to better serve the community. These staff members participated in a number of collaborative planning meetings and drills with designated County services and first responders.

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

Participation rates and follow-up activities (such as letters to participants with high readings) are tracked and measured weekly in the Health Smart minority church blood pressure program. Results are then evaluated annually to determine if changes to the program would improve outcomes. As a result of the 2008 evaluation, changes were made in 2009 which increased participation rates and follow-up compliance among participants. The Learn to Live program effectiveness is evaluated by the number of interactions each Health Educator has with consumers in each store each week. Program outcomes are reviewed annually by hospital and Health Department program coordinators to determine if changes are needed. In addition, many of AAMC's community-based initiatives involve pen and paper consumer-focused satisfaction tools. These program evaluations, or comment cards are provided to participants and/or consumers following the event, or delivery of services. Examples would be: our health education and exercise classes, our individual outpatient diabetes services, and our Healing Arts services.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

There are no gaps of any specialty for uninsured or underserved patients. See coverage description provided for question #6.

9. If you list Physician Subsidies, in your data, please provide detail.

The hospital contributed \$50,000.00 in FY09, working in collaboration with Johns Hopkins Physicians to treat the uninsured that present at the Kent Island Urgent Care Center. The hospital also covers \$52,000.00 of costs for physicians and midwives that participate in the Anne Arundel County Department of Health Prenatal Maternity Clinic, which provides care for undocumented, uninsured Latina women.

Appendix 1

A. Notification of Charity Care and Financial Assistance

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

Appendix 2

Hospital Charity Care Policy

PURPOSE

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

POLICY

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

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

ELIGIBILITY GUIDELINES

INCOME REQUIREMENTS

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

The Policy is summarized in the following table:

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

Qualification may be calculated by either of the following methods:

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

INCOME VALIDATION REQUIREMENTS

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

DETERMINATION OF ELIGIBILITY

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

MEDICAID ELIGIBILITY

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

Appendix 3

At AAMC there is a shared culture that patients and visitors can sense as well as see when they come in contact with one aspect or another of AAMC's services. It is an energy, a spirit, and a personality unique to AAMC. This shared culture is defined and shaped by five core values: Compassion, Trust, Dedication, Quality, and Innovation.

Together these core values amount to a promise our people make to one another every day. And that promise translates to a pledge we make to our patients and their families to use every bit of our talent, experience, technology and sensitivity to provide quality care at the highest level.

Appendix 4

Hospital Mission Statement

Mission

To enhance the health of the people we serve.

Vision

To be the destination health system in our region.

Core Values

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

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

Overarching Goals

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

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?
 - 62 inpatient beds
 - 3,781 inpatient admissions
 - 33,429 Emergency Room visits (significant in the services of AGH)
2. Describe the community or communities the organization serves.
 - Describe the geographic community or communities the organization serves.
 - Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet.

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

The population is approximately 49,000 residents. According to the 2006 census the median income for a household in the county was \$40,650, and the median income for a family was \$47,293. The per capita income for the county was \$22,505. About **7.20%** of families and **9.60%** of the population were **below the poverty line**, including 17.00% of those under age 18 and 6.40% of those age 65 or over. The median age was 43 years. For every 100 females there were 95.20 males. Nearly one fourth of Worcester County residents are over 65. At Atlantic General our rate of Medicaid and self-pay patients was 12% of our revenue in FY09.

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

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

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

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

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

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

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

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

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

Our auxiliary volunteers are another great resource we use for keeping our pulse on the community. We have over 400 auxiliarians. They are active on many committees within the hospital and also represent the hospital on community boards.

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

Yes, members of the hospital staff sit on many committees and boards of the health department; Alcohol and drug council, Tobacco and Cancer Board, Community Safety Net, Disaster Preparedness, Flu. Also there are many members of the health department who sit on committees within the hospital. We work very closely with our local health department to plan services to meet community needs and decrease the duplication of services. With the recent budget cuts we are looking at services more closely with the County Health Department and our County Commissioners to eliminate duplication of services.

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

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

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

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

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

Community Benefits is addressed by every department in the hospital and all participate on some level. There is a Community Benefits Committee, with members from each department, which oversees the process. The Community Education Department provides oversight to the Community Benefits Committee and Visions Advisory Board (see question 3) as well as all hospital departments regarding community benefits. This year we began using the Lyons software CBISA system for tracking our activity. Through the process of transition to the new system we were able to identify knowledge deficits within the organization and provide the needed education. Awareness was raised of the Community Benefit picture at Atlantic General. Now that department reporters can enter data immediately after an event the data is a much better representation of what we do. The accuracy of the data collection has definitely improved since we transitioned to self-reporting on CBISA.

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

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

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

AGH is always recruiting new physicians. During this year we credentialed 29 physicians, acquired 3 primary care providers, 4 nurse practitioners/physician assistants, 2 gynecologists, as well as granting admitting privileges to other community physicians. The targeted recruitment specialties FY09 were: urology, anesthesia, gynecology, psychiatry and orthopedic surgery. We were successful in bringing all but urology and orthopedic surgery.

In FY09 we also formed a Cancer committee. Through this group we were able to begin tumor boards and begin the process of recruiting a medical oncologist to join the team at AGH. This will allow us to not only diagnose cancer but to treat our patients as well. Since our community is rural this will be a great service to the residents; allowing them to stay close to home and their support system while getting treatment.

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

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

- Mental health services

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

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

- Transportation to appointments, testing and treatments

In providing a step in the solution to the transportation issue faced across our county we are ever increasing services throughout the area. In our county, as well as in most rural areas, people are reluctant to travel outside their immediate locale to get health services. Realizing this we believe an important part of providing care is to take as many services as possible into the communities we serve. As mentioned before we have acquired 3 primary care physicians and 4 nurse practitioners/physician assistants this year, increasing the number of patient visits that we can accommodate in our primary care offices. We have also increased our lab and imaging services offered in our most distant community in the county. Part of our goals for FY09 was to increase the offering of health screenings and education to the distant areas of the county. We have offered additional health fairs (with screenings) and education to area churches and senior center in those communities.

We have also begun the process of putting open access clinics in 3 local Rite Aid pharmacies in the outlying areas of our service area. One of the communities has no physician office in the town, this will be a definite asset to those who have transportation issues.

- Diabetes

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

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

Since it is never too early to begin good health habits the hospital set a goal of addressing childhood obesity in some way. We have found a program (Food Play) which we can sponsor in the local schools which teaches a positive health message including, healthy eating exercise and positive self-image. The plan is do the program in September, 2009 at the beginning of the school year. That gives the schools the rest of the year to reinforce the message using the follow-up materials given to each school.

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

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

b. Year of evaluation: 2008 conference

c. Nature of evaluation: participant satisfaction survey

d. Result of evaluation: Beginning in 2007 the location and time of year for the conference was changed. It was moved from the busy tourist season in Ocean City to the fall (after the season) into the local high school. This change has allowed us to serve the local community better and resulted in a higher attendance and increase in satisfaction according to the participant surveys.

2a. – Name of initiative: Living Well Chronic Disease Self Management Program

b. Year of Evaluation: FY 2009

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

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

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. Problems that could be handled appropriately on an outpatient mental health basis end up becoming physical problems resulting in emergency room visits and hospital admissions or social problems resulting in arrests or incarcerations. We have recently recruited a new psychiatrist and support team which will provide mental health services through our Atlantic Health Center location; this is a collaborative venture with the Health Department.

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

In the northern part of the county the hospital has a walk-in site that treats patients and charges on a sliding fee schedule. In the next county to the southwest there is a similar medical service clinic (not run by AGH). This does somewhat serve the southern part of the county but because of the rural nature of our area and the lack of comprehensive public transportation there is still a need for more such services.

9. Physician subsidies:

We amortized previous payouts of \$110,513, which we report on the Community benefits report. We also spent \$222,575 on physician recruitment which we also include in the Community Benefit report.

Appendix 1

1. Describe your Charity Care Policy

Dedicated financial counselors help those who are uninsured or underinsured, with few resources on which to rely, navigate the options that may be available to them, including the available Maryland Medicaid programs. If no other financial avenues are available to a patient, he or she may apply for financial assistance for those services deemed medically necessary. We base our financial assistance on 200 percent of the poverty level guidelines set by the federal government. Financial Assistance is available to all patients who qualify. This year, Atlantic General Hospital and Health System dedicated \$1,016,205 to this program.

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

In March, 2009 we participated in a fair which was held in our hospital lobby as part of the “Cover the Uninsured Week” to educate the public on our provision for financial assistance as well as other healthcare coverage options in the area. In August we provided

the same education at a “Reach Out to the Homeless” event which took place at the County Health Department.

As part of mandatory yearly education all associates had to complete a module on our Financial Assistance policy. This assures all associates will be aware and can assist our patients in getting the needed information.

Appendix 2

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

Appendix 2

TITLE: FINANCIAL ASSISTANCE POLICY

DEPARTMENT: ADMINISTRATION/FINANCE

POLICY:

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

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

A patient must have a valid social security number in order to be eligible for Financial Assistance.

1. AGH bases Financial Assistance on 200% of the Federal poverty guidelines (Exhibit A). Only income and family size will be considered in approving applications for Financial Assistance unless the amount requested is greater than \$30,000, the tax return shows a significant amount of interest income, or the patient states they have been living off their savings accounts. If one of the above three scenarios are applicable in the application, liquid assets will be considered including checking and saving accounts, stocks, bonds, CD's, money market or any other accounts for past three months along with the past year's tax return and a credit report may be reviewed.
2. Financial Assistance can be applied to all active outstanding balances at the time of approval. Only in extraordinary circumstances will Financial Assistance be applied to a balance transferred to an agency.
3. A patient can be eligible for Financial Assistance in a catastrophic medical situation when medical liabilities are greater than 40% of the annual income or claims totally over \$30,000.
4. Approvals can remain active for one year from date of application provided all information is reaffirmed. If information has changed at time of reaffirmation a new application must be submitted for approval. Medicare deductibles can be included on a previous application if service is within the same benefit year. All information must be reaffirmed. In special circumstances the committee may only grant financial assistance for accounts on the current application and not extend the financial assistance for one year.
5. Patients are not eligible for Financial Assistance if the account is for workers compensation, litigation, or the balance is pending an estate settlement.
6. If a patient is approved for Medicaid with a spend down, financial assistance can be applied to the spend down without completing the application process. A valid 216 or a screen print of the condition/occurrence code screen must be attached indicating the amount of the

spend down. (Note: this does not grant financial assistance for a year, this automatic financial assistance only applies to the spend down.

7. If patients have paid any amount towards their bill prior to approval, the payment will not be refunded.
8. If patients do not comply with insurance requirements which results in a denial by the insurance company, they will not be eligible for Patient Financial Assistance.
9. If patients do not agree with the decision, they can file a written appeal to the Director of Patient Financial Services, who will review the documentation and make a recommendation to the Patient Financial Services Committee for a decision.

Patient Financial Services Procedures

1. Self pay patients or balances after insurance.
 - a) It is the responsibility of the PFS (Patient Financial Services) Associate to determine that all available resources (Medical Assistance, private funding, family members, credit cards and /or payment arrangements) have been exhausted and noted on account.
 - b) PFS will have the patient or representative of the patient complete a Financial Assistance Application. (Exhibit B) Applications may be accepted from the patient by telephone. PFS documents on the signature line the application was verbal.
 - c) PFS updates the account to payer code PCHA (pending charity), plan code PCHA when application is completed by the patient or completed verbally over the phone with the patient/representative. The application **MUST BE COMPLETED** before using payer code PCHA. If patient/representative does not complete the application, payer is SELF. The completed original applications must be sent to the Collection Specialist in Patient Accounting via interoffice mail. A copy of the application (stamped COPY), along with the instruction letter should be provided to the patient/representative or mailed if completed over the phone.
 - d) PFS must put a REGS note type, and note code **PCAC** (Patient Charity Application Completed) with date, time, and initials on all pending financial assistance accounts.
 - e) If patient applies for Medical Assistance and completes our Financial Assistance application at the same time, use payer code PEND for primary and PCHA for secondary.
 - f) If patient has applied for Medical Assistance and approved, our Financial Assistance should be removed from payer except in the case of PAC, then CHAR stays as primary payer.
 - g) If patients are not eligible based on income, but an extenuating circumstance applies, an application with all supporting documentation can be referred to the Committee for review and a recommendation to the Director of Patient Financial Services to forward to senior leadership.

Procedures for Pending Applications

1. The Collection Specialist must follow guidelines below on the applications received:
 - a. Accounts Balances of \$0-\$500 no reminder call to patient
 - b. Account Balances of \$500-\$1000 1 reminder call to patient
 - c. Account Balances of \$1000-\$3000 2 reminder calls to patient
 - d. Account Balances > \$3000 3 reminder calls to patient
2. The patient receives statements based on the schedule below if documentation is not received accounts will automatically transfer to collection agency.
 - a. 2 days Summary Bill
 - b. 4 days Statement 1
 - c. 20 days from Statement 1 (24 days) Statement 2
 - d. 20 days from Statement 2 (44 days) Statement 3 **FINAL NOTICE**
 - e. **10 days from Statement 3 the system will pre-list (Bad Debt pre-list) the account.**
 - f. **7 days from pre-list the system will transfer the account to Collection Agency.**
3. If patient is uncooperative or cannot be located and does not return supporting documentation within 30 days, Collection Specialist may forward account to collection agency prior to completion of the statement cycle for non-compliance. Collection Specialist places account in F/C BMAN and changes payer over ride flag to Y.
4. Messages generated on the statements:
 - a. **Statements 1 and 2 message** – Thank you for utilizing the services of Atlantic General Hospital. Please return all required documentation for your Financial Assistance application or remit payment today. If information is not returned you will be ineligible.
 - b. **Statement 3 message** – This is your final notice. Your account is past due and full payment is required. If payment is not received within 10 days your account may be referred to a collection agency.
5. Accounts may be put on bad debt hold at the discretion of the Collection Specialist if he/she believes the patient/representative needs additional time to send documentation. Accounts are placed on bad debt hold by:
 - a. Entering Collection Status Code BDHD on an account.

Application Requirements

1. Family size – a family unit is defined as all exemptions filed on the income tax return filed for the individual filing the application whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to

be one. If a tax return has not been filed, then income from all members living in the household must be submitted

2. Income – Income is to be determined for the **entire family unit**. It should be supplied for the twelve months preceding the request or for the three months preceding the request. If 3 months is used, multiply the 3 month annual income by four to calculate the annual income. Income must be verified through a recent pay stub **and** the previous years' tax return. The annual income or the annualized income will be compared to 200% of the Federal Poverty Guidelines (Exhibit A) to determine eligibility. If anyone in the family unit owns a business, the net income from the business will be used for the calculation. If anyone in the family unit owns a business, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year tax return 1040 and Schedule C must be submitted.
3. For each family member receiving unearned income the following must be submitted with the application.
 - 1) Proof of Social Security Benefits
 - 2) Proof of Disability Benefits
 - 3) Proof of Retirement/Pension Benefits
 - 4) Proof of Veterans Benefits
 - 5) Proof of Child Support.
4. If anyone in the family unit is not working or has unreported income a signed notarized

statement must be provided by the individual or a letter from a Government Agency that is

providing financial information indicating the amount of the unreported income and/or the

employment status.

5. The amount requested is greater than \$30,000, interest income is significant, or the patients

state they are living off their savings, bank statements, copies of CD's, and bonds must be

provided.

6. If the tax return shows IRA or annuity distributions, the amount will be included in the income calculation unless the patient can prove the funds have been eliminated.

7. After the application is received the Collection Specialist reviews the application and if eligible completes the Approval of Financial Assistance Form. (Exhibit D) If the **patient** is eligible the Collection Specialist forwards the application for approval. Prior to sending the application for approval the Collection Specialist will EVS to insure the patient does not have Medicaid.
8. A decision will be rendered within 15 working days of receipt of a completed application.
9. The Collection Specialist notifies the patient of the decision for Financial Assistance in writing (Exhibit E or F).

Approval

- a) The Collection Specialist completes the Approval of Financial Assistance Form (Exhibit D) and refers the form for the following authorized signatures:

Less than \$2,000	Director of Patient Financial Services
\$2,000 - \$5,000	CFO/Vice President of Finance
Over \$5,000	CEO/President
Over \$30,000	Committee Chair and senior leadership
- b) If the amount requested is greater than \$30,000 the application and supporting documentation will be forwarded to the Patient Financial Assistance Committee for recommendation to senior leadership. All recommendations and decisions will be made on a case by case basis based on the documentation provided.
- c) After the Financial Assistance Application has been approved, the Collection Specialist allowances off the appropriate amount to procedure code: 1031098
- d) The Collection Specialist documents the system and indicates the patient was approved for Financial Assistance and the date of approval.
- e) The Collection Specialist updates all accounts with payer code CHAR (Financial Assistance), plan code CHAR, and enters the effective and termination date of the Financial Assistance on the payer screen. Collection Specialist must be sure the history account has the payer code CHAR listed.
- f) The Collection Specialist monitors accounts using a worklist identifying all accounts where CHAR is secondary and the primary insurance has paid.
- g) Financial Assistance approvals and supporting documentation will be filed by month and maintained for a period of ten years.
- h) Once applications are approved the Collection Specialists forward the applications with supporting documentation to the General Clerk for storage and retention.
- i) The General Clerk balances the Financial Assistance Allowances to the monthly TRANSMTH01 report and provides the report to the Manager for review. The General Clerk files the TRANSMTH01 report showing transaction code 1031098 with the monthly Financial Assistance approvals.

Reaffirmation

- a) If the patient presents for any additional services during the year approval period, the Registrar pulls forward the payer information and payer code CHAR will be present. Registrar verifies the approval dates are within the range of the approval period. The registrar affirms whether or not the patient's information has remained the same. If the information is the same then the registrar will answer "Y" to the reaffirmation question on the payer screen. If information has changed or date of service is outside the approval period, the patient must reapply for Patient Financial Assistance.
- b) If patient returns within the year approval period for inpatient stay or surgical service, patient must be re-evaluated for Medical Assistance and notes posted on account. If the patient was previously approved and has an account greater than \$30,000 within the one year eligibility, a recalculation must be done with liquid assets.
- c) Once the CHAR payer code is on the account the system will automatically write off the balance at time of billing to code 1031098. The Collection Specialist reviews daily the automatic contractual write off report (PBRP110-001) to insure that the reaffirmation questionnaire is completed on the payer screen, and the account date of service is within the effective/termination dates of the 180 day approval period. If the questionnaire has not been answered the Collection Specialist must contact the patient. If CHAR is secondary on the account the Collection Specialist reverses the automatic write off pending outcome of primary payer.
- d) To complete the reaffirmation, Section 4 must be followed and the Reaffirmation form (Exhibit C) must be completed for all accounts greater than \$2000. For accounts less than \$2000 the Collection Specialist must complete the Patient Financial Assistance confirmation (Exhibit G) indicating all information has been confirmed and forward to the Director of Patient Financial Services for approval.

Appendix 3

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

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

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

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

Appendix 4

Appendix 4

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

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

POLICY:

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

Atlantic General Hospital and Health System

VISION

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

MISSION

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

VALUES

These values serve as the foundation for achieving our mission.

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

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

Ethical Commitment

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

BWMC FY09 COMMUNITY BENEFIT REPORT

1. Baltimore Washington Medical Center is a 311 licensed bed facility with 19659 inpatient admissions in FY09.
2. Anne Arundel County is compact but diverse, including within its borders the state's capital and its largest airport, 534 miles of coastline, and long strips of farmland and other sparsely populated territory. Nearly 500,000 residents call Anne Arundel County home.

BWMC Primary Service Area

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

BWMC South Service Area

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

BWMC West Service Area

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

Demographic Characteristics (2007 Estimates)

Total Population	512,154
Median Household Income (2006 inflation adjusted \$)	\$80,158
Families below poverty level	2.6%

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

	Life Expectancy (Years)
White	78.5
Black	77.2
All Races	78.4

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

In FY09, there were 157,920 patient registrations at Baltimore Washington Medical Center. Of these registrations, 20,323 or 12.9% were uninsured.

3. Baltimore Washington Medical Center utilizes the Anne Arundel County Department of Health Report Card of Community Health Indicators to direct community outreach activities each year. This report card is issued by the Anne Arundel County Department of Health and reviewed by BWMC each year. The May 2008 Report Card was utilized to direct FY09 community outreach efforts.

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

4. The Anne Arundel County Department of Health Report Card of Community Health Indicators allows BWMC to research, develop and implement programs that are beneficial to the community. The major community needs identified in the May 2009 report card remained the same from 2008 and were heart disease, cancer, stroke and infant mortality.
5. To ensure that the community's most pressing health care issues are addressed, BWMC's Community Mission Committee continued to meet in 2008/2009. This committee reviews the Anne Arundel County Department of Health Report Card of Community Health Indicators annually. Comprised of select BWMC board members, BWMC foundation board members, BWMC administration and community outreach staff, the committee oversees the hospital's community benefit mission and determines which community needs will be addressed through community benefit activities each year.
6. Infant Mortality/Stork' Nest

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

Women can continue to earn points after their babies are born by taking them to well baby check-ups and making sure they receive immunizations on time. Participants can use the points until their babies are one year old. Any pregnant woman in Anne Arundel County is eligible to participate in Stork's Nest, but the program's emphasis is on engaging pregnant women who do not receive regular prenatal care and are at an elevated risk for having a low birth weight or premature birth – potential causes of infant mortality.

In FY09, BWMC expanded Stork's Nest from six to eight classes with the additional two classes covering the topics of early parenting, Shaken Baby Syndrome, safe sleeping and Sudden Infant Death Syndrome (SIDS). Additionally, a part-time program coordinator was hired to develop relationships and encourage program participation by underserved populations. As a result, BWMC saw a three-fold increase in program participants in FY09 from FY08.

Heart Disease/Day of Dance

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

dance demonstrations and participate in free health screenings such as cholesterol, blood pressure and body mass index. Educational information on heart disease, cancer and diabetes is also available. This wellness event is widely promoted and well attended by all ages of community members.

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

Stroke

As a Primary Stroke Center, BWMC offers a monthly stroke support group that serves as a resource for patients who are recovering from a stroke or who are at high risk for having a stroke. Additionally, informative talks on stroke prevention are offered each year at a variety of locations throughout the community.

Vascular Screenings

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

Results are made immediately available to participants and for abnormal results where follow-up is indicated, a clinician from the Maryland Vascular Center calls the participant's primary physician to discuss the findings.

Cancer

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

7. Program Evaluation

- 1a. Name of initiative: Stork's Nest
- 1b. Year of evaluation: FY09 (ongoing)
- 1c. Nature of evaluation: Comprehensive demographic data is captured on each program participant to ensure the program is serving the target population. Additionally, three-month (obtained earlier if the participant contacts the program coordinator) and 12-month phone calls (based on participants due date) are made to program participants. Infant birth data is obtained and participants are asked a set of questions based on the information presented in the classes (i.e. the proper safe sleeping environment for baby). If indicated, the program coordinator uses this as an opportunity to re-teach concepts. Participants are also asked to rate their satisfaction with the overall program. BWMC utilizes feedback and comments to continually improve Stork's Nest.
- 1d. Result of evaluation: The program coordinator was unsuccessful in reaching 22% of program participants (with due dates on or before 6/30/09) to obtain infant data. Several findings are summarized in the table below:

Enrolled in WIC (Women, Infants and Children)	69%
Attended Eight Classes	54%
Births by Gestational Age (at or >35 weeks)	95%
Baby Birth Weight (at or > 6 lbs.)	85%
Baby Birth Weight (at or > 5 lbs.)	97%
Overall satisfaction with program	100%

- 2a. Name of initiative: Prostate Screening Follow-Up
- 2b. Year of evaluation: 2009 (June)
- 2c. Nature of evaluation: Prostate results from both the PSA blood test and the digital exam (DRE) are reviewed by the screening physicians. Follow-up letters are mailed to all screening participants. This letter contains screening results and if indicated, the recommended follow-up such as scheduling an appointment with a physician. Additionally, all abnormal screenings are followed-up with a phone call from BWMC's Tate Cancer Center outreach and education coordinator. During this call, the coordinator verifies that the participant received and understands the screening results. The outreach and education coordinator is also able to link the participant with an appropriate physician if the participant has not already selected one. The coordinator also follows up by phone 6-8 weeks later to determine if the participant is receiving appropriate care.

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

- 2d. Result of evaluation: 108 men participated in the prostate screening offered at BWMC on June 11, 2009. It was determined that 20 men had abnormal findings (abnormal PSA, DRE or both). This represents approximately 18.5% of participants. Attempts were made to contact the 20 men - the outreach coordinator was successful in reaching 12 participants. (7 participants did not return our calls and one participant did not provide a working telephone number). 19 participants have or will receive two follow-up phone calls from the outreach coordinator during the 12 month post-screening period.
8. While Anne Arundel County is generally not considered underserved, there is a significant portion of the population surrounding BWMC that houses an underserved, uninsured and indigent population.

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

OB/GYN Services

Baltimore Washington Medical Center did not operate a hospital-based obstetrics program in FY09, however a \$117 million expansion project was completed in September 2009. In addition to four labor, delivery and recovery rooms, two dedicated operating rooms for Cesarean births and 18 private post-partum rooms, BWMC patients have access to the resources within the University of Maryland Medical Center's (UMMC) women's health program. These valuable resources include a satellite office of the University of Maryland's Center for Advanced Fetal Care, prenatal genetic counseling, critical care obstetrics and fertility services through the Center for Assisted Reproductive Technologies offering diagnostic testing and clinical support services for the community, including the underserved population regardless of insurance status or ability to pay.

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

Appendix 1

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

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

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

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

Appendix 2

Financial Assistance Policy

POLICY

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

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

RESPONSIBILITY

Vice President of Finance

PROCEDURE

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

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

Appendix 2 continued

PROCEDURE continued

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

ORIGINATOR

Senior Vice President and Chief Operating Officer

REVIEW CYCLE

3 Years

Appendix 3

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

Appendix 4

VISION STATEMENT

Outstanding People, Exceptional Service,
Uncompromising Quality

MISSION STATEMENT

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

Bon Secours Baltimore Health System 2009 Community Benefit Narrative

Bon Secours Hospital (“BSB” or the “Hospital”) is a 125 bed facility with 6,719 admissions for the fiscal year ended August 31, 2009. Bon Secours Hospital serves west, north and southwest Baltimore where almost one third of the city’s total population reside. Dominated by the elderly, women and children, BSB’s service area includes some stable neighborhoods as well as many neighborhoods facing significant social challenges in the areas of housing, employment education and health. Slightly more than half of BSB’ admission’s are either Self- Pay or Medicaid patients.

The main focus of the community efforts by Bon Secours Hospital is the immediate area around the Hospital’s campus. Represented by Operation Reach Out Southwest (“OROSW”), this area contains a community of approximately 21,000 persons containing 13 distinct neighborhoods surrounding Bon Secours Hospital. Although the community is located in close proximity to the hospital it meets the federal guidelines of a medically underserved population. Not surprisingly, the residents of these neighborhoods have some of the worst indicators of poor health status in the State. Our residents have some of the highest rates in the State for childhood diseases, breast and cervical cancer, poor nutrition, cardiovascular disease and diabetes. The community has been challenged by a host of social and economic ills including, vacant housing, high unemployment, illicit drug activity and drug related crime.

Bon Secours approach to needs assessment is a collaborative one. Bon Secours works very closely with OROSW to develop, implement and monitor community benefit programs. OROSW, in partnership with Bon Secours, has developed and is implementing a 20 year revitalization plan in which Bon Secours has and will continue to serve as an anchor of stability and hope.

Decision making ultimately rests with the BSB board. The board works closely with the Executive Leadership Team of Bon Secours Hospital, the Executive Director of the Bon Secours Foundation, the Bon Secours Foundation board and the national Bon Secours Health System, Inc. (“BSHSI”) board to insure the most effective use of the resources available. Ongoing needs assessment is done by Foundation staff and OROSW.

With participation from over 200 residents and local stakeholders, BSB and OROSW completed a comprehensive revitalization plan in 1998. This plan includes a vision statement and desired outcomes and strategies in each of six issue areas: economic development, education, health, physical planning, public safety, and enriching activities for youth and seniors. Programs have been launched and many positive outcomes have been achieved in each of these areas, including:

- 559 units of affordable housing for the elderly;
- Over 400 people placed in jobs through the OROSW Career Development Program;
- More than 200 graduates of the OROSW Youth Employment and Entrepreneurship Program;
- Establishment of Our Money Place, a community-based financial service center at which over 1,100 West Baltimore residents have opened accounts;

- Over 1,000 families served through the Bon Secours Family Support Center; and
- 600+ vacant lots transformed into green space through our Clean & Green Program.

Much of the coalition's work has moved from a planning and implementation focus to one of managing programs and services. The Coalition's current leadership has aged and there is an effort underway to engage younger community residents into leadership roles. A major challenge is maintaining participation and related momentum at all levels (coalition, neighborhood, and block). This is critical because much remains to be done and we have learned that the most successful initiatives are resident led and community driven.

Through the OROSW coalition, we have set up a decision making infrastructure that ensures meaningful resident participation in *planning and implementation*. We have also learned that success is more certain when you reverse thinking from addressing deficits in the community to building upon assets. We have also learned that success is more likely when we implement strategies and initiatives that are consistent with the communities' plans *and* appropriate to our organizational resources and skills.

Although the original 20 year vision and plan remain as our overarching "roadmap", we periodically engage in specific engagement projects in order to assess current levels of community needs. Most recently we held a Health Care Community Discussion as part of the Obama-Biden Transition effort in late December 2008 and are continuing this effort in partnership with OROSW and several community service providers. The coalition steering committee has identified three committees (Crime & Grime, Housing & Physical Planning, and Health) that are meeting to identify priority issues/projects to present to the broader coalition membership in early 2010. In November 2009, we

launched a community health engagement process in partnership with OROSW and with assistance from the University of Maryland at Baltimore Social Work Community Outreach Service who are providing the staff organizing and outreach aspects of the process. The goal of this project is to engage the community around the hospital in a process that should culminate with:

- an agreed-upon *vision* of an improved healthcare system which leads to a healthier community *and* is financially sustainable
- a *plan* to achieve our vision

This planning process will conclude its next phase in June 2010 and should identify specific desired outcomes and strategies towards the realization of our newly defined vision.

Appendix 1**Bon Secours Baltimore Health System****Description of Charity Care Policies**

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

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

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

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

BSBHS is required to adhere to the system-wide Patient Financial Assistance/Charity Care Policies. These policies have been attached for your information and use ("Appendix 2").

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

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

Appendix #3**Bon Secours Health System, Inc.
System-Wide Policy Manual**

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

Policy

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

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

Procedures

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

Procedure**Policy Section**

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In the absence of the above two points...

- The most current account

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

Program Enrollment Assistance	POLICY No. CYC-01/FAP_0025 Section 7
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- 7.1 The Medical Eligibility Vendor/Medical Assistance Advocacy screens referred patients for eligibility for the following programs (this list is not inclusive of all available programs) :
- SSI Disability / Federal Medicaid
 - State Medicaid
 - Local/County Medical Assistance Programs
 - State-Funded Charity Programs
 - BSHSI Patient Financial Assistance Program
- 7.2 The Medical Eligibility Vendor/Medical Assistance Advocacy assists the patient in completing and filing application forms for all programs for which the patient may be eligible, including the BSHSI Patient Financial Assistance Program.
- 7.3 The Medical Eligibility Vendor/Medical Assistance Advocacy forwards the completed Patient Financial Assistance Program application form (and any documentation) to Patient Financial Services for processing.
- 7.4 Patients should be encouraged to apply for financial assistance as soon as possible, and in the State of New York, Patients will have at least ninety (90) days from date of discharge or date of service to apply for financial assistance

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

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

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

UNINSURED ONLY:

Note: This Table Does Not Address New York Patients.

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

UNDERINSURED ONLY:

Note: This Table Does Not Address New York Patients.

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

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

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

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

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

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

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

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

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

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

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

**Prepared
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Related Policies & Procedures; Notes; Controls:

**Revision Date:
(Use if Revised.)**

**Review Date:
(Use if Reviewed
No Changes.)**

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

Filename: BC

E5101

Date: September, 1999

Appendix 3

Description of Mission, Vision and Values

While in many ways the Mission of Bon Secours speaks for itself, an outside observer would benefit from the knowledge that the Mission is driven by and sustained through the Eight Core Values of the system. They are Respect, Justice, Integrity, Stewardship, Innovation, Compassion, Quality, and Growth.

It is part of the culture of Bon Secours to live these values on a day to day basis. They drive the System's desire to treat patients in a holistic way, by treating mind, body, and spirit.

Our community benefits programs reflect the System's desire to help the people of West Baltimore attain and maintain good health by helping in the areas of housing, career development, and health awareness.

It is through the values of Respect and Justice that we strive to provide adequate housing. It is because of the values of Integrity and Stewardship that we seek to use the resources available in the most effective manner. Compassion and Quality compel us to treat all patients in a caring way. And Innovation and Growth drives our desire to continue to serve the community for many years into the future.

Appendix #4

BON SECOURS BALTIMORE HEALTH SYSTEM

MISSION

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

VISION

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

VALUES

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

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

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

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

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

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

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

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

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

Calvert Memorial Hospital

FY 2009 Community Benefit Narrative Report

1. What is the licensed bed designation and the number of inpatient admissions for FY2009?
 - The licensed bed designation is 105 beds. The number of inpatient admissions (acute adult - 8333 and newborn - 876) for FY 2009 is 9209.

2. Describe your community:
 - Calvert Memorial Hospital is the sole hospital provider in Calvert County, Maryland. Calvert County is located in Southern Maryland and is essentially a peninsula bordered on the east by the Chesapeake Bay and on the west by the Patuxent River. With a long and skinny topography, the county's "spine" is Maryland Routes 2/4 running from Dunkirk in the north to Solomons Island in the south for approximately 45 miles. This topography presents challenges to both transportation and service delivery that are unique to Calvert County. In response to this unique topography, Calvert Memorial Hospital strategic goal is to ensure access to primary care services within a 15 minute drive from any county location and specialty care within 30 minutes. In addition, Calvert Memorial Hospital secondary market area includes the surrounding areas of southern Prince Georges and Anne Arundel Counties, St Mary's County on its southern border and Charles County on its western border.

 - Calvert County is in the outer ring of suburban Washington, D.C. Estimated growth rate for the county was nearly 18% for the period from 2000-2005. Population density increased in the county from 238.7 to 346.5 people per square mile over the period of 1990-2000. Population projections are for Calvert to continue to grow to 95,700 in 2010 and 100,700 people in 2020. The future is projected to bring small growth in population of young people, large increases (on a percentage basis) of the elderly, and modest growth in total number of households and in size of the labor force. Calvert County's estimated median household income for 2008 is \$81,662. Despite its relative high income level, Calvert County is home to people who live in poverty. US Census American Community Survey data indicated that 5% of families in Calvert had income below the federal poverty level. The census revealed a relatively high rate of poverty among children (about 5%) and among the elderly (about 6%). Financial analysis of FY2009 for Calvert Memorial Hospital reveals that 5.2% of gross revenue is from self-pay or uninsured patients and 10.5% of gross revenue is from Medicaid recipients. Maryland Vital Statistics report that Calvert County's mortality rate for all causes of death is 689.2 per 100,000 people which is below the state average of 781.7 deaths per 100,000

people. Heart disease and cancer are the leading causes of death in Calvert and higher than the other surrounding counties. Death from cancers in Calvert County is higher than the Maryland state average.

3. Identification of Community Needs:

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

- In the fall of 2007, the Community Wellness Department of CMH surveyed its Faith-Based Ministry Council for their concerns and perceptions regarding the health of the community and what recommendations they had for CMH to address in future planning.
 - In January 2008, CMH's 2004 Medical Staff Development Plan was updated . This process is completed every 4 years. Applying very specific quantitative analysis along with qualitative medical staff input, the study showed the need for a significant number of primary care physicians as well as medical and surgical sub-specialties.
 - In the Spring of 2008, CMH's Board of Directors initiated a strategic planning process for the years 2009-2012. The purpose of the Plan is to amalgamate and synthesize the key findings and recommendations of key studies and to present a "roll-up" of recommended actions that remain to be implemented. The plan was completed in FY-09 and serves as a guide for service development, implementation and continuation.
 - The local health department is integral to the assessment and planning of health care services at CMH. Through active participation on the Community Health Roundtable and other collaborative efforts the hospital and the health department work closely to improve the health of the community. For example, both the county health officer and the hospital's CEO presented the results of the community health assessment to the county commissioner's at their meeting on December 16, 2008.
4. List the major needs identified through the process explained in question #3:
- The recent community health assessment identified six (6) areas of concern:
 - Children's and adolescent health issues: alcohol and drug use; teen pregnancy; juvenile crime; pediatric dental care and autism
 - Elderly care and end-of-life issues: support services for family caregivers; skilled nursing services; assisted living services and end-of-life care; medical management of disease related to aging
 - Recruitment and retention of health care providers with emphasis on access to a local physician in a timely manner
 - Motor vehicle crashes
 - Mental health services
 - Increased prevalence of obesity
 - Care for the uninsured
5. Who was involved in the decision making process for determining which needs in the community would be addressed through community benefit activities of the hospital.

- The Community Health Assessment was presented at the Board of Director's Planning and Marketing Committee as well as at their annual board retreat to discuss which areas should be addressed by CMH. The Board of Directors, under the CEO's guidance, was also instrumental in developing the hospital's recent Strategic Plan Update. During the preparation of the Strategic Plan, input was solicited from hospital department directors, the President's Panel (comprising staff representative of all the major hospital departments) and the Executive Team.
6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

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

- Lack of Pediatric Dental Care for the Medicaid Population: CMH has been attempting to address this serious issue for several years by working with the local dental community and other key stakeholders. Just recently, a new plan was developed that utilizes contract dental providers providing services in already existing, under-utilized dental space with the hospital as the billing agent and program coordinator. Though this initiative was awarded at the end of FY08, funding was not received until winter FY09 from MD's DHMH Office of Oral Health. In FY09, staff were hired, contracts with dentists and local dental offices for space were completed, supplies ordered, operating plan developed and policies and procedures written. Patients started receiving care in FY10.
- Care for the Uninsured: CMH has served on the Board of Director for Calvert HealthCare Solutions. This organization is a grass-roots effort to utilize existing medical resources in the community to provide primary care for the uninsured who meet income qualification guidelines. CMH has written several grant proposals to assist this organization in its mission. One recent grant that CMH is managing is from the Maryland Community Health Resource Commission (MCHRC). Its goal is to reduce inappropriate utilization of Emergency Services by those without health insurance. CMH provides a case manager to work with those who are uninsured to help them establish a medical home. CMH also provides basic lab and Xray diagnostic tests to those enrolled in Calvert HealthCare Solutions at no-cost. In FY09, this totaled \$70,339. In FY09, it was also identified that there was a need for daily operational leadership for Calvert Healthcare Solutions so a grant was also obtained by CMH to assist in the funding of the Executive Director until local fundraising is sufficient to cover this expense. An employee of CMH was selected by the Board of Directors of Calvert Healthcare solutions and is serving the organization in a part time capacity while the hospital employees him fulltime and covers his benefits.
- Lack of access to primary and specialty medical care: CMH has taken this problem area as a major initiative. This lack of access results in excessive wait times for appointments, inappropriate use of Emergency Services, seeking care out of the area at hardship to the

patient and family, disease progression due to not receiving health care as well as other problems. CMH regularly reviews and updates its Physician Recruitment and Retention Dashboard to keep the Board of Directors, medical staff leadership and community stakeholders apprised of its efforts to improve access to care. CMH employs a physician recruiter to assist with this effort as well as works with local area physicians to assist them with recruitment. In recent months, CMH has increased the employment of physicians in order to meet this critical community need. Currently CMH owns 3 family practices, one each in the southern, middle and northern regions of the county ensuring that primary care is accessible with a 15 minute drive of any region of the county.

Lack of access to specialty care continues to be a challenge as the patient population is not sufficient to support many specialty services. In order to provide these services, CMH has entered into a variety of collaborative partnerships with tertiary care facilities to provide diagnostic evaluation services at CMH with access to the tertiary hospital for treatment if necessary with follow-up at CMH. This model has been very successful in providing vascular services (from Washington Hospital Center), neurospine services (from Georgetown Hospital), pediatric cardiology services (from Children's Hospital), high-risk OB services from Johns Hopkins and starting in Sept 09, gyn-oncology services from Mercy Hospital.

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

A) Pediatric dental care for Medicaid population

- Grant was awarded at the end of FY08 but funding not distributed until winter FY09 .
- During FY09, program guidelines completed, relationships with area dentists developed and contracts for leasing of their space were completed, staff hired and trained, targeted advertising delivered and patients started being provided services in the summer 2009.
- A formal evaluation will be completed after one year of grant funding though there is ongoing evaluation after each dental session and problem areas addressed.

B) Access to care for the uninsured

- Calvert Healthcare Solution's annual report is not yet completed for FY09.
- Grant from MCHRC totaled \$500,000. It is titled "Aligning Community Health Resources: Improving Care for Marylanders in Calvert County" and is a three grant.

- Milestones to date:
 - 16 specialty providers recruited to provide services at Calvert Healthcare Solutions
 - 213 new clients enrolled in Calvert Healthcare Solutions
 - 362 physician offices visits
 - 32 new sliding scale patients initiated care at hospital clinics
 - 613 patients seeking care in the Emergency Department contacted through case management with 85 of these actually obtaining follow-up services.
 - 1 patient received 7 mental health visits at the Health Department
- Result of Evaluation: \$182,957 estimated to remain unspent at end of grant period. Modification request submitted and approved for a one year extension. Program will now incorporate a RN care coordinator to provide medication and nutrition counseling in addition to wellness and disease prevention coaching for all Calvert Healthcare Solution patients. Additional services provided to this population include: free health risk assessment and lifestyle coaching, diabetic self-management classes for eligible patients who are newly diagnosed with diabetes, delivery of 2 Health and Family Fairs in collaboration with community partners, development of a health and human services resource guide and improvements to the database and tracking system.

(C) Recruitment of primary care and specialty care providers

- Calvert Memorial Hospital generally prepares a bimonthly dashboard for physician recruitment and retention status that is provided to the Board of Directors and key hospital leaders. For the end of FY09, the physician needs survey indicated the community needs the following:: 1 family practice MD, 2 pediatricians, 1 cardiologist, 1 gastroenterologist, 1 oncologist/hematologist, 1 psychiatrist, 1 vascular surgeon, 1 plastic surgeon, 1 ENT MD, 2 orthopedic MDs, 1 OB-Gyn, and 1 urologist. The hospital has successfully recruited 1 psychiatrist, 1 general surgeon, and 1 OB-Gyn MD.
 - Efforts will be continued in the next year with full reassessment of needs to be done 2012.
8. Describe gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured in the hospital.

- The Maryland Physician Workforce Study indicated that in Southern Maryland there are shortages in all specialties with the exception of allergy and neurology. This accounts for 24 specialties or 83% of all specialties reviewed.
 - Calvert Health Care Solutions works with local area physicians to try to arrange primary and specialty care services for patients enrolled in their program. This has had very limited success for specialty care with better success in primary care services.
 - Physicians employed by CMH are expected to provide medical care to the uninsured as appropriate for specialty area. At the end of FY09, these specialty areas include one gastroenterologist, two general surgeons, one ENT surgeon, one spine surgeon, and two OB-GYN surgeons. CMH has continued to support a fulltime hospitalist and fulltime pediatric hospitalist program so that any patient seeking inpatient care at this facility is ensured quality medical services. In the recent year, CMH has opened a third family practice center with hours available for walk-in patients and continues to support a family practice in the southern region of the county with two physicians and the Twin Beaches Community Health Center which provides primary care to both the insured and uninsured, using a sliding scale process.
 - Hospital-owned physician practices require substantial start-up funding. For the first several years, it is not uncommon for these practices to experience a net revenue loss. The types of practices that the hospital funds are based on the physician needs assessment and community needs assessment.
9. If you list physician subsidies in your data, please provide detail.

• Emergency Psychiatric Services	\$362,584
• Psychiatric On-Call Coverage	\$ 15,680
• Emergency Dept call Coverage	\$182,328
• Ob-Gyn Call Coverage	\$ 19,149
• Hospitalist Program Subsidy	\$540,294
• Pediatric Hospitalist Program	\$357,298
Total	\$1,477,333

Calvert Memorial Hospital

FY 2009 Community Benefit Narrative Report

Appendix 1:

Description of Calvert Memorial Hospital's Charity Care Policy and How Its Communicated

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

- 1) The Hospital posts a summary of our financial assistance program at all registration points within our hospital.
- 2) All registration areas and waiting rooms have Patient Financial Services brochures that describe the Hospital's Financial Assistance Program and provides a phone number for our Patient Financial Advocate for the patient to call to seek additional information or an application.
- 3) As part of the registration process, all self pay patients receive three items: 1) a "Notice of Financial Assistance", 2) a Patient Financial Services brochure which has a summary of the Hospital's Financial Assistance Program, and 3) the Uniform State of Maryland Application for Financial Assistance.
- 4) The Hospital's website has a section devoted to Patient Financial Services and has an entire page on the Hospital's Financial Assistance Program and allows the user to download the Uniform State of Maryland Application for Financial Assistance from our website.
- 5) At least annually, the Hospital publishes in the local newspapers a Notice of Financial Assistance and also highlights other programs the Hospital offers for patients without insurance or for patients in financial need.
- 6) The Hospital also provides financial counseling to patients and discusses with patients or their families the availability of various government benefits, such as the Medical Assistance program and we also assist patients in understanding how to complete the appropriate forms and what documentation they need in order to prove they qualify for such programs.
- 7) Effective June 2009, the Hospital provides a notice of its Financial Assistance program at least twice in the revenue cycle. The first point is at the time of admission and the second point is when patients receive their bill/statement.

Calvert Memorial Hospital

FY09 Community Benefit Narrative Report

Appendix 2

Charity Care Policy

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

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

FINANCIAL ASSISTANCE

I. PURPOSE

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

II. SCOPE

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

III. POLICIES

- **Provision of Financial Assistance**
CMH recognizes that the provisions of Federal Anti-Kickback Laws may be violated when an organization forgives financial obligations for reasons other than genuine financial hardship because this could be interpreted as unlawfully inducing the patient to request the provision of medical services. Therefore, financial assistance will be provided to patients solely based upon the patient's ability to obtain assistance through appropriate agencies (i.e. appropriate Department of Social Services), and the patient's ability to pay. CMH also recognizes that as a not-for-profit hospital, part of its mission is to provide appropriate and high quality medical care, within the resources available, to members of its community regardless of the patient's ability to pay.
- **Financial Advocacy**
The Hospital supports financial advocacy for patients through the role of the Financial Advocate. The Financial Advocate's role is to:
 - Interview and assess the financial needs of our patients
 - Review the patient's financial and medical status against the eligibility criteria for Medical Assistance for a possible referral

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

- **Elective Services**

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

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

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

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

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

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

- **Hospital Financial Assistance Guidelines**

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

PROCEDURE

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

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

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

- D) A special exception for financial assistance may be considered in circumstances where the patient is over the income scale if the patient has a significant medical debt to the hospital and has no net assets. Any special exceptions must have the approval of the President and CEO.
- E) Once a financial assistance application has been approved, all medical services provided three months prior to the approval date may be included in the charity care adjustment upon written request by the patient/guarantor. The initial eligibility period is six (6) months. Each patient will have to reapply at the end of each six-month period in order to continue in the financial assistance program. If there is a change in financial circumstances during the initial or subsequent six-month period such as income or family status, an updated or new application must be completed.
- F) All financial assistance applications along with all supporting documentation should be kept in accordance with the hospital's record retention policy, currently a minimum of 5 years.
- G) The Financial Advocate will keep a database of all financial assistance applications. This database will include the following information:
 - a. Patient Account Number
 - b. Determination of eligibility
 - c. Income
 - d. Family size
 - e. Approved charity care adjustment
 - f. For denied accounts, reason for denial
 - g. Zipcode
 - h. Account Type (Hospital Service)

APPROVED:

**Dean Schleicher, Chairman
Board of Directors**

James J. Xinis, President & CEO

Kirk Blandford, Vice President of Finance

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

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

Exhibit A

Documentation Requirements

Verification of Income:

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

Size of family unit:

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

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

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

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

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

Calvert Memorial Hospital

FY 2009 Community Benefit Narrative Report

Appendix 3

Description of Hospital's Mission, Vision and Value Statement

Calvert Memorial Hospital revised its Mission, Vision and Value statement in 2005 after extensive input and review by the staff, managers, executive team and Board of Directors. There was an educational program for the hospital leadership on the value of a mission and vision statements as well as the guiding value statements. It was agreed that the statements should be simply written, direct and say exactly what we hope to provide to our community. This way it is easier for staff to remember and follow in everyday circumstances.

The Pillars of Excellence” were adopted as guiding principles after review by our Service Excellence Team. Since its adoption, the Pillars are used in preparing the strategic plan, the annual budget, annual personnel evaluations as well as establishing priorities for new program development, approval and implementation.

This revision in 2005 has stood the test of time over the past three years. It was reviewed in 2008 and no revisions were felt to be necessary at this time.

Calvert Memorial Hospital

FY 2009 Community Benefit Narrative Report

Appendix 4

Hospital's Mission, Vision and Value Statement

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

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

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

QUALITY

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

SERVICE

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

PEOPLE

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

INNOVATION

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

FINANCE

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

Approved CMH Board of Directors

Approved: 11/28/95

Revisions: 2001, 2002, 2005, 2008



FY 2009 Community Benefit Narrative

■ 1) Carroll Hospital Center (CHC) is a private, non-profit 213-bed acute care facility, governed by a community board of directors. In FY 2009, the hospital had 16,178 inpatient admissions and an annual total of more than 315,000 patient encounters for inpatient and outpatient medical care. With 1,763 employees we are the second largest employer in the county.

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

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

Geography

Land area	452 sq. miles (289,280 acres)
Persons per square mile (2008)	387
Land in farms (2002)	147,252 acres
Agricultural Land Preservation farms (1996-2007)	452
Agricultural Land Preservation acres (1996-2007)	51,296

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

Population

Total population estimate (2009)	175,192
Projected population (2010)	182,800

Race (2008):

White	157,777	93.2%
African American	6,775	4.0%
Hispanic	3,194	1.9%
Asian/Pacific Islander	2,731	1.6%
Native American	396	.2%

Age (Projections for 2010):

0 – 4	10,814
5 – 19	40,584
20 – 44	52,013
45 – 64	51,677
65+	20,812

Sources: Carroll County Department of Planning, MD State Data Center Carroll County Demographic and Socio-Economic Outlook

Family

Total number of households (2008)	51,663
Average household size (2008)	2.8 persons

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

Economics

Per capita personal income (2007)	\$ 41,147
Median household income (2007)	\$ 78,200
State rank	11th
Households below poverty level (2008)	5,565, 8%
Unemployment rate (2009)	6.5%
Median cost of homes purchased (2008)	\$299,450
Housing units authorized for construction (2007)	312

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

Business

Private non-farm establishments with paid employees (2007)	4,650
Private non-farm employment (2005)	51,718

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

Other Significant Demographic Characteristics

According to the most recent MD BRFSS (Maryland Behavioral Risk Factor Surveillance Survey) data report (2008), our community has a high rate of insured residents with 96.3% of residents reporting that they have some level of health insurance. In 2009, of the Carroll County residents that were hospitalized (either at CHC or other hospitals), 2,259 or approximately 10% were Medicaid admissions and 290 or 1% were uninsured.

■3) Identification of Community Needs:

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

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

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

To track and trend our progress as a community, The Partnership has organized Healthy Carroll Vital Signs - Measures of Community Health. This data is provided by various sources including the Carroll County Health Department and other branches of the Carroll County Government as well as through hospital-based community outreach activities and education. (Data Charts Attached) Since not all of the data charts are updated each year, The Partnership developed a dashboard report to track progress and outcomes of key indicators (Attached).

Other Assessments used include:

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

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

Hospital/Partnership Work Groups

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

Additional Partners Utilized in Community Need Assessment

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

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

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

- Patients
- The Partnership for a Healthier Carroll County (with our community partners)
- The Learning Center
- The Women’s Place
- The Marketing, Business Development and the hospital’s multidisciplinary Community Benefit Planning and Review Team
- The hospital’s executive team and Board of Directors

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

- \$5,210,626 in charity care provided to more than 4,865 patients by the hospital.
- Access Carroll, a free clinic offering care to the uninsured of the county, with over 6,340 visits last year.

- In-home and inpatient Hospice services offered with 20,211 encounters provided last year regardless of a patient's ability to pay.
- Significant investment made to ensure an adequate number of physicians to provide primary care and specialty medical care.
-
- SAFE program for pediatric and adult victims of sexual assault.
- Free or low-cost screenings for blood pressure, cancer, heart disease, osteoporosis nutrition and vascular abnormalities provided to 1,610 people to help prevent and manage disease and wellness.
- More than 2,524 support group encounters to help people manage diseases like prostate and breast cancer, diabetes, Parkinson's disease, fibromyalgia, Crohn's and Colitis, MS and Lupus.

■ 7. In addition to the evaluations listed in the attached reports, the hospital also surveys program participants, tracks participation in programs/screenings/support groups and stays well-connected to industry and health care trends. A dashboard report also was developed by the Community Benefit Planning and Review Team to monitor progress on key CB Indicators (Draft Attached).

Examples of specific outcomes include:

A. Lose to Win Program

Description: Twelve-week collaborative community program to promote weight loss and wellness.

Year of Evaluation: Developed in early 2009, our first session was held in the spring of 2009.

Results/Evaluation: As a result of a healthy collaboration between Carroll Hospital Center and its partners in the South Carroll (Eldersburg) area, Martin's Food Market, Merritt Athletic Club and Samsara Salon & Spa, the Lose to Win Wellness Challenge marked its successful completion on May 21. Fourteen participants, 13 females and one male, lost a combined total of 174 pounds during this innovative and rigorous 12-week program that featured:

- Unlimited access to exercise sessions at Merritt Athletic Club
- Weekly group nutritional classes at Martin's Food Market
- Weekly weigh-ins and regular blood pressure checks
- Weekly prize incentives
- Pre- and post-program comprehensive blood profiles

While everyone involved was a big winner, the biggest loser was Christine Hohl who dropped 30.2 pounds, 15.8 percent of her body weight. Christine won a Grand Prize gift basket that included a certificate for a complete personal makeover from Samsara valued at \$300, a \$150 gift certificate to Martin's, free massage and yoga classes at The Women's Place at Carroll Hospital Center and a variety of other goodies.

While the results for the initial program were good, changes were made in the candidate criteria and selection and program format and the second session (held this fall), had even better outcomes:

20 out of 21 people stuck with the 12-week program

The group lost a total 340 pounds

1st place - Lost 14.6% of her body weight

2nd place - Lost 12.6% of his body weight

3rd place - Lost 12.0% of her body weight

Weight loss ranged from 5 to 34 pounds.

Reductions in:

Body Fat - 15 people

Total Cholesterol - 13 people, LDL - 8 people, Triglycerides - 14 people

Three people saw significant reductions in blood sugar and blood sugar control (based on fasting Blood Sugar)

B. Best Beginnings Program

Description: Program to provide women without health insurance access to high-quality prenatal, labor and delivery, and in-hospital newborn care at an affordable cost.

Year of Evaluation: FY 2009

Results/Evaluation: In place since August 2007, the Best Beginnings Program has provided uninsured women with vital prenatal care in addition to in-hospital labor, delivery and newborn care who otherwise would not have access to such services. The program is a joint effort between the hospital and its affiliated physicians who agree to see and care for patients for a nominal fee, ensuring a healthier pregnancy, delivery and newborn.

The program was revamped and renamed in FY 2008 and outreach was done to at risk populations to ensure those individuals were aware of the program. There were a total of 35 patients in FY 2008 and the hospital was able to provide the program to an additional 35 patients in FY 2009. All mothers had successful deliveries with newborns at or over normal birth weight. What's most notable is the increase of women we reached during their first trimester instead of later in their pregnancies, which helped significantly to having both mom and baby healthy throughout the pregnancy and delivery. In FY08 only 16, or 46%, of the 35 women were in their first trimester but in FY09 we were able to enroll 23, or 66%, of the 35 participants in their first trimester when we could more positively affect the pregnancy and delivery.

The hospital plans to continue to monitor the above and also investigate other effective measures to report and track outcomes in FY 10.

■ **8. Gaps in Care:** Like most hospitals, Carroll Hospital Center is challenged to provide care to an ever-increasing number of uninsured patients. Last fiscal year, more than 2,500 patients received some form of charity care/financial assistance from the hospital, totaling \$5,210,626. Assistance ranged from emergency, inpatient and outpatient care and testing that was written off, to care provided in our free outpatient clinic, Access Carroll.

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

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

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

To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Carroll Hospital Center has continued two major, costly initiatives to address the gap proactively. First, the hospital contracts with ten medical specialties to ensure 24/7 coverage in the ED. Those specialties include neurosurgery; general, plastic, vascular and oral surgery; orthopaedics; urology; podiatry; ophthalmology and ENT. Implemented in January 2006, in FY09, the expense to pay physicians for ED call has cost the hospital nearly \$689,198.

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

Another ongoing significant undertaking in the hospital's mission to continue to provide for the uninsured is our partnership with the Carroll County Health Department to fund Access Carroll, a health care facility that cares for uninsured people in the area. Many Carroll Hospital Center affiliated physicians and specialists donate their time to and accept referrals from Access Carroll. In FY09, Access Carroll had 6,340 patient visits, up 18% from

FY 08, with the number of individual patients served up 36%, from 2,048 in FY08 to 2,818 in FY09. Access Carroll also has distributed nearly \$470,553 in free medications to its clients. This clinic will hopefully continue to ease the use of the ED as a source of primary care for the uninsured and ensure they have access to general health care when they need it, so health conditions don't worsen due to their inability to pay for services. In only its third full year, Access Carroll has been very successful in helping its patients manage chronic diseases including diabetes, hypertension, respiratory conditions, chronic pain and mental health issues.

As the population continues to grow, demand for physicians continues to increase in virtually all specialties while the supply of physicians continues to decrease. The trend is leaving hospitals faced with significant challenges in recruiting and retaining the number of physicians required to continue to provide adequate health care access for all patients. In FY 09, \$3.7 million was spent in recruiting and retaining physicians.

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

Equally as important, is access to physicians on an outpatient basis, not just for the uninsured, but for all patients in our growing community. To ensure our community has access to quality physicians, Carroll Hospital Center continually monitors statistically calculated need by developing a comprehensive medical staff development plan based on the health care needs of our medical service area. The report includes both an analysis of the hospital's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. The physician needs assessment methodology used is based on a qualitative standard established by the Internal Revenue Service (IRS). The report guides the hospital's recruiting strategy, helps us to prioritize recruiting efforts and allows the hospital to place contingencies on recruited physicians to ensure they see medically underserved, uninsured, Medicare and Medicaid patients. Just over \$6 million was spent in various physician subsidies in FY 2009.

APPENDIX 1



FY 2009 Community Benefit CHARITY CARE – Financial Assistance

Carroll Hospital Center (CHC) has a number of programs to assist patients with their payment obligations. First, we provide a Medicaid enrollment service to patients who qualify for medical assistance. This service assists patients with paperwork and will even provide transportation if needed. This past year, CHC successfully enrolled 530 patients in the state's medical assistance program. In addition, the hospital held a free enrollment session for "Cover the Uninsured Day" for uninsured community members to come in to see if they qualified for medical or financial assistance.

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

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

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

Department:	FINANCE
Subject:	FINANCIAL ASSISTANCE APPLICATION
Effective Date:	January 01, 2005
Revised:	November 18, 2009

I. Purpose

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

Policy Statement/Philosophy

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

III. Procedures

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

- A. All services considered medically necessary are covered under the Program for patients living in the primary or secondary service area of the Carroll Hospital Center, and for patients referred by a physician affiliated with the hospital.
- B. For non-United States citizens, services that can be postponed without harm to the patient or that are not medically necessary are not covered under the program.
- C. Applicants with medical expenses >\$1,500 who meet eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration. If eligibility criteria according to Hospital Support Services, (age 21 – 64, not disabled and no children), is not met, the Medicaid application process is omitted and the Financial Assistance application is started. The Hospital Support Services representative will submit a letter stating the patient is considered not to be a medical assistance candidate.
- D. Patients with medical expenses <\$1,500 are strongly encouraged to file for Federal Medical Assistance. However, the Medicaid application is omitted if the patient is non-compliant and the Financial Assistance application is started.
- E. The following criteria is used to determine financial eligibility for financial assistance:
 - i. Eligibility will be based on gross household income plus liquid assets. Gross income is defined as wages and salaries from all sources before deductions. Liquid assets are defined as cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc.

- ii. Household Income - All wages and salaries within the household such as social security, veteran's benefits, pension plans, unemployment and workers compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home.
 - iii. Assets - The availability of liquid assets plus annual income will be considered up to 375% of the current poverty guidelines published in the Federal Register.
 - iv. Expenses are collected and taken in consideration for analysis purposes.
 - v. Proof of Income - For each employed house hold member, submit one of the following with the application:
 - Pay stubs for the previous four weeks
 - Employer certification of income
 - Most recent State and Federal tax returns
 - vi. For each household member receiving unearned income, submit the following if applicable:
 - Proof of Social Security Benefits
 - Proof of Disability Benefits
 - Proof of Retirement/Pension Benefits
 - Proof of Unemployment Benefits
 - Proof of Veterans Benefits
 - Proof of Child Support
 - Proof Alimony
 - Rental property income
 - vii. Other required documents
 - Applicants claiming zero income must supply proof of how their living expenses are paid
 - The current and previous savings and bank statements
 - Statements of certificates of deposit, stocks, bonds, and money market funds
- F. Certain unique cases not meeting the above criteria may on a case-by-case basis be approved by the Director of Patient Financial Services or appointed designee. Consideration will be given to the possible impairment or improvement of the future income potential, as well as cases considered to be catastrophic, which may or may not change the outcome of the application.
- G. Homeless – Patient's declaring a homeless status which is later verified by the Manager is consistent with what the patient is stating, may be eligible for financial assistance.
- H. Deceased – If an estate does not exist or has been exhausted, financial assistance is offered.
- The following criteria is used to approve or deny the application:
- A. Combined gross income in relation to the number of family members is 300% of the poverty guidelines. Applicant will be eligible for 100% Financial Assistance (Exhibit B)

- B. If combined gross income is more than 300% of the poverty guideline - applicant may be eligible for Financial Assistance with a resource based on a sliding scale.
- C. Financial Assistance eligibility decisions can be made at any time during the revenue cycle as pertinent information becomes available. If the financial information is not available a financial assessment can be completed through other avenues such as credit reports, debt and asset reviews, and referrals from the Medical Assistance Eligibility Company and Collection Agency. If the determination is made that there is a low probability of collections, the account can be approved for Financial Assistance. This write off is account specific, therefore, cannot be applied to other open accounts.
- D. Patients referred to Carroll Home Care or Carroll Hospice from the Carroll Hospital Center will automatically qualify based on the application approved by the hospital. Patients referred from an outside source will follow the same application.
- E. The completed and signed application is forwarded to the Patient Accounting Manager to enter the write off to transaction code 1035. Specific accounts approved through other avenues are written off to transaction code 1094 in an active AR status. Home Care and Hospice accounts are written off to a Financial Assistance classification.
- F. Applications are stored for 7 years.
- G. All applicants are notified of probable eligibility within two (2) business days by the Manager after a request for financial assistance.
- H. Self Pay accounts are handled as follows:
 - i. The Financial Counselor will present all Inpatient self pay patients with the application if unable to pay monthly installments. All accounts must be referred to Medical Assistance Advocacy if the initial financial screening indicates the possibility of eligibility.
 - ii. All outpatient accounts with a combined total of \$1,500 are referred to Medical Assistance Advocacy and are given the Financial Assistance Application if the installment plan payments cannot be met.
 - iii. All accounts are reviewed for grant eligibility (i.e. Maryland treatment fund for cancer diagnosis, children's fund for patients though the age of 18).
 - iv. If assistance is requested with deceased patients, a verification of an existing estate is completed. If no estate can be found, financial assistance is applied.
 - v. Assistance with MHIP applications is given for Maryland residents who are unable to get medical insurance coverage and have one of the 60 qualifying health conditions listed in the MHIP manual.
 - vi. All applications are pursued to completion; including patients referred to Medical Assistance Advocacy with one follow-up letter and one phone call.
 - vii. Requests for financial assistance received after services are referred to the Financial Counselor for processing.

- viii. Open accounts with dates of service prior to the time of the approved application, and accounts with dates of service up to 6 months after the approved application are eligible for Financial Assistance if there has been no change in status. Bad debt accounts will be returned to active AR prior to write off.
- ix. Applications must be completed and returned to the Financial Counselor within 15 days of receipt. All uncooperative applicants will be transferred to self-pay unless Medical Assistance is pending.
- x. The Financial Counselor will call the patient a minimum of two times, and send 1 reminder letter within the 15 day period to obtain information.
- xi. The Financial Counselor will mail the appropriate letter confirming the approval or non-approval.
- xii. Payments received before, during, or after the completion of the Financial Assistance application will not be refunded. The amount of the approved write off will be reduced by the amount of payments received.
- xiii. All completed Financial Assistance applications will be reviewed and the patient notified of the decision within two business days of receipt.

Submitted By:	Janice Napieralski Director, Patient Financial Services	Date:
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Administrative Approvals:	Kevin Kelbly Senior Vice President of Finance	Date:
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Leslie Simmons Chief Operating Office & Senior Vice President PCS	Date:
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Exhibit A**Maryland State Uniform Financial Assistance Application****Information about You**

Name _____
 First Middle Last

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

US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

 City State Zip code Country

Employer Name _____ Phone _____

Work Address _____
 City State Zip code

Household members:

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

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Carroll Hospital Center
 200 Memorial Avenue
 Westminster, MD 21157

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Car payment(s)	_____
Credit card(s)	_____

Carroll FY 09
 Car insurance
 Health insurance
 Other medical expenses
 Other expenses

Total

Do you have any other unpaid medical bills? Yes No

For what service?

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

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

Applicant signature

Date

Relationship to Patient

EXHIBIT B

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia			
Persons in family	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,830	\$13,530	\$12,460
2	\$14,570	\$18,210	\$16,760
3	\$18,310	\$22,890	\$21,060
4	\$22,050	\$27,570	\$25,360
5	\$25,790	\$32,250	\$29,660
6	\$29,530	\$36,930	\$33,960
7	\$33,270	\$41,610	\$38,260
8	\$37,010	\$46,290	\$42,560
For families with more than 8 persons, add \$3,740 for each additional person.			

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199–4201

Income Scale for CHC Financial Assistance Program

Based on 2009 Federal Poverty Guidelines

Family Size	FPG	Income Level 300%	75% Reduction	50% Reduction	25% Reduction
1	\$10,830	\$32,490	\$35,198	\$37,905	\$40,613
2	\$14,570	\$43,710	\$47,353	\$50,995	\$54,638
3	\$18,310	\$54,930	\$59,508	\$64,085	\$68,663
4	\$22,050	\$66,150	\$71,663	\$77,175	\$82,688
5	\$25,790	\$77,370	\$83,818	\$90,265	\$96,713
6	\$29,530	\$88,590	\$95,973	\$103,355	\$110,738
7	\$33,270	\$99,810	\$108,128	\$116,445	\$124,763
8	\$37,010	\$111,030	\$120,283	\$129,535	\$138,788

VISION, MISSION, VALUES - DESCRIPTION

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

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

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

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

APPENDIX 4

VISION, MISSION, VALUES

OUR ACTIONS AND DECISIONS ARE GUIDED BY THESE VALUES.

SERVICE... exceed customer expectations.

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

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

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

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

TEAMWORK... work together, win together.

MISSION

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

VISION

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



Community Benefit Trending Report

DRAFT



Priority Community Benefit Indicators

1. Emphasis on Disproportionate Unmet Health Needs	FY 2009 Data	FY 2010	FY 2011
a. Total # of ED Behavioral Health assessments	2518		
b. Total # of Behavioral Health admissions via financial assistance*	5		
c. Total # ED uninsured / MA encounters	13,900		
d. Total # patients enrolled in Best Beginnings	35		
e. Total # Financial Assistance full applications	390		
f. Total # patients enrolled in MA via our assistance	530		
g. Total # of Access Carroll patients receiving lab procedures	1864		
h. Total # of free Imaging procedures to Access Carroll	49		
i. Total # of patient visits at Access Carroll	6,340		
j. Total # of Prescriptions Provided (Broader)			
2. Emphasis on Primary Prevention	FY 2009 Data	FY 2010	FY 2011
a. Total # of Patients self identifying as a smoker on admission	2,645		
b. Total # inpatients using Nicotine Replacement Protocols			
c. Total # CHC worksite wellness program enrollees per calendar year**	569		
d. Total # children/adult participants in all weight reduction programs	19		
e. Total # educational encounters re: skin cancer prevention	1273		
f. Total # of person screened for High Blood Pressure	1,902		
g. Total # of participants at TWP/TLC Chronic Disease Prevention programs			
3. Incorporates Collaborative Governance	FY 2009 Data	FY 2010	FY 2011
a. % of the partnership's annual Vital Signs trending toward target	15 of 25		
b. Total # of community partners (agencies) actively involved with CHIA efforts	355		
c. Total # of students utilizing CHC as clinical rotation site annually	568		
4. Demonstrates Community Capacity Building	FY 2009 Data	FY 2010	FY 2011
a. Total # of scholarship awarded to community students	5		
b. Total # of donations to support community organization's events			
c. Total # of seats on various community boards held by CHC leaders			
d. Total # of event sponsorship donations			
e. Total # of community events CHC participates in with educational content			
f. Total # of shadow students annually	116		
5. Demonstrates Seamless Continuum of Care Building	FY 2009 Data	FY 2010	FY 2011
a. Total # of Health Access call center encounters			
b. Total # of educational materials provided by The Women's Place			
c. Total # of bereavement cases managed by Carroll Hospice	1,079		
d. Total # of support groups (not sessions) provided	17 + 6		
e. Total # of visits by hospital employed doctors including hospitalists			
f. Total # of support group attendees	3,009 + 355		

*Inpatient, PHP, any kind of assistance

** Associates/screenings

Carroll Hospital Center/Partnership for a Healthier Carroll County Elder Needs Health Assessment 2008

Sample Selection

A total of 672 households responded to the survey, however 79 of the sampled households were not actual Carroll County residents (but were sampled due to cross-county zip codes). These households were filtered out giving a sample size of 593 households.

Surveys were also divided into 3 categories; those received the survey in the mail (consisting of 411 households) and those who received it in some other means (182 households). The surveys sent out in the mail are closer to achieving a random sample, so by separating respondents into these two categories any bias from the sample population that answered the survey through other methods will be apparent.

Demographic Information

Gender

	In the Mail	Other	Total	Census
Male	61.3%	22.9%	49.7%	*49.4%
Female	38.7%	76.5%	50.3%	*50.6%

*Census data based on 2006 census of Carroll County

Age

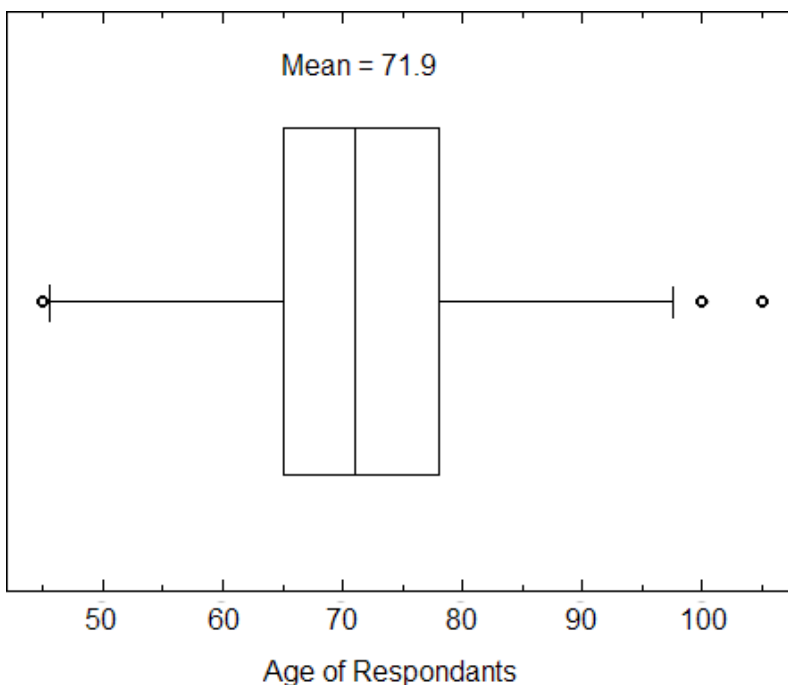
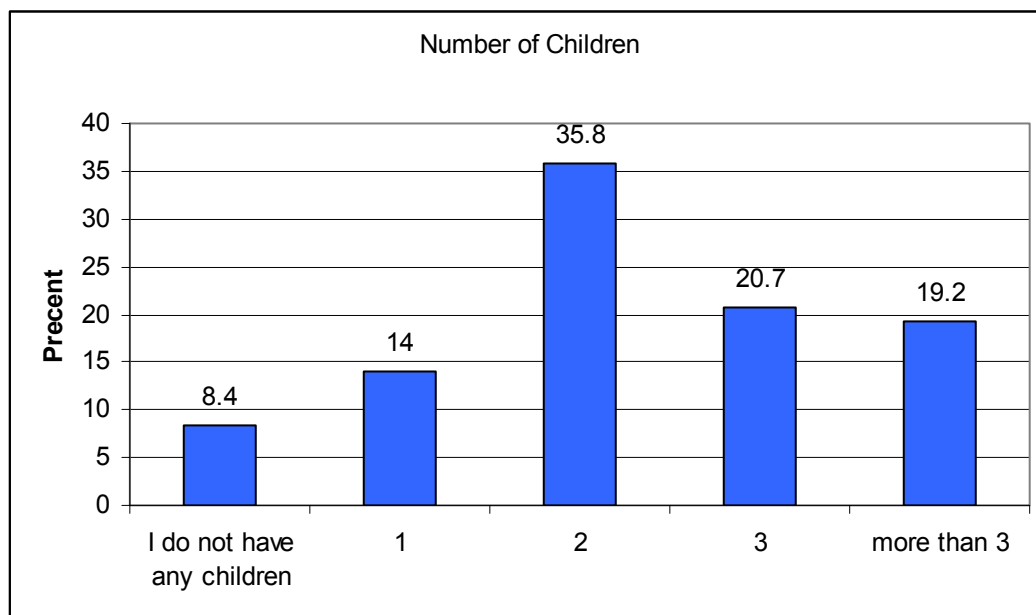


Chart Statistics:

Mean: 71.9 years old
 Standard Deviation: 8.18
 High: 105
 Low: 45
 Third Quartile: 78
 First Quartile: 65
 Median: 71

Marital Status/Family Life

Marital Status	In the Mail	Other	Total
Single	2.7%	5.6%	3.5%
Married	74.0%	30.2%	60.7%
Widowed	17.0%	49.2%	26.8%
Divorced	4.9%	11.7%	6.9%
Separated	1.0%	1.1%	1.0%
Times Married			
Never	1.9%	6.1%	3.2%
Once	75.7%	69.8%	73.9%
Twice	20.2%	17.3%	19.4%
Three times	1.0%	3.4%	1.7%
Four times	.5%	.6%	.5%
More then Four	.2%	0%	.2%

*Education*

Completed level	In the Mail	Other	Total
Middle School	7.1%	19%	10.6%
High School/GED	39.7%	44.7%	41.5%
Associates/ 2 year training program	12.2%	5.6%	10.1%
Bachelor's degree	20.4%	6.7%	16.5%
Master's degree	8.8%	5%	7.4%
Doctoral degree	1.9%	1.1%	1.5%

Other	9.0%	12.8%	10.1%
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Religion

Religious Affiliation	
Christian	87.2%
Judaism	1.5%
Buddhism	.2%
Islam	0%
Hinduism	.2%
No Affiliation	5.2%
Other	2.5%

Attendance at a place of worship	
Often, every week or more	43.2%
Regularly, at least once a month	8.4%
Occasionally, several times a year	14%
Rarely, once or twice a year	18.7%
Never	12.8%

Extent you are treated differently or discriminated against because of the following:

	Never	Sometimes	Often	Very Often
Age	53.3%	31.4%	2.7%	0.7%
Gender	59.9%	18.9%	2%	0%
Race/ethnicity	71.3%	8.8%	1.5%	.3%
Income	65.1%	14%	2.4%	1%
Education level	67.1%	13%	1.9%	.3%
Health/disability	65.6%	15.2%	1.2%	1%
Use of tobacco	66.6%	4%	1.7%	1.9%
Religion	74.9%	6.1%	.5%	.7%
Weight	69.0%	10.5%	2.4%	.8%
Sexual orientation	76.6%	3.5%	.5%	0%

Ethnicity	In the Mail	Other	Total	Census
White/Caucasian	96.6%	91.1%	94.8%	94.2%
Black/African American	1%	3.9%	1.9%	3.1%
Hispanic or Latino	0%	.6%	.2%	1.6%
Asian or Asian American	.7%	.6%	.7%	1.5%
Other	.7%	.6%	.7%	-

*Census data based on 2006 census of Carroll County

	In the Mail	Other	Total
In what country were you born?			
USA	80.9%	73.7%	78.4%
Other	2.9%	4.5%	3.4%

Household Information

	In the Mail	Other	Total
Home Adequate for future care needs?			
Yes	58.6%	50.3%	56.5%
No	13.4%	11.2%	12.6%
I don't know	26.3%	34.1%	28.5%
Housing Situation			
Single living alone	19.7%	55.3%	30.5%
Single living with a child	2.9%	8.4%	4.6%
Couple	74%	26.8%	59.7%
Single living with a grandchild	.2%	0%	.2%
Single living with another family member	1.5%	3.4%	2%
Single living with non-relative roommate	1%	.6%	.8%
Satisfaction with Housing Situation			
Very satisfied	59.4%	53.6%	57.5%
Quite satisfied	20.7%	17.3%	19.9%
Satisfied	13.6%	19%	15.2%
Neither satisfied nor dissatisfied	2.4%	2.8%	2.5%
Dissatisfied	1.9%	1.1%	1.7%
Rather dissatisfied	.2%	.6%	.3%
Very dissatisfied	.2%	1.7%	.7%
Number of people in your household			
1	19.5%	54.7%	30.2%
2	62.8%	29.6%	52.8%
3-4	13.6%	9.5%	12.3%
5-6	2.9%	1.7%	2.5%
7 or more	.2%	1.1%	.5%
Home			
Single family home	85.2%	38.5%	71.2%
Duplex	.2%	2.2%	.8%
Townhouse	1.9%	1.1%	1.7%
Multi-family apartment building	0%	.6%	.2%
Apartment complex	1.5%	5.6%	2.7%
Apartment in 55 or older housing	.5%	28.5%	9.1%
In-law apartment	1.5%	1.7%	1.5%
Condominium	1.7%	2.2%	1.9%
Condominium in 55 or older housing	3.2%	5.6%	3.9%
Mobile Home	.7%	.6%	.7%
Retirement community	2.9%	8.9%	4.6%

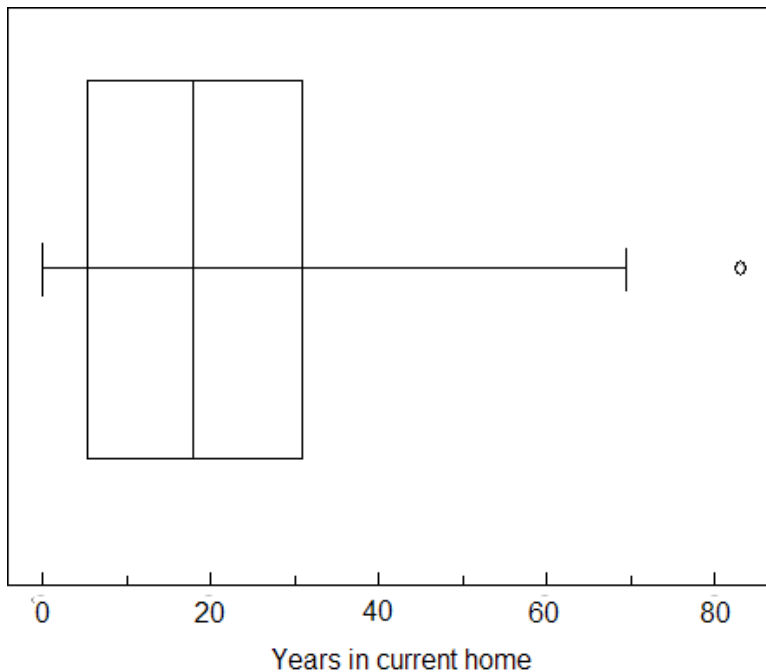
Years at current place of residence

Chart Statistics:

Mean: 19.67 years
 Standard Deviation: 15.1
 High: 83
 Low: .08
 Third Quartile: 31
 First Quartile: 5.375
 Median: 18

	In the Mail	Other	Total
Home Ownership			
Owned outright	60.6%	29.6%	51.4%
Owned with a mortgage	34.3%	12.8%	27.5%
Leased	.5%	12.3%	4.2%
Rented- furnished	.2%	1.1%	.5%
Rented- unfurnished	3.2%	26.3%	10.1%
Provided by state or federal agency	.2%	8.4%	2.7%

*Safety**Would you benefit from any of the following modifications?*

	Yes	Already have	No
Grab bars in bath/shower	48.2%	20.7%	19.4%
Grab bars near the toilet	36.8%	8.4%	30.9%
Ramp for wheel chair access	21.6%	5.7%	39.3%
Chair lift for stairways	18.2%	.8%	46.7%

	In the Mail	Other	Total
Safe in Home			
Yes, always	90.8%	82.1%	88%

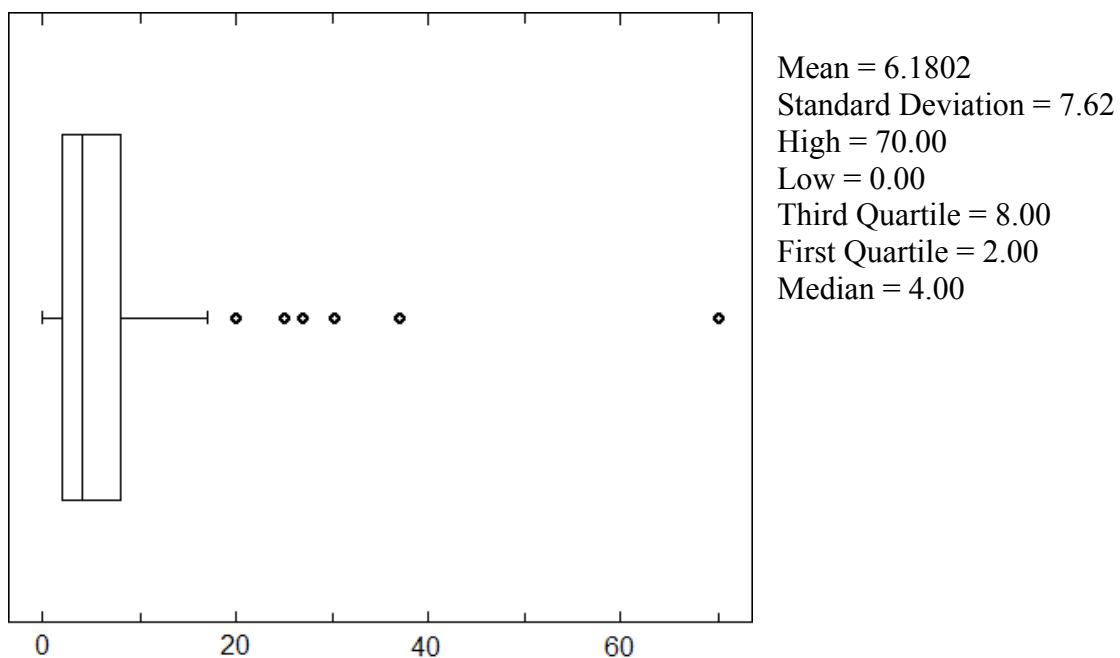
Yes, sometimes	8.8%	11.2%	9.6%
No	.2%	1.1%	.5%

	In the Mail	Other	Total
Safe in Community			
Yes, always	73.2%	64.2%	70.3%
Yes, most of the time	23.6%	23.5%	23.8%
Yes, sometimes	1.9%	4.5%	2.7%
No	0%	0%	0%
Afraid of being harmed or taken advantage by			
Spouse	0%	.6%	.2%
Child	1.5%	.6%	1.2%
Grandchild	.2%	.6%	.3%
Neighbor	1%	2.2%	1.5%
Other	5.4%	5%	5.2%

Employment and Volunteerism

	In the Mail	Other	Total
Employed			
Yes	29.4%	6.7%	22.9%
No	69.6%	87.2%	74.5%
Volunteer			
Yes	36.3%	44.1%	38.3%
No	63%	49.2%	59%

Number of hours volunteered (Of those who answered yes to above question)



Income and Expenses

How much of your monthly income do you spend on the following?

	0	Less then 1/4	Less then 1/3	Less then 1/2	Less then 3/4
Mortgage/Rent	37.4%	14.8%	8.4%	9.1%	3.2%
Electricity	3.5%	58.9%	7.6%	1.3%	1.3%
Telephone	2.4%	64.2%	3.7%	1%	1%
Heating/air conditioning	2.9%	48.7%	13.5%	2.9%	1%
Medical bills	6.7%	48.2%	11.1%	3.9%	.8%
Prescription drugs	4%	52.3%	9.1%	4.9%	1.2%
Food	1.3%	38.4%	25.5%	5.9%	1.5%
Clothing	6.2%	56%	6.2%	.5%	.8%
Other	3.2%	24.3%	5.1%	2.4%	.8%

	In the Mail	Other	Total
Income			
Less than \$50,000	46%	61.5%	50.6%
Between \$50,000 and \$100,000	35.3%	11.7%	28%
More than \$100,000	9.2%	3.9%	7.6%
Enough to make ends meet?			
Yes	65.9%	40.2%	58.2%
No	19.7%	29.6%	22.6%
Don't know	9%	10.6%	9.6%

How much financial help do you receive from the following?

	None	A little	Some	A lot
Son/Daughter	83.3%	3%	2.4%	.5%
Spouse/Partner/Formal spouse	49.1%	5.2%	12.1%	11.5%
Other relative	81.5%	.5%	.7%	0%
Friends or non-relatives	1.1%	.2%	.2%	0%

How much financial help do you provide from the following?

	None	A little	Some	A lot
Son/Daughter	62.4%	16.2%	7.8%	3.9%
Spouse/Partner/Formal spouse	46.5%	5.4%	10.6%	11.5%
Other relative	73.4%	4.7%	1.5%	.7%
Friends or non-relatives	75.4%	2.5%	.5%	0%

Transportation

	In the Mail	Other	Total
Satisfaction of transportation			
Very satisfied	47.4%	46.4%	46.9%
Quite satisfied	17%	9.5%	14.7%
Satisfied	19.7%	17.3%	19.2%
Neither Satisfied nor dissatisfied	9.2%	7.3%	8.6%
Dissatisfied	2.4%	4.5%	3.2%
Rather dissatisfied	.7%	3.4%	1.5%
Very dissatisfied	1%	1.1%	1%
Seatbelt Usage			
Always when driving	91.7%	73.2%	86%
Sometimes when driving	3.2%	1.7%	2.7%
Never when driving	.2%	1.7%	.7%
Always when passenger	48.9%	59.8%	52.3%
Sometimes when passenger	4.6%	5.6%	4.9%
Never when passenger	.7%	1.1%	.8%
If dissatisfied, why?			
Too expensive	14.1%	12.8%	13.8%
Inconvenient	5.1%	5%	5.1%
Unreliable	1.5%	2.2%	1.7%
Little flexibility with time	4.4%	9.5%	5.9%
Little flexibility with destinations	5.6%	7.8%	6.2%
Other	8%	10.6%	9.1%

In one week, how often do you use the following?

	0	1-2 days	3-4 days	5-6 days	Daily
Car (you drive)	3.7%	8.8%	19.9%	17.2%	40%
Car (someone else drives)	29%	24.8%	5.4%	2.5%	2.7%
Walking	33.6%	12%	6.1%	1.9%	8.6%
Bicycle	53.1%	1.5%	.2%	0%	.2%
Taxi Cab	54.6%	.3%	0%	.2%	0%
CATs system	52.1%	3.4%	2.2%	.3%	.2%
Apartment complex shuttle	43.2%	.7%	.2%	0%	0%
Car pool with neighbor	53.1%	13.5%	1.7%	.5%	0%
Senior center	52.6%	1.3%	.3%	.5%	0%

Social Support and Communication

	In the Mail	Other	Total
Visited by friends or relatives			
Daily	5.8%	7.8%	6.7%
Several times a week	25.1%	20.7%	23.4%
Weekly	13.9%	17.9%	15%
Several times a month	21.9%	20.7%	21.4%
Monthly or less often	30.2%	24%	28.5%
If ill, have a friend or relative to call?			
Yes	95.9%	90.5%	94.3%
No	2.4%	3.9%	2.9%
I don't know	.7%	.6%	.7%
Friend/relative willing to care for in the future			
Yes	52.6%	51.4%	51.9%
No	40.9%	31.8%	38.4%
I don't know	4.1%	7.8%	5.2%
Who would you ask for caregiving help?			
Son or daughter	54.3%	63.1%	57.2%
Spouse	56.9%	17.9%	45.2%
Other relative	3.2%	7.8%	4.4%
Friend/neighbor	3.6%	5%	4%
I don't know	6.1%	13.4%	8.3%
Other	2.7%	6.1%	3.7%
Own cellular phone	83.2%	52%	73.5%
Access to internet at home	70.3%	37.4%	60.2%
Use email to communicate	57.2%	26.8%	47.9%

How often do you use any of the following?

	Never	Daily	Weekly	Monthly
Cigarettes	87.5%	6.4%		.5%
Cigars	90.2%	0%		.8%
Snuff	91.4%	0%		0%
Chewing tobacco	90.7%	1%	0%	0%
Alcohol	54.1%	9.1%	13.3%	16.2%

	In the Mail	Other	Total
Hours spent on Internet (weekly)			
None	34.8%	62.6%	43.3%
1 or 2 hours	21.7%	12.8%	18.9%
2 to 5 hours	16.8%	9.5%	14.7%
5 to 10 hours	10.2%	4.5%	8.6%
10 to 15 hours	8.5%	1.1%	6.2%
More than 15 hours	6.3%	1.7%	4.7%
Hours spent watching TV (daily)			
Less than 1 hour	5.6%	4.5%	5.2%
1 to 2 hours	24.1%	14%	21.2%
2 to 3 hours	29.2%	25.7%	28%
3 to 4 hours	19.5%	19%	19.4%
4 to 5 hours	10.5%	11.7%	10.8%
5 or more hours	10.2%	19%	12.8%

How often do you participate in the following activities

	Never	Sometimes	Often	Very Often
Parlor/Barber	23.4%	44.9%	9.9%	1.9%
Bingo	72.3%	6.2%	5.4%	1.5%
Bowling	80.1%	1.9%	1.5%	.3%
Cooking	19.6%	22.4%	4.7%	42%
Crosswords puzzles	49.6%	11.3%	5.4%	20.4%
Dancing	71.8%	9.3%	1.9%	1.3%
Do-it-yourself projects	23.9%	28.8%	16.7%	16.2%
Drinking	55%	16.4%	6.2%	5.1%
Eating out	5.1%	41.1%	31.2%	13.3%
Gardening	28.7%	26.6%	15.7%	16.5%
Home videos/photography	44.4%	30.5%	7.6%	2.5%
Movie theater	56.3%	27%	1.5%	1.3%
Listening to music	6.6%	29.2%	12.6%	41.1%
Night club	83.5%	2.7%	.7%	0%
Read book	14.5%	29.2%	11.3%	35.8%
Read newspaper/magazine	3.2%	16.4%	8.4%	64.4%
Sewing/needlecraft	53.8%	17.2%	5.7%	12.3%
Television	2.5%	13%	5.4%	72.2%
Theater	56.2%	24.6%	.8%	1%
Visiting friends/family	6.1%	43.8%	22.8%	15.3%
Volunteer work	46.2%	16.2%	10.6%	11.8%

	In the Mail	Other	Total
Satisfaction with leisure activities			
Very satisfied	35.3%	35.2%	35.1%
Quite satisfied	20.2%	20.1%	20.4%
Satisfied	25.8%	27.4%	26.1%
Neither Satisfied nor dissatisfied	14.8%	6.1%	12.3%
Dissatisfied	1.9%	1.1%	1.7%
Rather dissatisfied	0%	.6%	.2%
Very dissatisfied	0%	.6%	.2%

Pets

	In the Mail	Other	Total
Concerns about care for pet should you be ill			
I don't have any pets	50.1%	59.2%	52.8%
Yes	16.8%	14%	16.2%
No	29.7%	14%	25%
I don't know	1.2%	1.7%	1.3%

Meals and Dining

	In the Mail	Other	Total
Meals per day			
1	1.2%	3.9%	2%
2	18.5%	21.8%	19.6%
3	77.6%	65.9%	74%
4	1.9%	1.7%	1.9%
More than 4	.2%	0%	.2%
If less than 3 meals, why?			
I don't have a big appetite	12.9%	16.2%	13.8%
It is too expensive to eat more often	1%	4.5%	2%
I don't like preparing meals	3.2%	7.8%	4.6%
I'm trying to lose weight	8.5%	2.8%	6.7%
Other	4.4%	5%	4.7%
Type of meals			
Prepared at home by me or spouse	93.4%	78.2%	88.7%
Prepared at home by another family member	6.3%	11.2%	7.9%
Delivered to home by non-profit organization	.5%	0%	.3%
Delivered to home by church	.5%	0%	.3%
Eat at local senior center	1.5%	11.7%	4.6%

Eat at local restraint	30.9%	20.1%	27.5%
Other	3.4%	6.7%	4.4%

	In the Mail	Other	Total
Times eat in a restaurant per week			
0	20.7%	20.1%	20.7%
1-2 times	63.7%	60.9%	62.6%
3-4 times	9.7%	7.3%	9.1%
5-6 times	2.7%	1.1%	2.2%
7-8 times	.5%	.6%	.5%
More than 8 times	1%	.6%	.8%
Reason for eating in restaurant			
I don't eat at restaurants	10%	15.1%	11.5%
It is inexpensive	4.1%	1.7%	3.4%
It is quick	14.8%	7.8%	12.8%
I like the food	33.1%	30.7%	32.4%
It is close to my home	10%	7.3%	9.3%
I don't like preparing food	7.8%	15.1%	9.9%
It is accommodating to older people	9.5%	10.6%	9.8%
Other	24.3%	22.9%	23.9%
Where do you do most of your grocery shopping?			
I do not go grocery shopping	5.6%	7.3%	5.9%
Carroll County	89.8%	84.9%	88.5%
Howard County	.2%	1.1%	.5%
Frederick County	1.2%	1.7%	1.3%
Harford County	0%	.6%	.2%
Baltimore County	1.7%	.6%	1.3%
Baltimore City	0%	1.7%	.5%
Pennsylvania	6.8%	6.7%	6.7%
Other	.7%	.6%	.5%
Why grocery shop there?			
I do not go grocery shopping	6.8%	7.8%	6.9%
It is located near my home	62.5%	55.9%	60.7%
It is friendly to older people	6.3%	13.4%	8.6%
The prices are cheaper	28.5%	20.7%	26.3%
The quality of food is better	17.3%	18.4%	17.5%
Coupons and/or discounts	20.4%	26.8%	22.3%
It is handicap accessible	2.9%	3.9%	3.2%
Easy parking	16.3%	23.5%	18.2%
Other	4.4%	2.8%	3.9%

Medical/ Health Care

	In the Mail	Other	Total
General Health			
Very good	28.7%	20.1%	26%
Good	47.2%	48%	47.7%
Fair	20%	22.9%	20.7%
Poor	2.4%	3.9%	2.9%
Very poor	1%	0%	.7%
Do you have a regular doctor?			
Yes	97.6%	91.1%	95.6%
No	1.7%	3.4%	2.2%
I don't know	0%	0%	0%
In past 12 months have you been in good health?			
Yes, good health throughout	38.4%	30.2%	35.6%
Yes, good most of the time	49.6%	47.5%	49.4%
No, occasional poor health	8.8%	14.5%	10.5%
No, poor health throughout	1.9%	2.2%	2%
Have you seen a doctor in the last year			
Yes	94.2%	88.8%	92.6%
No	2.9%	5%	3.5%
I don't know	0%	0%	0%

Where do you receive your health care?

	Most health care	Some health care	None
Carroll County	74.2%	9.8%	3.2%
Baltimore Co.	9.1%	11.6%	7.1%
Baltimore City	2.5%	7.6%	8.8%
Howard Co.	1.5%	2%	10.3%
Frederick Co.	2.7%	1.3%	9.9%
Montgomery Co.	1.7%	1.5%	10.3%

	In the Mail	Other	Total
Basis for selection of where you get health care			
It is close to my home	49.4%	51.4%	50.8%
Choice of doctors	68.6%	59.8%	65.8%
They accept my insurance	41.8%	50.3%	44.2%
Other	5.1%	6.7%	5.6%

Who in your household uses the following?

	No one	Self	Spouse	Other
Cane	66.8%	13.2%	3.4%	.8%
Walker	71.5%	6.2%	2.5%	.5%
Oxygen (in home)	72.8%	2.7%	.8%	.2%
Oxygen (portable)	73.2%	1.5%	.3%	0%
Wheel chair	71.7%	3.9%	1.2%	.3%
Chair life	73.2%	.8%	0%	.3%
Crutches	74%	.5%	.2%	0%
Hearing aid	63.1%	13.2%	3.2%	.3%
Glasses	6.2%	85.8%	50.9%	4.4%
Dentures	41.8%	36.8%	16.2%	1.5%

	In the Mail	Other	Total
Last year checked for:			
Mammogram/Prostate Exam	71.3%	53.1%	65.6%
Blood Sugar test for diabetes	56.7%	49.2%	54.3%
Pap Smear	24.6%	26.8%	25.5%
Blood pressure screening	85.9%	82.1%	84.7%
Cholesterol screening	80.8%	73.2%	78.4%
Colonoscopy	25.8%	19%	23.8%
HIV/AIDS test	1.7%	1.1%	1.5%
Chest X-ray	26.5%	30.7%	27.7%
TB test	5.1%	6.1%	5.4%
Screening for depression	2.9%	6.7%	4%
Screening for memory loss	2.2%	3.4%	2.5%
Hearing test	14.4%	16.8%	15%
Vision test	67.6%	61.5%	65.9%
Dental Exam	70.8%	49.2%	64.2%
Flu Shot	71.8%	72.6%	72.2%
Health State today			
I have no pain or discomfort	38.7%	31.3%	36.3%
I have some pain or discomfort	57.2%	54.7%	56.7%
I am in extreme pain or discomfort	3.2%	3.4%	3.2%

Diagnosed or told you have any of the following conditions and when

	Yes, less than 5 years ago	Yes, more than 5 years ago	No, I do not have
Arthritis	27%	25%	32.4%
High blood sugar/Diabetes	16.2%	20.7%	42.3%
Osteoporosis	8.8%	8.9%	51.4%
Heart disease	13.2%	16.4%	43.2%
High cholesterol	25.3%	30.7%	25.1%
Depression	6.7%	6.9%	54.3%
Memory Loss	4.4%	2%	59.2%
Breast Cancer	1.5%	2%	58.3%
Skin Cancer	7.4%	5.7%	53.1%
Prostate Cancer	3.2%	3%	53.8%
Sever Hearing Loss	7.3%	4%	54%
Macular Degeneration	4.7%	2%	57.8%

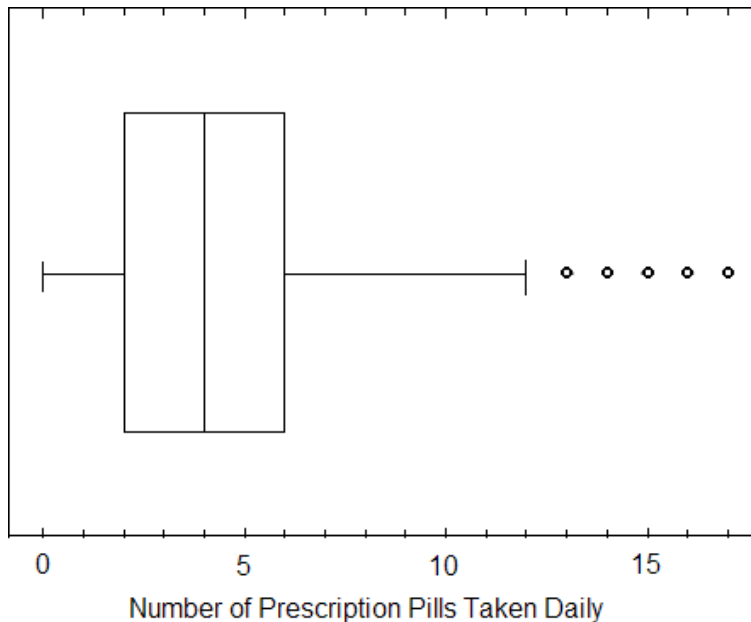


Chart Statistics:

Mean: 4.18 Pills
 Standard Deviation: 3.12
 High: 17
 Low: 0
 Third Quartile: 6
 First Quartile: 2
 Median: 4

	In the Mail	Other	Total
Able to pay for medications			
Yes	86.9%	63.1%	79.9%
Yes, but only with help from others	9.7%	15.1%	11.3%
No	.5%	3.9%	1.5%
I don't know	1%	2.8%	1.5%

	In the Mail	Other	Total
Payment Method for medications			
Private insurance	67.6%	46.9%	60.9%
Medicare	31.6%	46.9%	36.4%
Prescription assistance programs	9%	16.2%	11.1%
Out of pocket	22.4%	22.9%	22.6%
Veteran's benefits/Tricare	5.8%	4.5%	5.4%
Other	2.2%	3.9%	3%
Medications currently being taken			
Tylenol	29.7%	43.6%	33.9%
Aspirin	52.1%	49.2%	51.4%
Advil/other pain reliever	21.4%	14%	19.2%
Sudafed/sinus medication	8.5%	6.1%	7.8%
Benedryl/allergy medication	10.5%	7.3%	9.4%
Calcium supplements	32.4%	41.9%	35.4%
Tums/antacids	22.1%	19.6%	21.1%
Laxatives	9.7%	12.3%	10.5%
Other	14.1%	11.7%	13.3%
Herbal medications being taken			
Ginko	1.9%	2.8%	2.2%
Multi vitamins	40.4%	33.5%	38.3%
St. Johns Wart	.2%	.6%	.3%
Saw Palmetto	2.7%	.6%	2%
Garlic	2.4%	5%	3.2%
DHEA	1.2%	1.1%	1.2%
Other	13.9%	3.9%	10.8%
How often do you visit the dentist?			
Never	8.3%	14.5%	10.1%
Every 6 months	59.6%	41.3%	54.3%
Once a year	13.6%	15.6%	14%
Once every 5 years	4.1%	3.4%	3.9%
Only when needed	13.4%	17.9%	14.8%
Health state in relation to usual activities			
No problems performing my usual duties	64.7%	56.4%	62.4%
Some problems performing usual duties	32.1%	31.8%	32%
Unable to perform my usual duties	1.9%	3.4%	2.4%

Does your health limit you in these activities?

	Limited a lot	Limited a little	Not limited
Climbing several flights of stairs	15.3%	27.5%	50.1%

Normal work	12.1%	31.7%	48.2%
Leisure/Social Activities	8.4%	23.8%	57.3%

	In the Mail	Other	Total
Medical Insurance			
Medicare part A only	11.9%	15.1%	13%
Medicare part A & B	64.5%	73.7%	67.1%
Medicare part D	15.6%	21.2%	17.4%
Medicaid	2.9%	4.5%	3.4%
Supplemental Insurance	51.6%	48%	50.6%
Private Health Insurance	40.1%	22.3%	34.7%
Veteran's benefits/Tricare	6.3%	5%	5.9%
Don't know	.5%	2.2%	1%
Doctors ability to treat health problems			
Excellent	38.9%	38%	38.8%
Good	47.4%	38%	44.5%
Fair	5.8%	6.7%	6.1%
Poor	.2%	1.7%	.7%
Not sure	4.9%	5.6%	5.1%
Hospitals ability to treat health problems			
Excellent	22.9%	26.3%	23.6%
Good	46.7%	38.5%	44.5%
Fair	12.4%	7.8%	11%
Poor	2.4%	5.6%	3.4%
Not sure	12.9%	12.8%	13%
Household long standing illness/disability			
Yes, I do	21.7%	28.5%	23.8%
Yes, someone else does	16.8%	8.4%	14.3%
No	57.2%	48%	54.3%
Don't know	1.9%	2.8%	2.2%
Self Care			
I have no problems with self care	93.7%	83.8%	90.7%
Some problems washing/dressing myself	3.6%	6.7%	4.6%
Unable to wash/dress self	.5%	.6%	.5%
Have any of the following?			
Living will	64.2%	64.2%	64.4%
Medical power of attorney	50.6%	47.5%	49.7%
Advance directive	32.8%	25.1%	30.4%
Life insurance	73.2%	46.9%	65.1%
Long-term care insurance	18.5%	10.6%	15.9%

Do you need help with any of the following?

	No Help	Some Help	Must Have Help
Grocery Shopping	81.6%	7.6%	4%
Cooking	65.3%	3.2%	2.5%
Laundry	84.8%	3.9%	3%
Managing Money	87.7%	3.4%	1.7%
Housework	74.9%	14%	3.9%
Bathing	88.7%	2.2%	1.5%
Leaving the House	86.8%	2.7%	2.5%
Walking	83.3%	6.9%	2.7%

How familiar are you with the following programs?

	Not	Somewhat	Familiar	Very
Health care services	34.9%	26.3%	18.2%	8.1%
Dental care services	45.5%	13.2%	16.9%	10.3%
Mental health services	55%	15.7%	9.4%	4.2%
Transportation to health services	48.6%	21.6%	12.3%	3.5%
Other Public Services	47.9%	21.2%	10.3%	3.7%
Legal services	53.1%	16.5%	10.8%	3.7%
Food stamps	67.6%	8.9%	4.2%	1.9%
Senior center services	38.6%	23.6%	14.7%	8.6%
Adult day care	61.2%	12.3%	6.1%	2.7%
Public library	8.4%	17%	33.2%	31.5%
Services for disabled	58.7%	16.9%	5.7%	2.7%
Help with energy bill	62.9%	13.5%	7.4%	2.2%
Alcohol/drug abuse treatment	64.1%	12.5%	4.9%	1.7%
Domestic violence	65.9%	11.8%	4.2%	1.7%
Housing/rental assistance	67.3%	9.4%	5.7%	2%
Prescription drug assistance	52.6%	16.9%	10.3%	7.1%
English 2 nd language classes	63.1%	6.9%	3.4%	1.7%

Healthy Carroll Vital Signs II

Measures of Community Health®



A Publication of The Partnership, Inc.
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Dear Partners and Friends,

Since our original Community Health Assessment Project in 1996, you have worked in partnership toward a vision of a “healthier community.” Adults and young people, civic groups, public and private sector agencies, faith organizations, schools, neighborhoods, and so many more, have demonstrated the power of collaboration and cooperation. You described your vision of a “healthier community” as:

A true community, linked together by a central, coordinating hub that promotes:

- Community values and connections
- Partnership among organizations
- Locally available, accessible, affordable, and integrated health education and services for all
- Safe activities which enhance mind, body, and spirit
- Empowerment of individual responsibility

In 1999, The Partnership, Inc., was formed to be that coordinating hub. We define “community” as the jurisdictional boundaries of Carroll County, Maryland, and we subscribe to the World Health Organization’s broader definition of health which says, “Health is a state of complete physical, mental and social well-being — not merely the absence of disease or infirmity.”

Our history of facilitating collaboration and cooperation is only a means to an end — not the end itself. Since the early days, you, the visionaries of The Partnership, have sought measurability and results. “How will we know when we are a healthier community?” has been our constant organizational challenge. These Healthy Carroll Vital Signs II are another step in our journey. They take the pulse of our community’s health status in the areas you previously identified as the most important and needing improvement, including:

Prevention & Wellness	Interpersonal Violence
Access to Health Care	Mental Health
Cancer	Positive Youth & Family Development
Elder Health	Substance Abuse
Growth	Water Quality
Heart Health	

Healthy Carroll Vital Signs was published for the first time in May 2006. It contained outcome indicators, seeking to measure the well-being of our whole population — cross-community accountability, if you will. Taking our “pulse” metaphorically means identifying how our health is improving.

Two years later, we are publishing this, our second edition. This issue contains newly added contextual information by way of gold standard sources and corresponding improvement targets. These benchmarks provide reference for understanding our own community’s health status. With at least three comparison points, we are now able to construct trend patterns for each indicator. Because of space and expense, those graphs will be maintained in the online version only, but can be downloaded for your convenience. Also new in this version is inclusion of some of the key strategies undertaken by workgroups, to move those figures as desired.

Of continuing importance, please note these vital signs are not performance measures regarding the client populations of any agency, service, or program.

It is our hope that you will find many uses for this publication — in strategic planning, resource development, resource allocation, or in making personal lifestyle choices. It should help you to know if we are moving in the right direction; when any of our actions are most effective; and provide a common understanding of how our “HEALTH” and quality of life, are changing over time.

This effort to establish Vital Signs is uniquely ours, although numerous similar endeavors are common in the nationwide effort to “create healthier communities.” The Partnership is proud to bring you this work, developed by the knowledgeable and committed members of our community who participated. Archives, trending charts and this second edition are also on our website at www.healthycarroll.org.

As always, we thank you sincerely, for all you do to make ours a healthier community!

Members of the Board of Directors, Executive Council,
and Staff of The Partnership, Inc.
May 2008

Preface

Our Mission

The Partnership for a Healthier Carroll County, Inc. strives to build the capacity of individuals and organizations to improve the health and quality of life in Carroll County, Maryland.

Organizational Vision

The Partnership for a Healthier Carroll County, Inc. will be the leader in healthy community strategies, implemented by the Carroll County, Maryland community, to achieve the highest level of health possible.

Organizational Focus

Operational effectiveness or “doing things right” must be planned and accomplished. But, assurance that we are “doing the right things” is the essence of tactical planning. In 2006, during those planning sessions, The Partnership identified clear commonalities and risk factors among most of the 11 health improvement areas. They are:

- Appropriate healthy weight and levels of physical activity
- Tobacco usage/exposure
- Wellness and/or illness and injury prevention

It is no surprise that one-third of all deaths in our country are attributed to these elements as illustrated in the “What’s Really Killing Us” chart below.

Our leadership further determined that efforts in these areas should become the signature direct work of our organization. The Prevention & Wellness Work Group members are the primary collaborators in addressing wellness and illness/injury prevention. The indicators and strategies identified by the Prevention & Wellness workgroup will be the first measures featured in this publication we are calling Healthy Carroll Vital Signs II.

Reflections

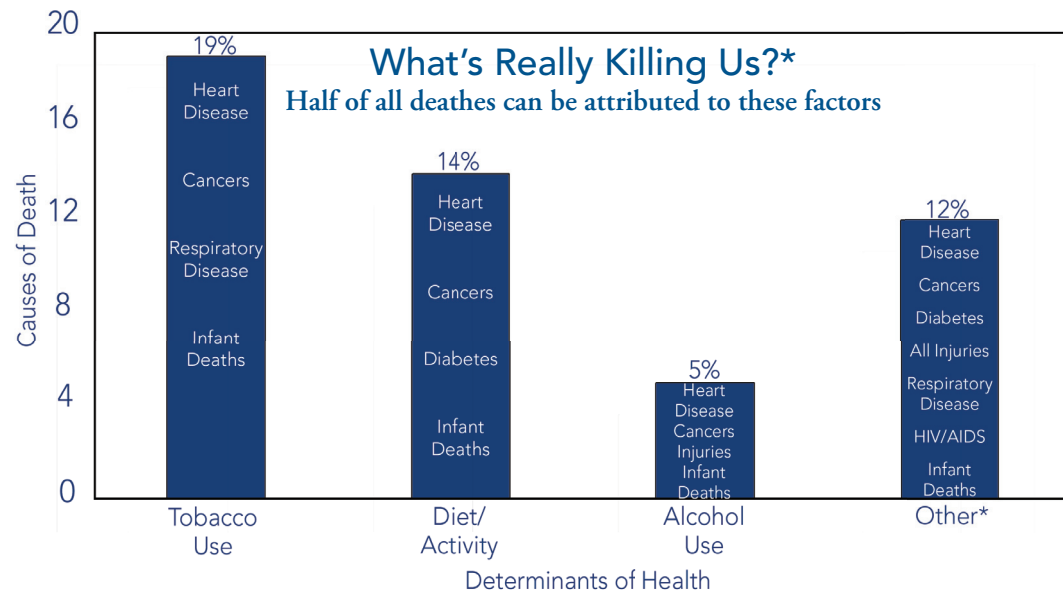
Eleven Community Health Improvement Areas comprise the scope of work for our organization. In 2006, we launched “Healthy Carroll Vital Signs: Measures of Community Health” (HCVS), a framework for achieving measurable health improvement results in those areas. HCVS was a preliminary draft, documenting our early efforts to track specific data points; something we plan to do annually for at least the next ten years.

The indicators and sources in that issue were selected by workgroups consisting of local stakeholders and experts. The document has served us well and we are ready to advance to the next step of this exciting journey.

Terminology

1. What is an indicator?

Indicators provide objective, measurable information via data points. To serve its purpose in accurately representing a value or concern of the commu-



* Other lifestyle and personal behavior (nongenetic) risk factors include microbes, toxins, firearms, sexual behavior, motor vehicles, and drug use. Source: McGinnis, J.M., & Foege, W.H. (1993). Actual causes of death in the United States. *JAMA*, 270(18), 2207-2212.

nity and in promoting and measuring effectiveness, an indicator must meet definitions and criteria established by The Partnership. An indicator must be valid, based on fact, readily measured, accessible and affordable, consistent and reliable, and be capable of showing change over time. An indicator will focus on results, not simply activity or resources expended, and its information source must be independent and likely to produce high quality data over a number of years for measurement of long-term results.

A good indicator will:

- be understandable to the general public
- be able to stand alone as an indicator of that specific health area in Carroll County
- be reliable and available on an annual basis

Source: Mark Freidman, The Fiscal Policy Studies Institute

2. What is an information source?

Valid, objective, consistent, reliable and respected sources of information are critical to accomplish the desired comparison of “apples to apples”. For the charts in this publication, information sources will be consistent from year to year.

If an information source meeting all of the above criteria does not exist, then the data point cannot be considered as an indicator.

3. What are supplemental measures?

Supplemental measures are information of major interest to the workgroup members and are listed on the indicators page, but separately. At this writing, these measures do not meet the indicator definition; possibly only because a data source has yet to be identified. Trending graphs will probably not be available for these measures.

4. What are benchmarks?

Benchmarks are gold standards organizations and their published realistic, achievable targets. These target or improvement objectives are to be accomplished within a defined period of time by a community like ours. Benchmarks provide context for interpreting our own community’s health status.

5. What are results statements?

The desired conditions of well-being, or results statements, are listed for each

of the health areas. They are the optimal conditions our partners and workgroup members are striving for and further define the objectives associated with each health improvement area.

How are we doing on the most important issues?

Carroll County is a relatively healthy and safe community in which to live and work compared to other Maryland counties. Preserving that status amid growth is our challenge. Improving that status is our mission.

Recent assessments support the general conclusion that Carroll County is in good health. Specific areas of concern include community-based behavioral health interventional services for children, youth and adults; dental services for uninsured; youth injury from motor vehicle accidents; overweight/obesity among all ages; and chronic disease management.

Current studies underway are looking at a rapidly growing portion of our population, older adults (60+). We need to better understand the factors that will help this booming population maintain healthy independence for a longer period of time. We also need more information on the health status and habits of our minority populations.

Conclusion

The Partnership for a Healthier Carroll County, Inc. believes that individuals and organizations in Carroll County, Maryland – with diverse skills, respectful work relationships, a willingness to be innovative, and a shared healthier community vision – can improve the health and quality of life in our community.

To stimulate and accelerate engagement in the vision of a healthier community, we add our passion, leadership and expertise and, occasionally, our resources. We achieve community ownership by forming purposeful collaborations that build unity, clarify direction and achieve measurable health improvement results.

Through diligent, scheduled monitoring and reporting on key indicators selected by local experts, The Partnership drives the local effort to create a healthier community.

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Demographics

Community

We define “community” as the whole jurisdiction of Carroll County, Maryland. Before looking at the results statements and indicators contained in this document, it is important to understand the community context. The population, the environment, the economy, and much more all play a role in our shared goal of being a healthier Carroll County community. To better understand that context, these demographics have been organized into five areas: geography, population, economics, business, and families.

Geography

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

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

Population

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

Race (2005):

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

Age (2005):

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

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

Economics

Per capita personal income (2005)	\$ 36,318
Median household income (2006)	87,000
State rank	9th
Persons in poverty (all ages, 2003)	8,084 (5%)
Youth in poverty (ages 0-17, 2003)	2,347 (5.6%)
Unemployment rate (2006)	3.0%
Average cost of a detached 4 bedroom home (2006)	\$272,665 - \$468,602
Housing units authorized for construction (2006)	507

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

Business

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

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

Family

Total number of households (2005)	58,500
Average household size (2005)	2.8 persons
Married-couple households (2000)	34,936 (66.5%)
Family households with children under 18 (2000)	20,863 (39.7%)
Female head of household, no spouse present (2000)	4,350 (8.3%)
Percent of married households (2000)	85%
Percent female headed households (2000)	11%
Percent male headed households (2000)	4%
Marriages in Carroll County (2006)	981
Divorces in Carroll County (2006)	504
Total number of children enrolled in public schools (2006)	28,346

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

Prevention & Wellness

In the most recent strategic planning efforts of our organization, wellness and illness / injury prevention was identified as a signature activity of our work. Within all of our Core Health Improvement areas a prevention focus is where our greatest opportunity for impact exists.

It is no coincidence then, that the workgroup addressing this health component is one of our largest and most active. In fact, additional coalitions like the Smoke-Free Carroll County Coalition have formed as adjuncts. Smoking and secondhand smoke exposure are risk factors in almost all of our health improvement areas. Thus, tobacco use/ exposure is a critical illness prevention action.

Similarly, we have had increasing concerns locally and nationally about the occurrence rates of overweight and obesity; and the high risk that occurrence adds in almost all of our health improvement areas. Thus overweight and obesity prevention, especially in children, is a critical illness prevention focus. The L.E.A.N. Carroll Coalition, another adjunct within this core area, has been formed.

Prevention & Wellness means improving health outcomes as measured by progress in lifestyle and behavior indicators; seeking to promote good health, prevent disease, and increase quality and years of healthy life in the community through education and by encouraging measurable changes in behavior and lifestyle.

To that end, we track data related to physical fitness, nutrition, tobacco-free living, and safety that present an overall view of how Carroll County is doing in terms of preventing chronic disease and making positive health behavior choices.

Please note that the terms “Prevention” and “Wellness” are broad terms that encompass many health areas other than the ones incorporated in this publication. Issues such as immunization, medical visits, and proximity to recreation areas also play a role in promoting a healthy lifestyle.

Other health areas related to Prevention & Wellness that can be found in Healthy Carroll Vital Signs include Cancer, Heart Health, and Substance Abuse.

Visit www.healthycarroll.org for participating organizations and the most recent result trending graphs.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Physical Activity	% of adults in Carroll County who exercise 30 minutes or more at least 5 times per week.	Maryland Behavioral Risk Factor Surveillance System	<i>Healthy People 2010</i> physical activity objective 22-2	30%	L.E.A.N. Carroll, Health Partners Registry, L.E.A.N. Carroll Insert (Summer 08), Carroll on the Move* (Fall 2008)

**Adult Project ACES*

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Nutrition	% of adults in Carroll County who consume fruits and vegetables at least 5 times per day.	Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)	Healthy People 2010 nutrition objective 19-6	50%	L.E.A.N. Carroll Nutrition Partners Healthy Dining Guide
	% of children in Carroll County who consume fruits and vegetables at least 5 times per day.	Maryland Youth Behavioral Risk Factor Surveillance System	Healthy People 2010 nutrition objective 19-6	50%	Healthy Recipes Project, Carroll on the Move* (Fall 2008)
	% of adults in Carroll County who are obese (Body Mass Index of 30 and over).	Maryland Behavioral Risk Factor Surveillance System	Healthy People 2010 nutrition objective 19-2	15% or less	L.E.A.N. Carroll Insert (Summer 08)
	% of adults in Carroll County who have ever been told they have diabetes by a physician.	Maryland Behavioral Risk Factor Surveillance System	Healthy People 2010 diabetes objective 5-2	2.5% or less	Diabetes Today Coalition / DHMH Grant
Tobacco-Free Living	% of CC adults who smoke every day.	Maryland Behavioral Risk Factor Surveillance System	Healthy People 2010 tobacco objective 27-1	25% or less	Smoke-Free Carroll County: Reduce exposure to tobacco through education and advocacy *Youth Mentoring Program
	% of Carroll County 12th graders who have smoked cigarettes in the past 30 days.	Maryland Adolescent Survey	Healthy People 2010 tobacco objective 27-2b	16% or less	
Safety	# of deaths in Carroll County from motor vehicle crashes.	Maryland Highway Safety Office	Healthy People 2010 Injury and Violence Prevention Obj. 15-15	9 per 100,000 or less	C.R.A.S.H. Coalition (Carroll Resources to Advance Safer Highways)
	# of injuries in Carroll County from motor vehicle crashes.	Maryland Highway Safety Office	Healthy People 2010 Injury and Violence Prevention Obj. 15-17	1,000 per 100,000 or less	
Supplemental Measures				*Proposed strategy worked on in 2008 Vital Signs training session.	
Physical Activity	# of visits to CC and municipal Parks and Recreation programs.	Carroll County Dept. of Recreation and Parks Annual Report			

Access to Health Care

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all residents in Carroll County. The three focus areas of access to health care indicators were determined by this workgroup in 2005 and are: preventive and primary care services, emergency services, and long-term care.

Preventive and primary care services have a substantial impact on many of the leading causes of disease and death. Improving access to appropriate preventive and primary care services requires addressing many barriers, including those that involve the patient, provider, and system of care. Patient barriers include lack of knowledge, lack of a usual source of primary care, and a lack of money to pay for services. System barriers include the lack of resources and the lack of coverage for adequate services. Indicators were selected for children's oral health, accessing free clinics, insured rates, medical transportation and prescription coverage.

Each year, emergency services are provided through Carroll Hospital Center's Emergency Department for the ill or injured. This care is provided to patients regardless of their socioeconomic status, age, or special need. In 2006, Access Carroll, Inc. was opened as a free, primary health care provider for uninsured adults. Data on those services is available and is amazing. Additional indicators tracking ED usage by Access Carroll patients is being explored.

In 2007, concerns regarding access to prenatal care for uninsured and MA ineligible women resulted in another active effort. Best Beginnings (see flyer at right) is helping to assure that all women receive the care they need during pregnancy.

Other areas related to Access to Health Care include mental/behavioral health.

Results statement: Residents of Carroll County have access to quality, affordable and available primary health care, dental care, behavioral health care, hospitalization and pharmaceuticals.

Best Beginnings

A program for eligible uninsured, pregnant women

All women deserve the best early care for themselves and their unborn babies. Prenatal care begun in the first three months of the pregnancy reduces complications for both the mother and child. For women without health insurance, getting early prenatal care can be a challenge.

Carroll Hospital Center, our community obstetricians and the Carroll County Health Department want to help. Best Beginnings is a team effort to provide high-quality prenatal, labor and delivery, and in hospital newborn care at an affordable cost. Participants receive the full range of prenatal services, including:

- Office visits with their private obstetrician
- Lab work
- Ultrasound and non-stress tests

(Please note: Best Beginnings does not cover high-risk obstetrics care, extended hospital stays for newborns or community pediatrics services.)

Eligibility

Pregnant women without medical insurance who meet income guidelines are eligible for this program.

Enrollment: Here's how it works in four easy steps:

1. Call the Carroll County Health Department at 410-876-4956 for an appointment.
2. After verifying the pregnancy, health department staff will set up an appointment for the expectant mother with a Carroll Hospital Center financial counselor. The health department also will provide information about other helpful programs. (WIC, Healthy Start, etc.)
3. Hospital financial counselors will work with the expectant mom to develop a payment plan based on household income and other financial factors.
4. Best Beginnings participants will then be sent to a participating doctor.

Make sure your baby has a Best Beginning, call 410-876-4956.

Note: If English language is a problem, please try to have an English speaker accompany the mother.



Best Beginnings is a partnership effort, designed to address an access to health care issue in the Carroll County community. The services provided by Carroll Hospital Center are a part of the hospital's community benefit commitment.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Medical Visits	Total # of CC residents accessing primary medical care.	Mission of Mercy and Access Carroll	<i>Healthy People 2010</i> Access to Quality Health Services Objective 1-5	85%	Promote Mission of Mercy and Access Carroll
	# of CC residents who at some point in the last 12 months could not afford to see a doctor	MD BRFSS	<i>Healthy People 2010</i> Access to Quality Health Services Objective 1-6	7% or less	Promote Mission of Mercy and Access Carroll
	Percent of CC residents report having any kind of health insurance.	MD BRFSS	<i>Healthy People 2010</i> Access to Quality Health Services Objective 1-1	100%	Legislative Agenda Advocacy Training*
Dental Care	# of CC children enrolled in MCHIP receiving dental care.	DHMH Maryland Children's Health Insurance Program (MCHIP)	<i>Healthy People 2010</i> Oral Health Objective 21-10	83%	Promote Pediatric Dental Clinic at CCHD, Legislative Agenda, Advocacy Training*
Supplemental Measures					
Medical Visits	# of CC residents coded as self-pay.	Carroll Hospital Center			Promote Mission of Mercy and Access Carroll, Legislative Agenda Advocacy Training*
Transportation	# of CC riders transported for medical reasons	Carroll Area Transit System			Transportation planning and advocacy
Prescription Medication	# of CC residents under 65 enrolled in state prescription drug programs	DHMH - MD Pharmacy Assistance Program			Promote PPA Express Van
	# of CC residents enrolled in Medicare Prescription Drug Plans	Medicare			

*Proposed strategy worked on in 2008 Vital Signs training session.

Cancer

The physical, emotional, and financial burden of cancer is costly. According to the most recent statistics from the Maryland Cancer Registry, Carroll County has a higher incidence rate of all cancers than the state, but below neighboring Baltimore and Harford Counties. Carroll County has a lower mortality rate for all cancers than the state. With this in mind, the results statement for cancer is to reduce the illness, disability, and death caused by cancer.

In the original Vital Signs document, breast, colorectal, lung, and prostate cancer were identified as the most prevalent cancers to report and track. This year, skin cancer has been added to that set because the dramatic increase in this type of disease warrants our attention.

Results statement: Illness, disability, and death caused by cancer in Carroll County will be reduced.

The cancer areas included in this document have been broken into three indicator sections per cancer: screening, incidence, and mortality with the exception of lung cancer. According to the Maryland State Cancer Plan, current research has not identified any screening mechanisms that lead to reduced mortality for lung cancer. The screening indicators that are included from the Maryland Behavior Risk Factor Surveillance System (MD BRFSS) are in line with the state Cancer Plan's goals and objectives for screening goals.

It is important to note that this publication does not break down cancer screening, incidence, and mortality by race only because of space restraints. It is our intention to have that data on our web site www.healthycarroll.org and in future publications to highlight and address disproportionate minority health differences in cancer.

Other health areas that address prevention efforts related to Cancer in Healthy Carroll Vital Signs II can be found in the Heart Health, Prevention & Wellness, and Substance Abuse sections.

Visit www.healthycarroll.org for participating organizations and the most recent result trending graphs.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Overall Cancer	Total Cancer incidences rate (all sites) in Carroll County	Maryland State Cancer Registry 1998-2002	American Cancer Society 2015 Challenge Goals	25% reduction in age-adjusted rate of cancer incidence	Develop Carroll County Cancer Plan with community partners
	Total Cancer mortality rate (all sites) in Carroll County	Maryland State Cancer Registry 1999-2002	Healthy People 2010 Cancer Objective 3-1	158.7 per 100,000	

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Breast Cancer	Percent of women age 40 or older that have had a mammogram within the past 2 years	MD BRFSS (aggregate 2000, 2002, 2004)	American Cancer Society 2015 Objectives	90%	
	Breast cancer mortality rate in Carroll County	Maryland State Cancer Registry 1999-2002	<i>Healthy People 2010</i> Cancer Objective 3-3	22.2 per 100,000	
Skin Cancer (new)	Percent of children under age 13 who use at least 2 protective measures that reduce the incidence of skin cancer ¹	MD BRFSS	American Cancer Society 2015 Objectives	75%	Increase skin cancer awareness (preschool education project)*
	Percent of adults who use at least one protective measure that reduce the incidence of skin cancer ¹	MD BRFSS	<i>Healthy People 2010</i> Cancer Objective 3-9	Developmental	
Colorectal Cancer	Percent of people age 50 and over who have had a sigmoidoscopy or colonoscopy in the past 5 years	MD BRFSS (aggregate 2002, 2002, 2004)	American Cancer Society 2015 Goals	75%	
	Colorectal cancer mortality rate in Carroll County	Maryland State Cancer Registry 1999-2002	<i>Healthy People 2010</i> Cancer Objective 3-5	13.9 per 100,000	
Lung Cancer	Lung cancer mortality rate in Carroll County	Maryland State Cancer Registry 1998-2002	<i>Healthy People 2010</i> Cancer Objective 3-2	44.8 per 100,000	Smoke-Free Carroll County (reduce exposure to tobacco through education and collaboration)

¹ Protective measures: avoid the sun between 10 a.m. and 4 p.m.; wear sun-protective clothing when exposed to sunlight; use sunscreen with an SPF of 15 or higher; avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths)

*Proposed strategy worked on in 2008 Vital Signs training session.

**All cancer incidence and mortality rates are per 100,000 people.

Cancer continued

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Prostate Cancer	% of men age 50 and over that have had a DRE in the past 2 years	MD BRFSS (aggregate 2001, 2002, 2004)	American Cancer Society 2015 Objectives ²	90%	
	% of men age 50 and over that have had a PSA in the past 2 years	MD BRFSS (aggregate 2001, 2002, 2004)	American Cancer Society 2015 Objectives ²	90%	
	Prostate cancer mortality rate in Carroll County	Maryland State Cancer Registry 1999-2002	<i>Healthy People 2010</i> Cancer Objective 3-7	28.7 per 100,000	
Supplemental Measures					
Breast Cancer	Breast cancer incidence rate in Carroll County	Maryland State Cancer Registry 1998-2002			
Colorectal Cancer	Colorectal cancer incidence rate in Carroll County	Maryland State Cancer Registry 1998-2002			
Lung Cancer	Lung cancer screening in Carroll County				Investigate current research
	Lung cancer incidence rate in Carroll County	Maryland State Cancer Registry 1998-2002			
Prostate Cancer	Prostate cancer incidence rate in Carroll County	Maryland State Cancer Registry 1999-2002			

*Proposed strategy worked on in 2008 Vital Signs training session.

**All cancer incidence and mortality rates are per 100,000 people.

²increase to 90* the proportion of men aged 50 and older who follow age-appropriate American Cancer Society detection guidelines for prostate cancer."

Elder Health

The Elder Health workgroup was developed in 2007 to identify issues and opportunities that can be addressed to improve the health and quality of life for the ever expanding older adult population and their caregivers. The ripple effect of that growth is expected to be far reaching and uncertain.

Five objectives have been identified including:

Results statement: Increase the quality and years of healthy life for Carroll Countians over age 60.

1. Studying the needs of 60+ year-olds in our community to determine issues and opportunities related to health and quality of life.
2. Staying aware of and supporting the HP2010 and beyond National Health Agenda with regard to older adults. For example:
 - Preventing disease, disability and death from infectious diseases including vaccine preventable diseases.
 - Improving quality of life through the prevention, detection and treatment of risk factors
3. Including and promoting networking/sharing among all entities addressing older adults in Carroll County to include, but not be limited to, Office of Aging, Commission on Aging, AARP, etc.
4. Studying the evidence-based and/or best practice approaches emerging from surrounding communities, and the broader field of older adult health and aging research and development. Incorporating that learning in our agencies, providers and general community practices.
5. Establishing long-range result statement for Elder Health and a set of Elder Health indicators (as per our established indicator definition) for inclusion in the “Healthy Carroll Vital Signs – Measures of Community Health” results accountability system.

The first major project of the workgroup is underway. A statistically valid needs assessment for older persons gathered via a household survey was completed in late April 2008. It took workgroup members more than a year to design, pilot test and prepare for distribution.

The purpose of the survey was:

- to provide scientifically valid insight into how older adults build and maintain the qualities that allow them to remain independent.
- to better understand the skills and support that may be needed in order to help older adults sustain their independence.

The assessment itself was a multi-page document consisting of a series of questions —answered with a simple check mark — covering the categories of health, self-sufficiency, physical activity, nutrition, community engagement, social activities, hobbies, pets, and household details.

Data collected from the survey will be used by community agencies that help older adults maintain their independence and will inform the workgroup in identifying the key indicators of older adult health in our community.

Visit www.healthycarroll.org for participating organizations and the most recent result trending graphs.

Growth

Carroll County has seen extensive growth in its population over the last two decades. The beautiful landscape, excellent schools and community-oriented neighborhoods have made it a popular place to live. Yet with growth has come many challenges to the overall quality of life. Issues with housing, business development, traffic, water and sprawl are some concerns of citizens.

Carroll County's Comprehensive Plan for growth is called "Pathways to Carroll's Future Landscape". The key goal is to develop a community-wide consensus of support for Carroll's future direction. "Carroll County wants a future where new development helps to maintain the character and heritage of our community, where more jobs are available in the county that match the skills of the people who live here, where we can sustain our natural systems, and where the transportation system allows all people to get from one place to another safely and efficiently."

The public has been involved in all phases of the plan with community meetings, conferences, surveys and online participation. Residents are encouraged to regularly check the website www.carrollpathways.org to participate and find out about meetings and surveys. Resources on the website include a housing study, Buildable Land Inventory Maps, Topic Papers such as Green Building, Walkable Communities, Health and Community Design and presentations on the key "pathways": Directing and Designing Growth, Taking Care of Business, Connecting with Our Heritage, Networking Transportation, Housing the Workforce and Sustaining Our Natural Systems.

Related data can be found at the Carroll County Government website (www.ccg.carr.org) under Public Works for traffic count studies, Department of Economic Development for a commuter survey, and www.healthycarroll.org/communityassessment.

Results statement: Carroll County will grow based upon a plan with community support which retains the heritage, quality of life and special places of the county.



Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Land Preservation	# of acres put in land preservation (Note: Carroll County ranks 5th in the nation in # of acres in land preservation)	Carroll County Dept. of Planning / Agricultural Land Preservation Program	Carroll County Government	100,000 acres in land preservation	
Development	# and % of tons of total recycled waste	Carroll County Bureau of Waste Management	<i>Healthy People 2010</i> Environmental Health Objective 8-15	At least 38% of waste recycled	Increase recycling at CCHD
Supplemental Measures					
Population	Total population	MD Dept. of Planning			
Recreation	# of County operated trail miles	Carroll County Recreation and Parks			
Development	# of tons of total waste disposed	Carroll County Bureau of Waste Management			
	# of building permits issued (residential units)	Carroll County Bureau of Development Review			



Heart Health

Heart disease is the number one cause of death for men and women in Carroll County, as it is in Maryland and the United States. Stroke is the number three cause of death, and a leading cause of disability. Cardiovascular health and quality of life can be improved with primary prevention efforts, early detection and treatment.

Much progress has been made in the treatment of heart disease, but the largest impact will happen as individuals make heart-healthy lifestyle choices. The risk factors for heart disease which can be controlled are tobacco use, physical activity, healthy diet, overweight, high blood pressure, high blood cholesterol and diabetes. Management of these areas greatly improves heart health.

Results statement: People across the lifespan have good cardiovascular health.

Heart health improvement efforts in our community have focused on increasing physical activity, reducing tobacco use and exposure, screening for blood pressure and cholesterol, increasing awareness of early warning signs of heart attack and stroke, the importance of early access to the emergency response system, and increasing access to Automated External Defibrillators (AEDs) in the community.



Heart health improvement efforts must be addressed to youth as well as adults. Many of the risk factors for heart disease are showing up in children, and will lead to a generation developing heart disease at earlier ages. Nationwide, concerns about overweight and obesity trends in young children are a cry for action. Fortunately, these trends can be reversed with individual and community-wide effort.

Other health areas related to Heart Health that can be found in Healthy Carroll Vital Signs II include Prevention & Wellness and Substance Abuse.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Physical Activity*	% of students participating in Project ACES who meet the goal of 60 minutes of physical activity per day	Carroll County Health Department	<i>Healthy People 2010</i> Physical Activity Objective 22-6	30%	School-based physical activity challenge (Project ACES)
Cardiovascular Disease	Deaths from Cardiovascular Disease	Maryland Vital Statistics	<i>Healthy People 2010</i> Heart Disease and Stroke Objective 12-1	166 per 100,000	Health Partners Registry, L.E.A.N. Carroll, Smoke-Free Carroll County
	% of people who have been told they have high blood pressure.	MD BRFSS	<i>Healthy People 2010</i> Heart Disease and Stroke Objective 12-9	16% or less	Health Partners Registry, L.E.A.N. Carroll
Stroke	Deaths from Stroke	Maryland Vital Statistics	<i>Healthy People 2010</i> Heart Disease and Stroke Objective 12-7	48 per 100,000	Body and Soul Program
Cardiac Arrest (new)	% of persons with out-of-hospital cardiac arrest who receive therapeutic electrical shock	Maryland Institute for Emergency Medical Services Systems (MIEMSS)	<i>Healthy People 2010</i> Heart Disease and Stroke Objective 12-5	Developmental	Advocate and educate to increase # of facilities that have AEDs
Supplemental Measures					
Physical Activity	% of students who participate in Project ACES	Carroll County Health Department			Revisions in Project ACES parent surveys; teacher training*
Cardiovascular Disease	Heart-related admissions to CHC (cardiovascular disease as primary diagnosis)	Carroll Hospital Center			
Cardiac Arrest	# of facilities that have AEDs	Maryland Institute for Emergency Medical Services Systems (MIEMSS)			Advocate and educate to increase # of facilities that have AEDs
	# of cardiac arrest cases				

Additional physical fitness data for adults can be found in the Prevention and Wellness indicators, along with related indicators for prevention of heart disease and stroke.

*Proposed strategy worked on in 2008 Vital Signs training session.

Interpersonal Violence

Results statement: People across the lifespan are free from violence and its effects in their relationships.

Carroll County, Maryland for the most part, is a very safe place to live, work or play. But, we still have issues of violence that are disturbing and unacceptable. Awareness of trends in this area is critically important in assuring we maintain a healthy and safe, community. Interpersonal violence (IPV) includes homicide, suicide, physical abuse or neglect, sexual abuse, rape or attempted rape, physical assaults, and verbal or physical threats of violence.

In 2007, the Domestic Violence Coordinating Council voted to serve simultaneously as The Partnership's Interpersonal Violence Work Group. Council members participated in training programs provided by The Partnership to begin aligning key strategies to already established indicators. That work is proceeding nicely. In FY 09, the council will reconsider the current indicators to assure they continue to serve as key markers of the status of interpersonal violence in our community.

For this 2008 publication, indicators selected by a previous IPV committee are still in place, and are divided into child and adult categories. The youth indicators chosen focus on child abuse referrals and investigations, juvenile assaults and weapons violations in Carroll County Public Schools for youth indicators. The adult indicators focus on domestic violence, aggravated assaults and rape and abuse of vulnerable adults. Vulnerable adult abuse includes the elderly and physically or mentally disabled adults.

The county murder rate is relatively small; therefore the committee chose pointers of other types of violence, many of which could lead to the death. Carroll County data is sometimes combined with other counties in regional reports contributing to the challenge of improving this area of community health. All research indicates that many of these types of crimes go unreported, especially adult sexual assault and domestic violence. There is no mandatory reporting, so the numbers are significantly lower than the actual events. As a result, the committee chose to focus on the number of reports and investigations as opposed to the actual arrests or guilty verdicts, as many different factors can influence the disposition of the cases.

Other health areas related to Interpersonal Violence include Mental Health, Substance Abuse and Positive Youth & Family.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Youth	# of child abuse investigations and arrests in Carroll County.	Carroll County Sheriff's Office Annual Report	<i>Healthy People 2010</i> Injury and Violence Prevention Obj. 15-33	11.1 cases or less per 1,000 children under age 18	
	# of weapons violations at Carroll County Public Schools	Carroll County Public Schools Annual Student Services Report	<i>Healthy People 2010</i> Injury and Violence Prevention Obj. 15-39	6% or less - all students grades 9-12	
	# of juvenile arrests in Carroll County for assault, including physical and sexual.	Carroll County Department of Juvenile Services	<i>Healthy People 2010</i> Injury and Violence Prevention Objective 15-38	33.3% or less - adolescents in grades 9-12 who report physical fighting in the previous 12 months (YRBS)	

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Adults & Families	# of cases filed with the court system in Carroll County for domestic violence and peace orders (combined circuit and district courts).	CC District and Circuit Court and CC Sheriff's Office Annual Report	Healthy People 2010 Injury and Violence Prevention Obj. 15-34	3.6 physical assaults or less per 1,000 persons age 12 and older	Interpersonal Violence Directory The Partnership Clothesline Project
	# of aggravated assaults and forcible rapes in Carroll County.	Uniform Crime report, Maryland State Police	Healthy People 2010 Injury and Violence Prevention Obj. 15-35	0.7 rapes / attempted rapes or less per 1,000 persons age 12 and over	
Supplemental Measures					
Youth	# of victims referred to child protective services in CC for physical abuse, neglect, sexual abuse, mental injury abuse and neglect, including referrals from other agencies.	Department of Human Resources (DHR) and Carroll County Public Schools (CCPS) Annual Report			
Adults & Families	# of new clients seeking domestic violence services through Family & Children's Services.	Family and Children's Services of Carroll County			
	# of new clients served at Rape Crisis Intervention Services, Inc.	Rape Crisis Intervention Services in Carroll County			
	# of long-term care abuse cases investigated in CC facilities including physical, sexual & verbal abuse, gross neglect and other abuses in nursing homes and assisted living facilities.	Carroll County Bureau of Aging – Long Term Ombudsman Program			

Mental Health

According to *Healthy People 2010*, Mental Health is a “state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and cope with adversity.” A mentally healthy community is indicated by many factors including: low suicide attempt rates; increased number of county residents whose insurance covers mental health services; an adequate number of inpatient, outpatient, residential and crisis service providers for all ages; and a decrease in the stigma associated with mental illness and emotional disturbances.



In 2007, the Mental Health Subcommittee of the Behavioral Health and Addictions Advisory Council voted to serve simultaneously as The Partnership’s Mental Health workgroup. At this writing, efforts are underway to align key strategies to impact the identified indicators in this area.

Results statement: Improve mental health across the life span and ensure access to appropriate, quality mental health services.

The mental health partners who selected the current indicators in 2006, explored other possibilities such as measuring the psychiatrist to client ratio, or measuring wait list time. However, those data points are not, to our knowledge, available at this time. They also explored measuring recidivism, a return to treatment, but felt that someone returning for more treatment was not necessarily a negative thing nor did it mean the previous treatment was ineffective, and once again, this data is not tracked in most agencies.

Recurring themes recounted as extreme problems in our county were the lack of enough psychiatrists, the wait time between discharge from hospital or jail before being able to be seen by a counselor, and the lack of quick intensive services for children in crisis, especially those who cannot remain in the home.

The committee chose to track behaviors that can indicate mental illness and that are destructive to the community. Therefore, they chose people in jail with mental health diagnosis and students suspended as the indicators having the most impact on the community.

Other health areas related to Mental Health that can be found in Healthy Carroll Vital Signs II include Substance Abuse and Interpersonal Violence.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Psychiatric Services Rendered*	# of public counseling and psychiatric services rendered for youths and adults in Carroll County	Carroll County Core Service Agency Crystal Report of APS Healthcare Data: ** •Youth 17 years & younger. Seriously Emotionally Ill •Adult 18 years & older Seriously Mentally Ill	Healthy People 2010 Mental Health Objective 18-6	Developmental	
Youth	# of Carroll County Public School interventions for suicidal thoughts.	Carroll County Public Schools Student Services Annual Reports	Healthy People 2010 Mental Health Objective 18-2	1% or less - suicide attempts by students in grades 9-12	
Adults	# of adults in the Carroll County correctional facility identified and case managed by Keystone with diagnoses of major depressive disorders, bipolar disorders and psychotic disorders.	Carroll County Core Service Agency Crystal Report of APS Healthcare Data	Healthy People 2010 Mental Health Objective 18-9	55% - adults 18 and over with mental disorders who receive treatment	
	% of adults in the Carroll County correctional facility with identified mental health disorders that are re-arrested within 1 year or psychiatrically hospitalized.				Mental health continuity of care for those in or released from Carroll County Detention Center*
Supplemental Measures					
Youth	% of students suspended from Carroll County Public Schools grades K through 12	Carroll County Public Schools Student Services Annual Reports			

*Proposed strategy worked on in 2008 Vital Signs training session.

**Data in Healthy Carroll Vital Signs represents public mental health services in Carroll County. Private services data not available.

Positive Youth & Family Development

Results statement: Child well-being and family life is supported throughout the community.

Positive Youth & Family Development was identified as a Core Health Improvement Area (CHIA) by the Partnership during its 2003 strategic planning process. This CHIA recognizes three critical points:

1. families are the cornerstone of a healthy community,
2. our youth represent our future, and
3. all community members should be involved as youth role models and mentors, as “it takes a village to raise a child.”

Positive Youth & Family Development focuses on children ages birth through adolescence, and on the roles of parents, other adults and front-line professionals, as well as, on the progress of children in specific areas.

In Maryland, we are fortunate to have the Local Management Board (LMB) system to identify priorities and target resources for each jurisdiction. According to the Governor’s Office for Children, “The major focus of LMBs is to increase local authority to plan, implement and monitor children and family services. LMBs serve as the coordinator of collaboration for child and family services. They bring together local child-serving agencies, local childcare providers, clients of services, families and other community representatives to empower local stakeholders in addressing the needs of and setting priorities for their communities.”

The excellent, highly collaborative Carroll County LMB is uniquely equipped to lead this CHIA. In 2007, the Carroll County LMB unanimously voted to

simultaneously serve as The Partnership’s workgroup in this area. Specifically fulfilling that role will be the members of the LMB’s School Readiness Team Subcommittee for 2007, 2008, and 2009. The Carroll County LMB has prioritized “Children Entering School Ready to Learn” and “Children Safe in Their Families & Communities” as result areas for focused efforts in 2007, 2008, and 2009.

If the future of our community is to be strong, we need to assure that all young people grow up to be healthy, principled and caring adults, and contributing members of our society and economy. But we must also work to protect our most vulnerable community members – our children – as we strive to continue the proud tradition of our community as a great place to raise a family.

Other health areas related to Positive Youth & Family Development that can be found in Healthy Carroll Vital Signs II include Heart Health, Interpersonal Violence, Mental Health, Prevention & Wellness, and Substance Abuse.



Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Babies Born Healthy	% of babies in Carroll County born to adolescents (15-19 years old).	Maryland DHMH Vital Statistics	Maryland Results for Children <i>Maryland Health Improvement plan 2000-2010</i>	46 pregnancies or less per 1,000 females aged 15-17	
	% of babies born weighing less than 2500 grams (5.5 lbs)	Maryland DHMH Vital Statistics		Incidence of low birth weight in no more than 8% of all live births	<i>Best Beginnings</i>
Healthy Children	# of Carroll County children fully immunized by age 2	Nat'l Immunization Survey from CDC	<i>Healthy People 2010</i> Objective 14-24	90% of children aged 19-35 months up to date	
	Rate of injuries per 1,000 children that require in-patient hospitalization in 3 categories: unintentional injuries (accidents), assault, and self-injury (attempted suicide)	Health Services Cost Review Commission - Office of Injury and Disability Prevention, DHMH	<i>Healthy People 2010</i> Objective 15-14 (Reduce nonfatal unintentional injuries)	Downward trend towards zero	
	Rate of child fatalities among children 1 year or older	Maryland DHMH Vital Statistics	<i>Healthy People 2010</i> Objective 16-2a <i>Healthy People 2010</i> Objective 16-2b	Less than 29.8 per 100,000	
Children Completing School	Dropout Rate (high school)	MD School Performance Assessment Program (MSDE)	<i>No Child Left Behind / CCPS Master Plan</i>	0%	
	High School Program Completion	MD Report Card (MSDE)	<i>No Child Left Behind / CCPS Master Plan</i>	100%	

Positive Youth & Family Development continued

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Children Completing School continued	High School Diploma /Equivalent	US Census Bureau	<i>No Child Left Behind /</i> CCPS Master Plan	100%	
	Graduation/school completion of children with emotional disturbances	MSDE Special Services Information Systems Exit Data	Maryland Results for Children		
Children Enter School Ready to Learn	% of Carroll County kindergarten students who have reached on of three levels of readiness on the Work Sampling System Kindergarten Assessment: full readiness, approaching readiness, or developing readiness	Kindergarten Assessment - Maryland State Department of Education	Maryland Results for Children	75% fully ready by 2008	Educational booth for 100+ pregnant women at 2008 Baby Shower*
Children Successful In School	% of students absent more than 20 days of school annually	Maryland State Assessment	Maryland Results for Children	Downward trend (towards zero) all time low is 11%	
	% of public school students in 3rd to 8th, and 10th grades scoring proficient or advanced on Maryland School Assessment (MSA). ¹	Maryland State Assessment	Maryland Results for Children	Upward trend of proficiency % in reading and math skills	
Children Safe in their Families and Communities	Deaths due to Injury	MD Vital Statistics	<i>Healthy People 2010</i> Objective 15-13	20.8 deaths or less per 100,000	

*Proposed strategy worked on in 2008 Vital Signs training session.

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Children Safe in their Families and Communities continued	Juvenile violent offense arrest rates ages 10-17	MSP Uniform Crime Report	Maryland Results for Children	Downward trend	Teen Scene 2008
	Juvenile non-violent offense arrest rates ages 10-17	MSP Uniform Crime Report	Maryland Results for Children	Downward trend	
	Rate of child abuse or neglect investigations ruled as indicated or unsubstantiated	MSP Uniform Crime Report	Maryland Results for Children	Downward trend	
	Rate of injury resulting in deaths to children	MSP Uniform Crime Report	Maryland Results for Children	Downward trend	
Stable and Economically Independent Families	Single Parent Households	Recent household survey	Maryland Results for Children	Downward trend	
	Out of Home Placements	OCYF from DJJ, DHR, DHMH, MSDE	Maryland Results for Children	Downward trend	
	Permanent Placements	SSA Foster Care and Adoption Child Tracking System	Maryland Results for Children	Downward trend	
	Homeless adults and children	DHR/CSA and HSP of Carroll County	Maryland Results for Children	Downward trend	
	Child Poverty	MD DHR Fact Pack - County Snap Shots	Maryland Results for Children	Downward trend	

¹ For students with significant cognitive disabilities, the Alternate Maryland School Assessment (Alt-MSA) is used to measure student progress in reading and mathematics.

Substance Abuse

Substance abuse and its related problems are cited as a leading health indicator. It is recommended that programs that focus on reducing substance abuse in their communities target efforts to increase substance abuse treatment options, increase the number of middle schools and high schools who provide information about health risk behaviors, and increase abstinence from alcohol, drugs and cigarettes by pregnant women.

In 2007, the Substance Abuse subcommittee of the Carroll County Behavioral Health and Addictions Advisory Council voted to simultaneously serve as The Partnership's Substance Abuse workgroup. These workgroup members represent a very strong cross-section of public substance abuse treatment and prevention experts who are knowledgeable about the ever-changing, ever-challenging related issues.

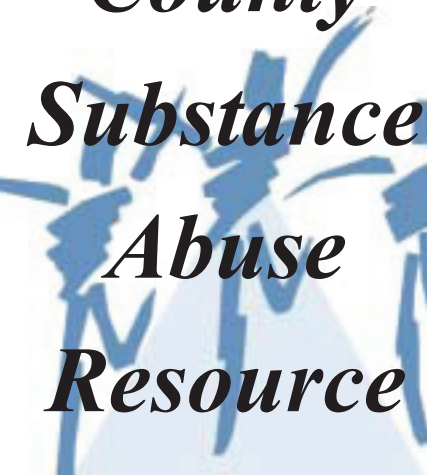
The addition of Ms. Susan Doyle RN, to our Executive Council underscores our organization's understanding of the impact use and abuse of illegal and legal substances has in the health of our community. As the Director of Addictions Services for the Carroll County Health Department, Sue brings great insight, leadership skills and a real understanding of this social disease entity.

The late fall 2007 opening of the first-ever local facility for long-term substance abuse treatment, sited in the South Carroll area, is a major accomplishment. Our appreciation to all who made this possible is sincerely offered.

The workgroup acted quickly to completely revise the key indicators related to this core health area. This action allows comparison of our community to other Maryland jurisdictions and assures focus, lexicon understanding and key strategy alignment.

Other related health areas in the Healthy Carroll Vital Signs II include Prevention & Wellness, Mental Health, Cancer and Interpersonal Violence.

Results statement: People across the lifespan are free of addiction and abuse of illegal and legal substances and their effects.



Carroll County Substance Abuse Resource Directory

2008 edition

*The Partnership for a Healthier Carroll County, Inc.
535 Old Westminster Pike, Suite 102
Westminster, Maryland 21157
410-871-7645 ♦ www.healthycarroll.org*

Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Youth	% of 12th graders who drank alcohol in the last 30 days	Maryland Adolescent Survey	HealthyPeople 2010 Objective 26-10	11% or less	
	% of 12th graders who used drugs other than alcohol or tobacco in the last 30 days	Maryland Adolescent Survey			
	% of 12th graders who used cigarettes in the last 30 days	Maryland Adolescent Survey	HealthyPeople 2010 Objective 27-2b	16% or less	
Supplemental Measures					
Adults	# of patients in outpatient programs who should be in treatment for 90 days	ADAA Data from State of Maryland Automated Record Tracking (SMART)	National Institute of Drug Abuse (NIDA) Principles of Drug Addiction Treatment: A Research Based Guide	65% or greater	
	% of substance use by those who are in outpatient care completing treatment	ADAA Data from SMART	Guidelines established by Maryland Alcohol and Drug Abuse Administration	50% or greater	
	% employment of patients completing treatment	ADAA Data from SMART	Guidelines established by Maryland Alcohol and Drug Abuse Administration	26% change from admission to discharge	

Water Quality

Carroll County residents identified adequate water supply and the safety of water for drinking and recreation as concerns in community assessments since the late 1990s. The concern has grown more urgent as the county has grown and during times of drought. Many towns have restricted growth due to limited water supply. New water sources are being developed but county-wide concerns about sufficient water availability remain.

Our municipal and county governments have made significant progress in addressing these issues through the Master Plan for Water and Sewage, expansion of water supply facilities, growth management and water resource management efforts. A County Water Conservation Plan was adopted in 2008. A process

to assess and monitor the county's watersheds is in place for restoration and protection.

Public water supplies must meet state standards, set by the Maryland Department of the Environment (MDE). Over 40% of Carroll County residents have private wells. Citizens must maintain private wells and septic systems to protect their water and others in the area. The Health Department provides publications online (www.carrollhealthdepartment.dhmdh.md.gov/envirohealth.html) on well and septic care.

Results statement: Carroll County has a safe and adequate water supply both now and in the future.

Every citizen can take an active part in protecting resources with daily conservation habits. The Carroll County Bureau of Utilities offers water-saving devices at reduced cost or free. Be cautious in using chemicals in household products, pesticides and lawn care products, as all eventually end up in the water supply. Together we can make an impact in protecting and conserving valuable resources.

In addition to these indicators, information can be found online at www.mde.state.md.us on water conservation, fish consumption advisories, and a link to the Maryland Biological Stream Survey. Data relating to preservation and recycling is in the Growth section of this report.



Areas	Indicators	Data Source	Benchmark Source	Improvement Objective	Key Strategies
Safety/Quality	# of public sewage overflows per year reported to CCHD	Carroll County Health Department	<i>Healthy People 2010</i> Environmental Health Objective 8-6	2 or less per year	
Recreation/Quality	# of fish kills reported	Maryland Department of the Environment	<i>Healthy People 2010</i> Environmental Health Objective 8-10	Developmental	
	Cumulative streams miles assessed	Carroll County Dept. of Planning / Office of Environmental Compliance	<i>Healthy People 2010</i> Environmental Health Objective 8-8	Developmental	
Supply	Average water usage per household	Carroll County Bureau of Accounting	<i>Healthy People 2010</i> Environmental Health Objective 8-7	90.9 gallons per day	County Water Conservation Plan Carroll County Health Department Poster Contest*
Supplemental Measures					
Safety/Quality	Number of public notices per year of violations to the drinking water of Carroll County	Carroll County Health Department / Maryland Dept. of the Environment			
Supply	Annual rainfall.	Carroll County Health Department / Wastewater Treatment Plant			
	Water levels for wells in relation to average level	Carroll County Health Department			Carroll County Health Department well manuals

*Proposed strategy worked on in 2008 Vital Signs training session.

Acknowledgements

So, where do we go from here? We are well on our way with the publication of this edition of Healthy Carroll Vital Signs II. Additionally, training programs conducted from December 2007 through February 2008 by Shattuck and Associates brought together a diverse group of concerned community organizations and members to learn the methods for key strategy identification and results accountability. Greater understandings of the outcomes approach enhanced bonding within and between workgroups. Renewed energy is the best byproduct of that learning.

Developing skills in key strategy development allows each workgroup to select priorities, to streamline their focus on the desired outcomes and to improve their productivity. Everyone was excited to tackle the strategies identified during the training, and in fact several have already been completed just weeks later. We are certain that in using these new skills, each workgroup will develop goal opportunities for FY 09 and beyond. Action and results will follow.

As always, our intended goal is that community agencies and organizations will use Healthy Carroll Vital Signs II in strategic planning, helping to move our community results from the baseline to the targets. We also hope it assists in grant development or other aspects of that work. Remember, the trending graphs for each indicator are located on www.healthycarroll.org

For our own organization, we know that our greatest opportunity for impact exists by focusing on prevention. Education about lifestyle choice; challenging everyone to compliance with age appropriate health screenings; promoting healthy activities for youth and adults; eliminating tobacco exposure and health disparities; and more.

The process is far from over, this document is just step two of what we hope will be a reliable and resourceful way of tracking the health changes in our community. Remember that while governments or developers build houses or retail centers, it is the people who build the community. In fact, as one of the early leaders of the Healthier Communities movement, Tyler Norris, once said, “The choices we make at home, work, school, play, and worship, determine most of what creates personal health and community vitality.”

Everyone who lives and works in the Carroll County community has a role to play to make certain we do better. That includes everything from individuals making personal healthy eating choices to the health education programs available in the community, to faith organizations, doctors, and other community groups....everyone. We are in this together.

The Partnership would like to gratefully acknowledge the numerous individuals, groups, businesses, agencies, and organizations; and especially our work group partners that contributed in so many ways to this document. You are the voice of our community; and provide the essential expertise and skills needed for this change effort!

The initial work in goal planning is immense but the benefit will endure. Football legend Paul “Bear” Bryant once said “It’s not the will to win, but the will to prepare to win that makes the difference.” In Healthy Carroll Vital Signs II we continue our preparations to secure that “Healthier Community” vision making winners of us all.

A special word of thanks is offered to all those agencies listed below whose representatives participated in the Shattuck training programs, listed by CHIA group distribution.

Cancer

American Cancer Society
Carroll Hospital Center (CHC)
Catastrophic Health Planners, Inc.
Cigarette Restitution Fund Program

Prevention & Wellness

Carroll Chiropractic
Carroll Community College (CCC)
Carroll County Health Department
(CCHD) - Health Ed./Nursing
Carroll Home Care / Carroll Hospice
CHC
Carroll Lutheran Village
Freedom Fitness
Kombat Martial Arts
Maryland Department of Health
& Mental Hygiene (DHMH)
Springfield Hospital Center (SHC)
Transitions

Heart Health

Carroll County Department of Recreation
& Parks
Carroll County Public Schools
Community Volunteers

Elder Health

Carroll County Bureau of Aging
CHC
EMS Committee of Carroll County
Episcopal Ministries to the Aging
Family & Children Services (FCS)
Patient Care Consulting

Access to Health Care

Access Carroll
Carroll County Dept. of Management &
Budget - Grants Office
CCHD - Nursing Bureau
DHMH
Emmanuel Baust UCC
Mission of Mercy

Water & Growth

CCHD - Environmental Growth
CHC

Substance Abuse

CCHD - Shoemaker Center
Junction, Inc.
State's Attorney Office of Carroll County

Positive Youth & Family Development

CCC
Carroll County Children's Fund
CCHD
Catholic Charities Head Start
Local Management Board

Interpersonal Violence

CCHD - Nursing Bureau
Circuit Court for Carroll County
FCS
Human Services Programs
Rape Crisis Intervention Services

Mental Health

CCHD - Core Service Agency
Granite House
Keystone
SHC

The Executive Council expresses their appreciation for the leadership, commitment, and determination of the following Partnership, Health Department and Carroll Hospital Center employees in making this publication possible: Selena Brewer, Dawn Eldridge, Dot Fox, Becky Herman, Barb Rodgers, Lexi Schafer, Kim Spangler and Terry Stair.

“In medicine, vital signs refer to the pulse rate, temperature and respiratory rate of an individual; that is, those things considered necessary (i.e. vital) to sustain life.... But those are minimum and hence limiting requirements. The word “vital” shares the same Latin root as vitality, which suggests the capacity not just to live, but to grow and develop in vigorous ways.”

Reprinted with permission , University of Maryland, School of Social Work
Jim Kunz, Ph.D., Baltimore Neighborhood Indicators Alliance

Healthy Carroll Vital Signs II is a publication of The Partnership for a Healthier Carroll County, Inc.

Healthy Carroll Vital SignsTM DASHBOARD

Released May 2009



Priority health indicators from Healthy Carroll Vital Signs: Measures of Community HealthTM

POPULATION: CARROLL COUNTY, MARYLAND

TOTAL: **174,650** (2008 estimate) Ages 0-4: **6%** Ages 5-19: **23%** Ages 20-44: **31%** Ages 45-64: **28%** Ages 65+: **12%**

INDIVIDUAL BEHAVIORS / INJURIES	* Target	Most Recent Available Data
1. Physical Activity: Adults Who Exercise Regularly	30%	44.7% ●
2. Nutrition: Adults Who Eat Fruits & Vegetables at Least 5 Times a Day	50%	26.4% ●
3. Substance Abuse: 12th-graders Who Drank Alcohol in the Past 30 Days	<11%	44.2% ●
4. Tobacco: Adults Who Smoke Every Day	<26%	13.6% ●
5. Safety: Motor Vehicle Deaths	<10 per 100k	12 per 100k ☺
6. Safety: Motor Vehicle Injuries	<1k per 100k	736.9 per 100k ☺
7. Screening: Adults Age 50 and Over Screened for Colon Cancer	75%	63.4% ☺
8. Screening: Women Age 50 and Over Who Had Mammogram	90%	92% ☺
9. Immunization: Adults Over 50 Who Received Flu Vaccination	90%	42% ●
10. Youth and Families: Teen Pregnancies	<47 per 100k	21.2 per 100k ☺
11. Youth and Families: Children Ready for Kindergarten	75%	69% ☺
12. Youth and Families: Juvenile Arrests for Assault	Downward	181 per 100k ☺
13. Youth and Families: Child Fatalities Due to Injuries	20.8 per 100k	12.8 per 100k ☺
DISEASE / RISK FACTORS	* Target	Most Recent Available Data
14. Obesity: Adults	<16%	30.1% ●
15. Heart Disease: High Blood Pressure	<17%	23.2 ☺
16. Heart Disease Deaths	<167 per 100k	205.9 per 100k ●
17. Stroke Deaths	<49 per 100k	58.2 per 100k ☺
18. Cancer: Total Incidence	25% reduction	485.9 per 100k ●
19. Cancer Mortality	<159 per 100k	195.5 per 100k ☺
20. Diabetes: Adults	<2.6%	6.7% ●
21. Mental Health: Youth Interventions for Suicidal Thoughts	<2%	1.4% (394) ☺
HEALTH CARE	* Target	Most Recent Available Data
22. Health Insurance Coverage	100%	88.5% ●
23. Unable to Access Care During The Last 12 Months Because of Cost	<8%	10.5% ●
ENVIRONMENT	* Target	Most Recent Available Data
24. Percentage of Waste Recycled	38%	31.3% ☺
25. Water Supply: Average Daily Household Water Usage	91 gallons	157 gallons ☺

☺ - Data shows improvement (moving toward target) ● - Data moving away from target

This **Healthy Carroll Vital Signs DASHBOARD** is published annually. Data are for most recent year available as of April 2009.

* Most Targets are based on **Healthy People 2010** (see reverse side for more information).

Additional data information is available at www.HealthyCarroll.Org/healthycarrollvitalsigns.htm

INDIVIDUAL BEHAVIORS / INJURIES

1. Percentage of adults who exercise 30 minutes or more at least 5 times a week. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 22-2*.

2. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 19-6*.

3. Data Source: Maryland Adolescent Survey. *Target Source: Healthy People 2010 Objective 26-10*.

4. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 27-1*.

5. Data Source: Maryland Highway Safety Office. *Target Source: Healthy People 2010 Objective 15-15*.

6. Data Source: Maryland Highway Safety Office. *Target Source: Healthy People 2010 Objective 15-17*.

7. Percentage of adults age 50 and over who had a sigmoidoscopy or colonoscopy within the past 5 years. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 3-5*.

8. Women aged 50-65 who had a mammogram in the past 2 years. Data Source: 2006 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: American Cancer Society 2015 Challenge Goals*.

9. Target for non-institutionalized adults aged 65 and older. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 14-29a. Not a Healthy Carroll Vital Signs™ indicator.*

For more about Healthy People 2010, visit www.HealthyPeople.gov

10. Percentage of pregnancies among females aged 15-19. Data Source: Maryland Vital Statistics. *Target Source: Maryland Health Improvement Plan 2000-2010*.

11. Percentage of kindergarten students assessed as fully ready for school. Data Source: Kindergarten Assessment, Maryland Department of Education. *Target Source: Maryland Results for Children*.

12. Juvenile arrests for physical or sexual assault. Data Source: Carroll County Department of Juvenile Services. *Target Source: Healthy People 2010 Objective 15-38*.

13. Data Source: Maryland State Police Uniform Crime Report. *Target Source: Healthy People 2010*

DISEASE / RISK FACTORS

Objective 15-13.

14. Percentage of adults with a Body Mass Index (BMI) of 30 or more. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 19-2*.

15. Percentage of adults who have been told by a doctor that they have high blood pressure. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 12-9*.

16. Data Source: Maryland Vital Statistics. *Target Source: Healthy People 2010 Objective 12-1*.

17. Data Source: Maryland Vital Statistics. *Target Source: Healthy People 2010 Objective 12-7*.

18. Data Source: Maryland State Cancer Registry. Target: 25% reduction in age-adjusted rate of cancer incidence by 2015. *Target Source: American Cancer Society 2015 Challenge Goals*.

19. Data Source: Maryland Vital Statistics. *Target Source: Healthy People 2010 Objective 3-1*.

20. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 5-2*.

21. Data Source: 2007 Carroll County Public Schools Services Report. *Target Source: Healthy People 2010 Objective 18-2*.

HEALTH CARE

22. Percentage of adults who have any kind of health insurance. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 1-1*.

23. Data Source: 2007 Maryland Behavioral Risk Factor Surveillance Survey. *Target Source: Healthy People 2010 Objective 1-6*.

ENVIRONMENT

24. Data Source: Carroll County Bureau of Waste Management. *Target Source: Healthy People 2010 Objective 8-15*.

25. Data Source: Carroll County Health Department. *Target Source: Healthy People 2010 Objective 8-7*

Indicators in the Healthy Carroll Vital Signs Dashboard are excerpted from Healthy Carroll Vital Signs: Measures of Community Health™, with one exception noted.

The Partnership for a Healthier Carroll County, Inc. is a not-for-profit community health organization supported by Carroll Hospital Center and Carroll County Health Department.

Healthy Carroll Vital Signs

Health Care

Data Charts

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health
ACCESS TO HEALTH CARE Data Charts
Updated April 2009

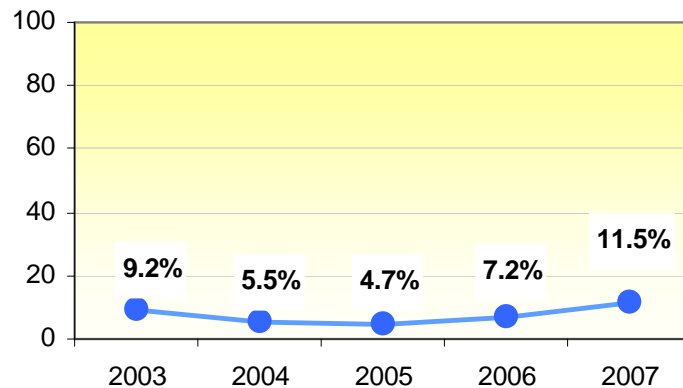
Medical Visits: Residents With a Usual Primary Care Provider	1
Medical Visits: Residents Unable to Afford Care	2
Medical Visits: Residents Who Have Health Insurance	3
Dental Care: Children Enrolled in MCHIP Who Get Dental Care	4



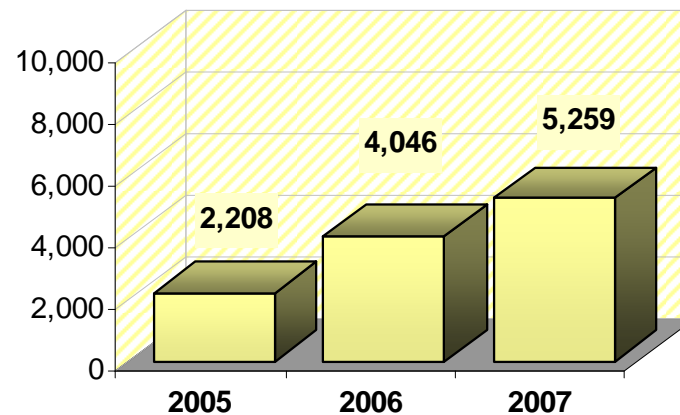
Access to Health Care: Medical Visits Residents With A Usual Primary Care Provider

Improvement Objective: 85% of all residents have a usual primary care provider

**Percentage of survey participants
who report having
no health insurance**



**Number of income-eligible Carroll residents
served by Access Carroll or Mission of Mercy**

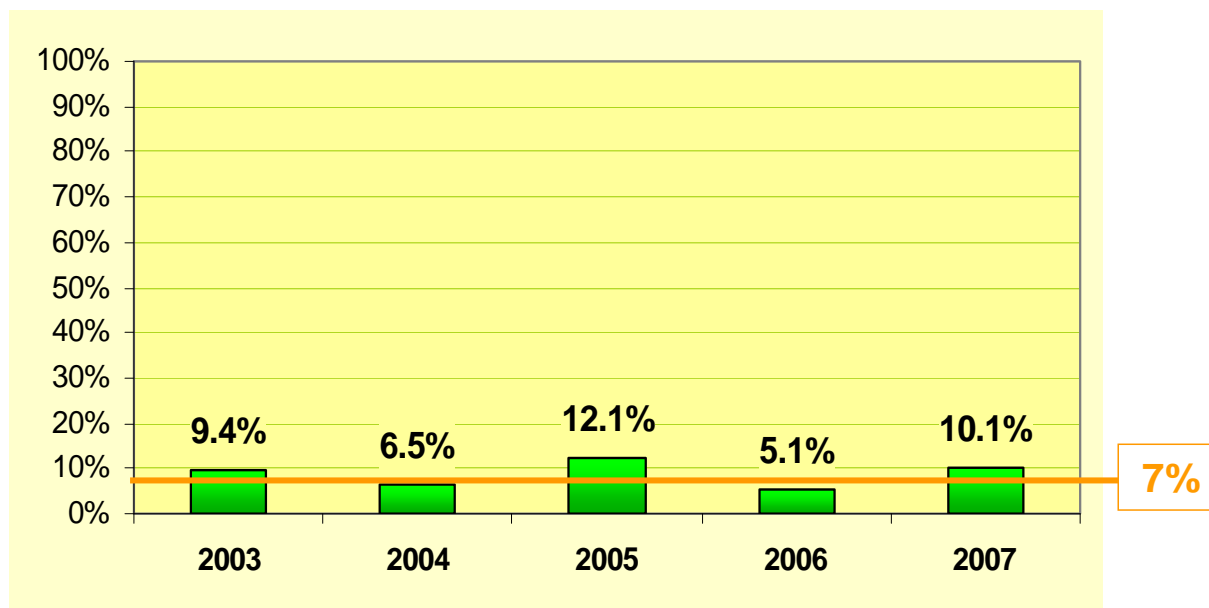


DATA SOURCES: Maryland BRFSS, Access Carroll Inc., Mission of Mercy

Access to Health Care: Medical Visits Residents Unable to Afford Care

Percentage of Carroll County Residents Who at
Some Point in the Last 12 Months
Could Not Afford to See a Doctor

Improvement Objective: 7% or Less

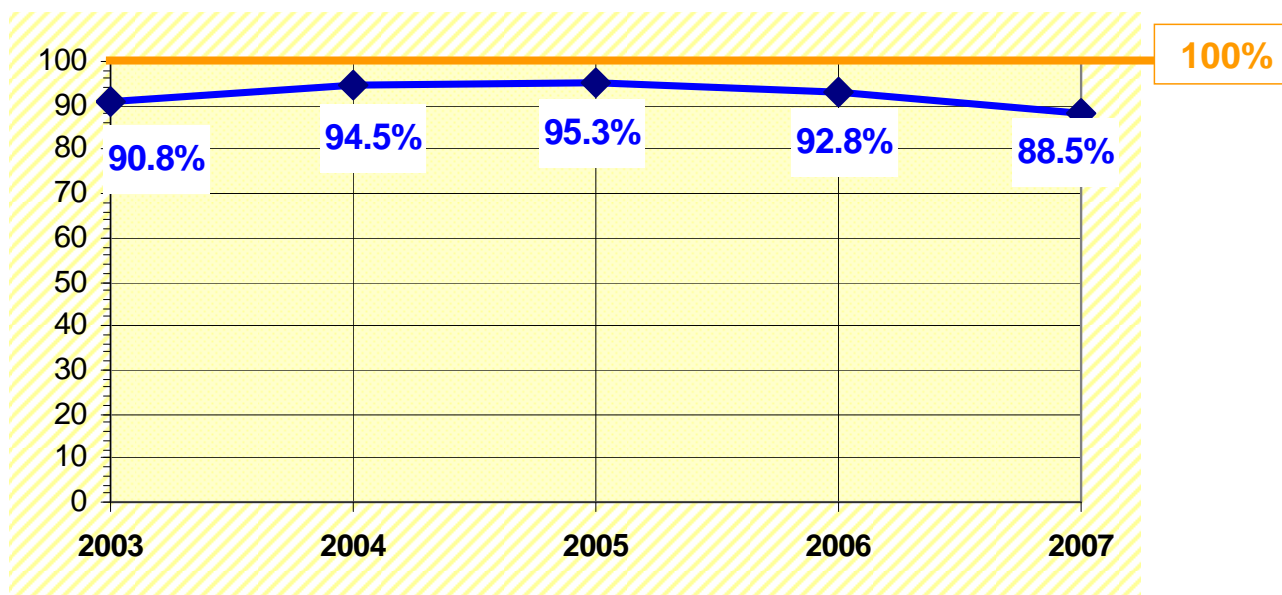


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Access to Health Care: Medical Visits Residents Who Have Health Insurance

Percentage of Residents Who Report Having Any
Kind of Health Insurance

Improvement Objective: 100%

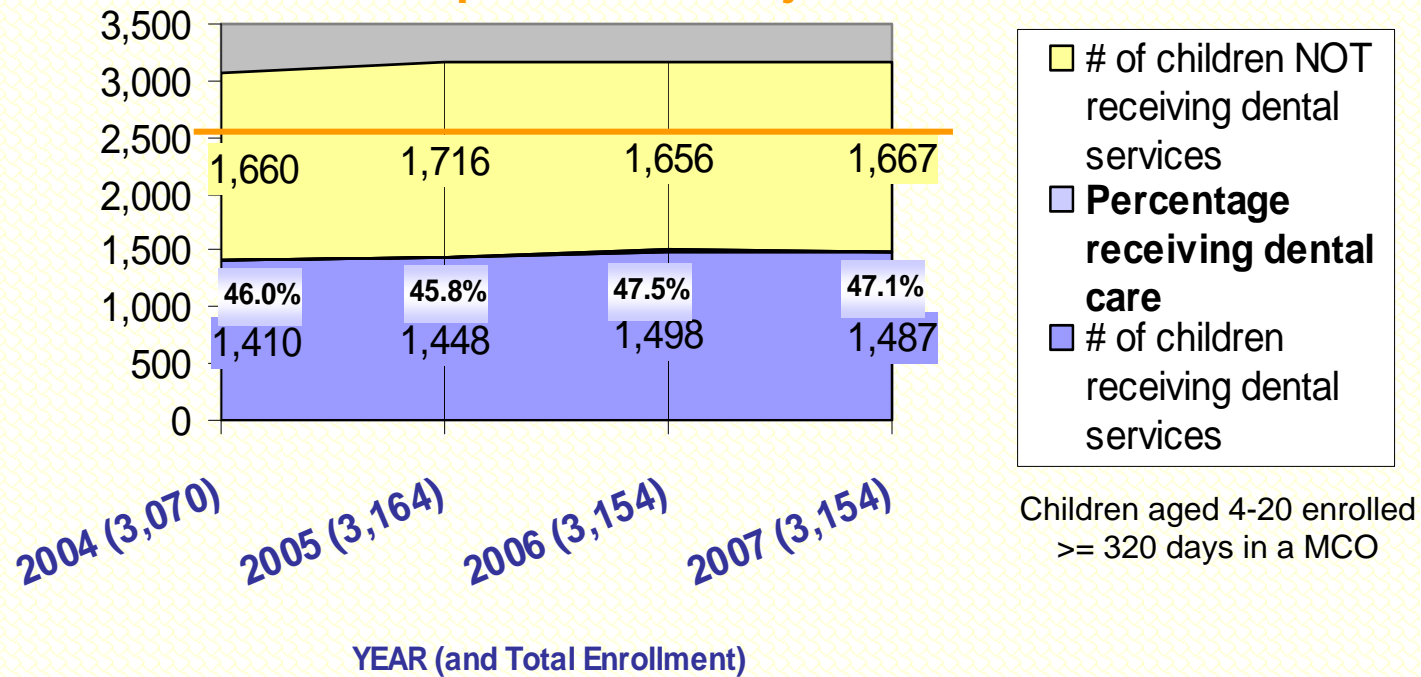


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Access to Health Care – Dental Care

Percentage of Carroll County Children Enrolled in MCHIP Receiving Dental Care

Improvement Objective: 83%



DATA SOURCE: Maryland Children's Health Insurance Program

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health**CANCER Data Charts****Updated April 2009**

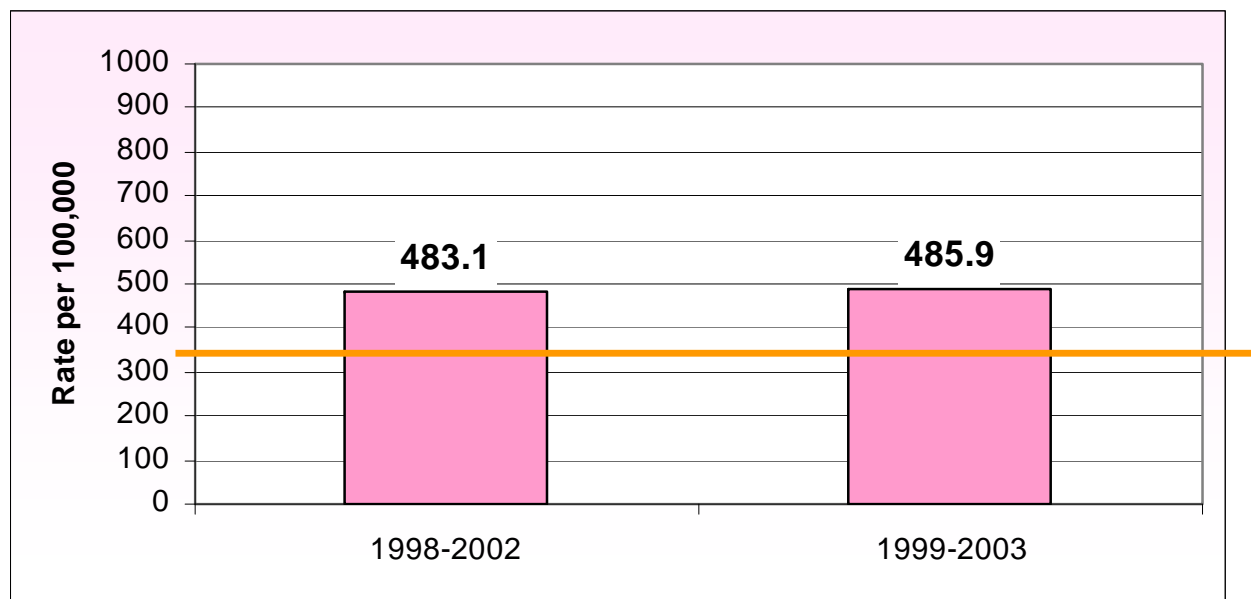
- | | |
|--------------------------------------|-------------------------------------|
| 1. Overall Incidence Rate | 7. Colorectal Cancer Screening |
| 2. Overall Mortality Rate | 8. Colorectal Cancer Mortality |
| 3. Breast Cancer Screening | 9. Lung Cancer Mortality |
| 4. Breast Cancer Mortality | 10. Prostate Cancer Screening – DRE |
| 5. Skin Cancer Prevention – Children | 11. Prostate Cancer Screening – PSA |
| 6. Skin Cancer Prevention – Adults | 12. Prostate Cancer Mortality |



Cancer – Overall Cancer

Total Cancer Incidences Rate (all sites) in Carroll County

Improvement Objective: 25% reduction in age-adjusted rate of cancer incidence by 2015 (362 per 100,000)

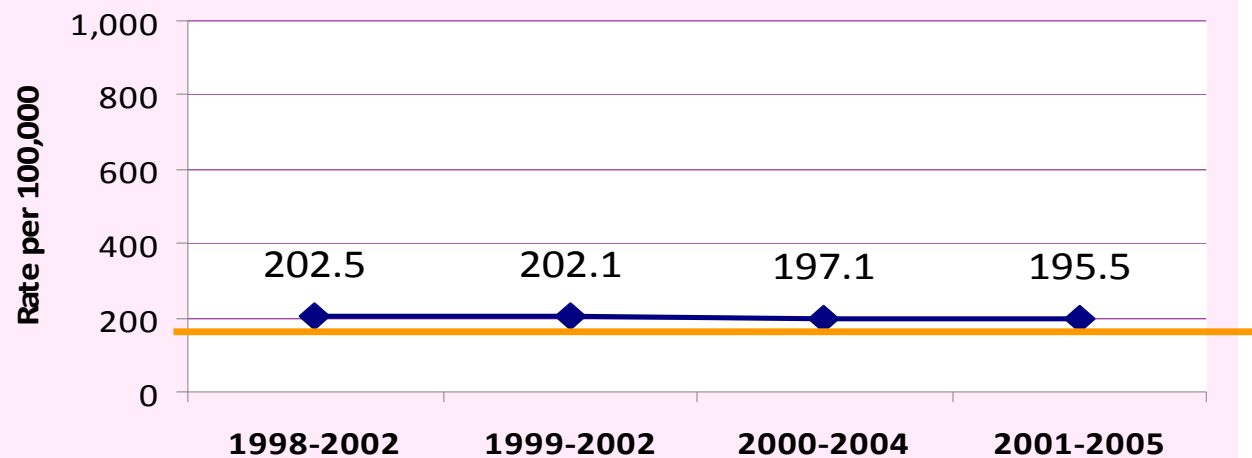


DATA SOURCE: Maryland State Cancer Registry

Cancer – Overall Cancer

Total Cancer Mortality Rate – All Sites

Improvement Objective: 158.7 per 100,000 or less

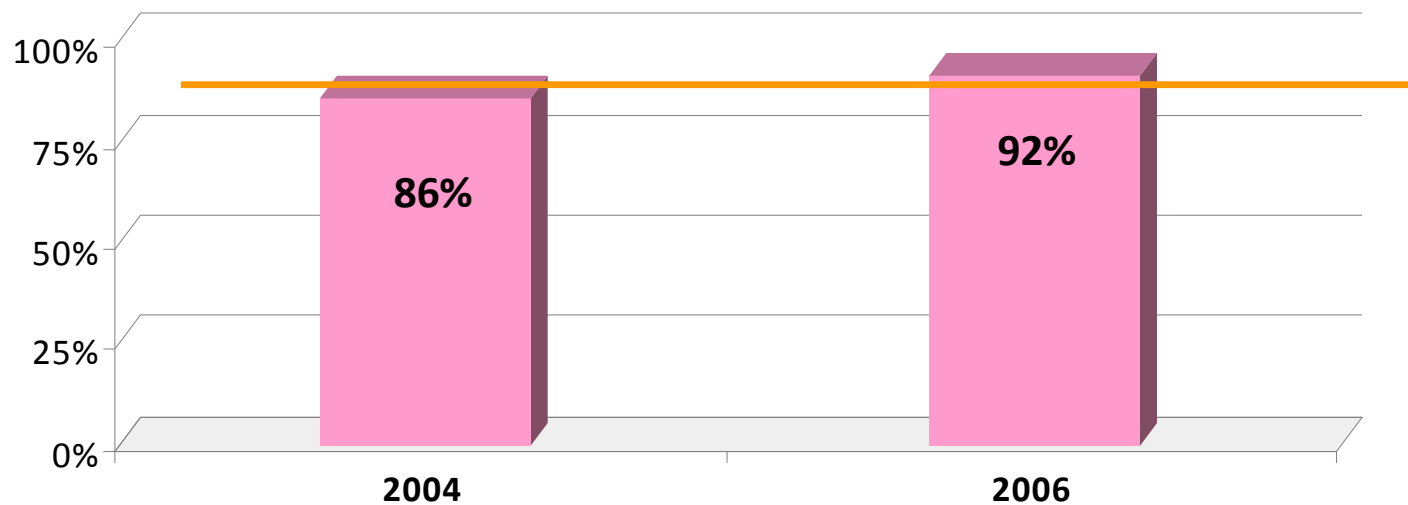


DATA SOURCE: Maryland State Cancer Registry

Cancer – Breast Cancer

**Percentage of Women Aged 40 and Older Who
Have Had a Mammogram Within the Past 2 Years**

Improvement Objective: 90%



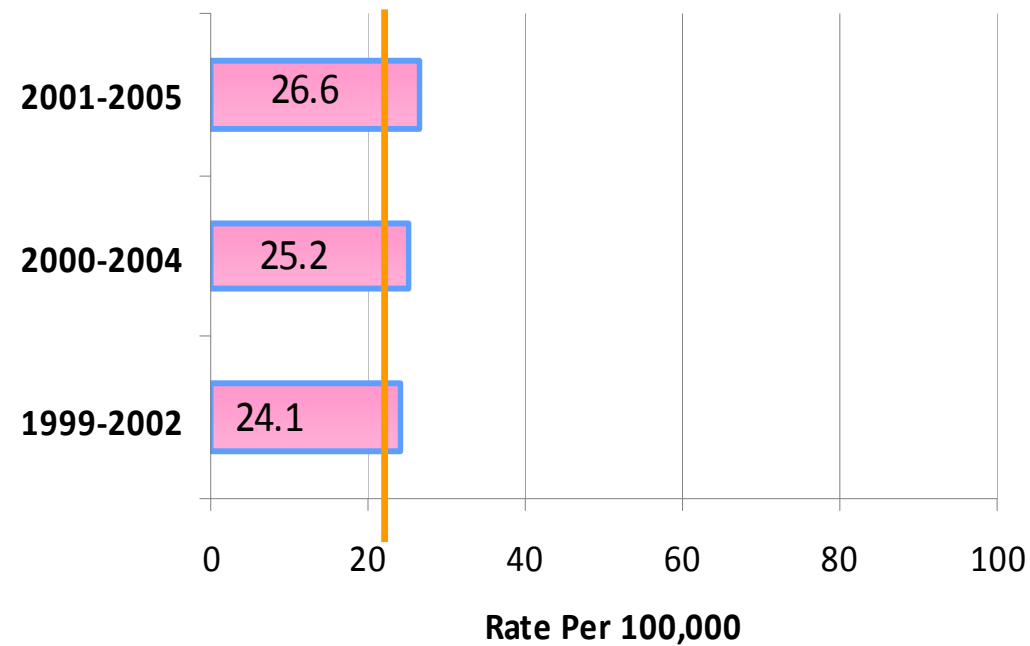
*** NOTE: 2006 data is for women aged 50 and older**

DATA SOURCE: Maryland State Cancer Registry

Cancer – Breast Cancer

Breast Cancer Mortality – Rate Per 100,000

Improvement Objective: 22.2 per 100,000 or less



DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Skin Cancer

**Percent of children under age 13 who use at least 2 protective measures
that reduce the incidence of skin cancer**

Improvement Objective: 75%

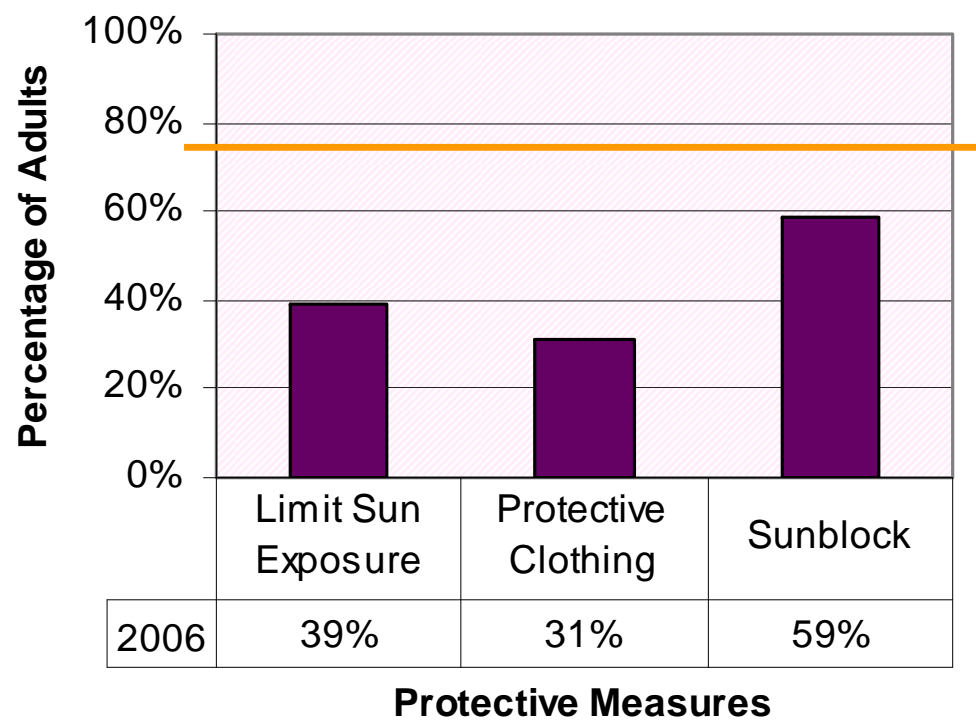
Data unavailable: Sample sizes of <50 are statistically unstable.
Therefore, data is not displayed.

DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Skin Cancer

Percent of Adults Who Use at Least One Protective Measure that Reduces the Incidence of Skin Cancer

Improvement Objective: 75%

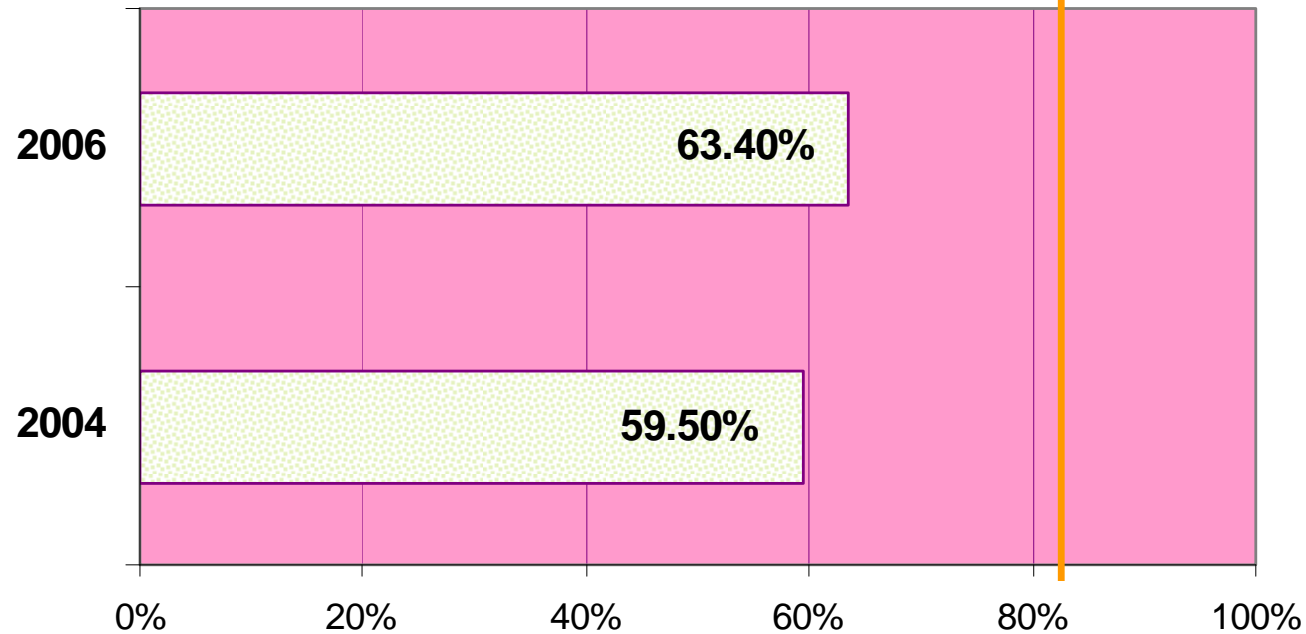


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Colorectal Cancer

Percentage of people aged 50 and older who have had a sigmoidoscopy or colonoscopy in the past 5 years

Improvement Objective: 75%

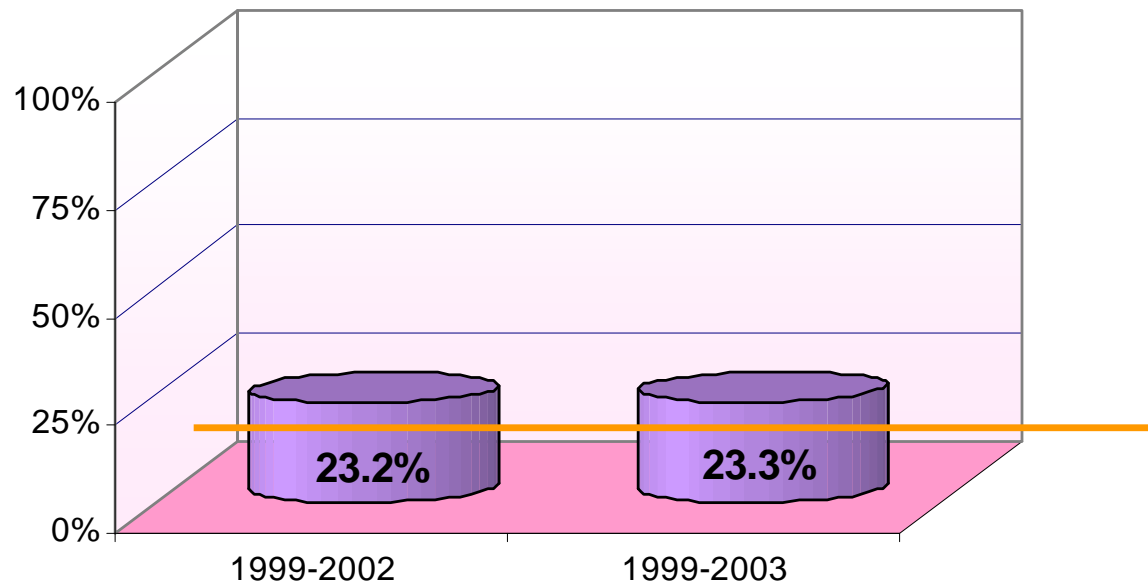


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Colorectal Cancer

Colorectal Cancer Mortality Rate in Carroll County

Improvement Objective: 13.9 per 100,000 or less

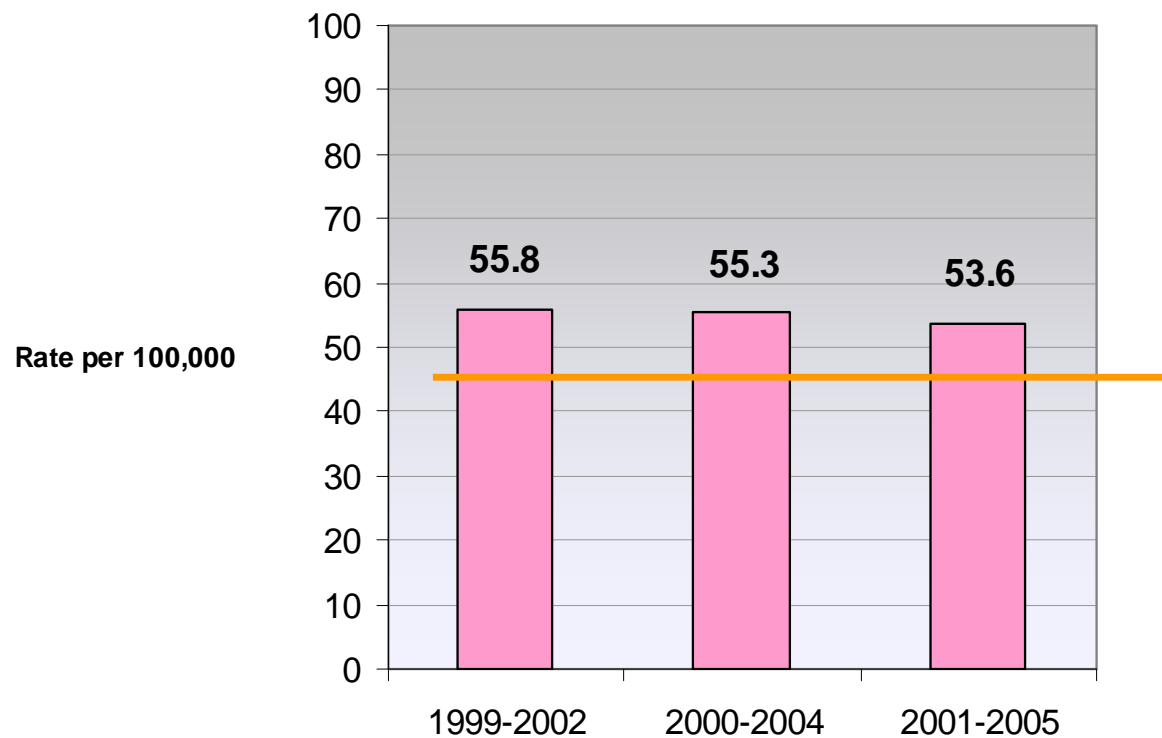


SOURCE: Maryland Vital Statistics

Cancer – Lung Cancer

Lung Cancer Mortality Rate – Carroll County

Improvement Objective: 44.8 per 100,000 or less

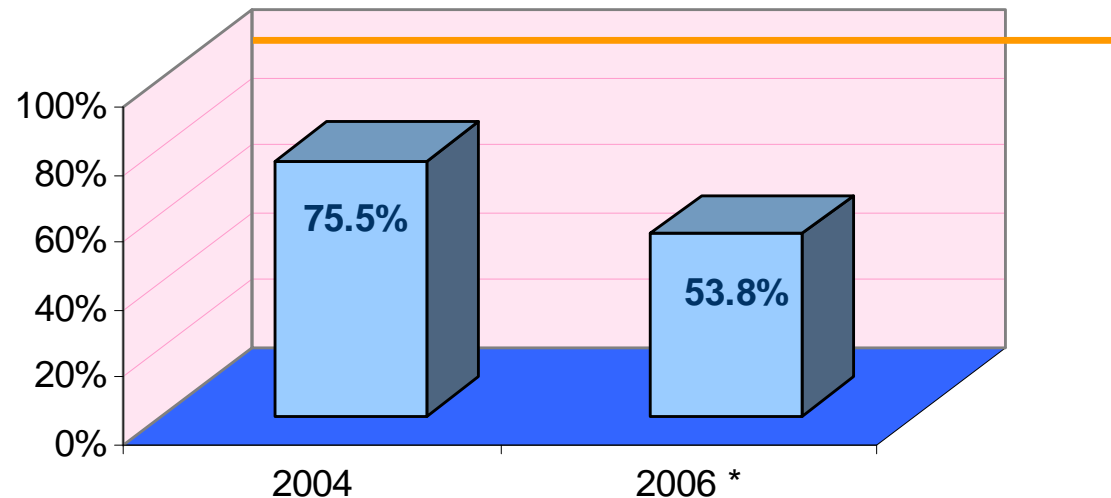


DATA SOURCE: Maryland Vital Statistics

Cancer – Prostate Cancer

Percentage of men age 50 and over who had a Digital Rectal Exam (DRE) in the past 2 years

Improvement Objective: 90%



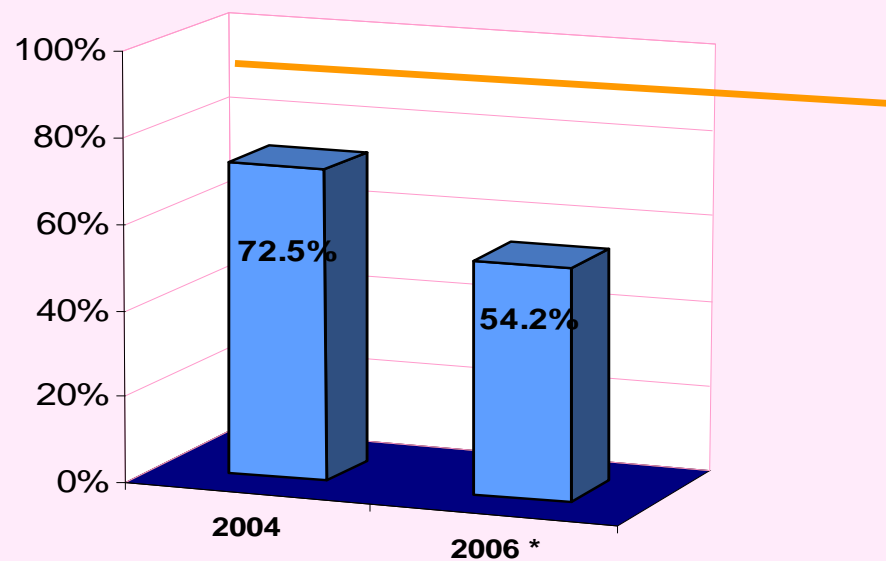
* 2006 question asked for men aged 40 plus

DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Prostate Cancer

Percentage of men age 50 and over who have had a Prostate-Specific Antigen test (PSA) in the past 2 years

Improvement Objective: 90%



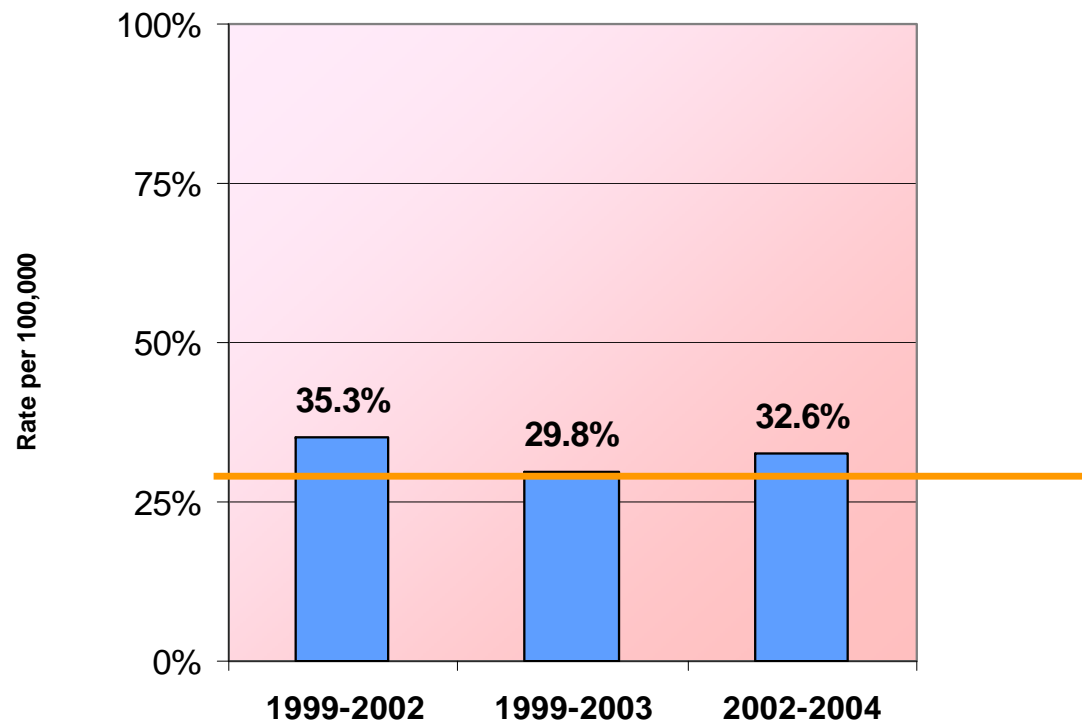
* 2006 question asked for men age 40 plus

DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System

Cancer – Prostate Cancer

Prostate Cancer Mortality Rate – Carroll County

Improvement Objective: 28.7% or less



DATA SOURCE: Maryland Vital Statistics

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health **ELDER HEALTH Data Charts**

Updated April 2009

1. In-Home Safety: Hip Fractures

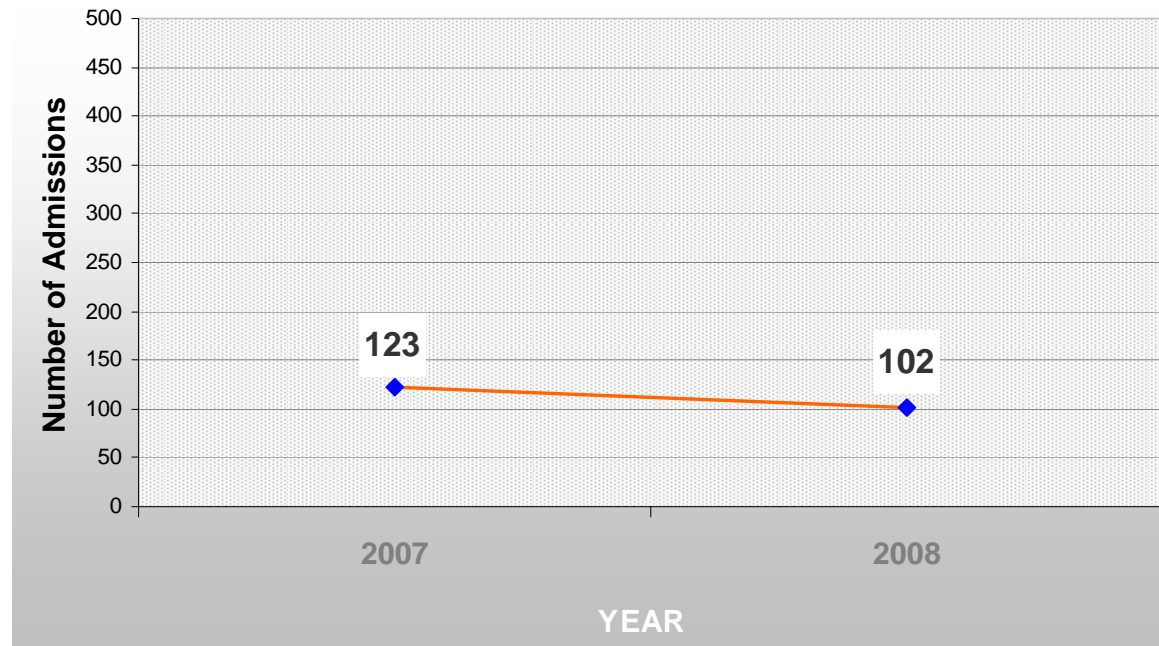
NOTE: Additional indicators for Elder Health are currently under consideration.



ELDER HEALTH

Number of admissions at Carroll Hospital Center for hip fractures,
patients aged 60 and older

Improvement Objective: Downward Trend



DATA SOURCE: Carroll Hospital Center

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health

SUBSTANCE ABUSE Data Charts

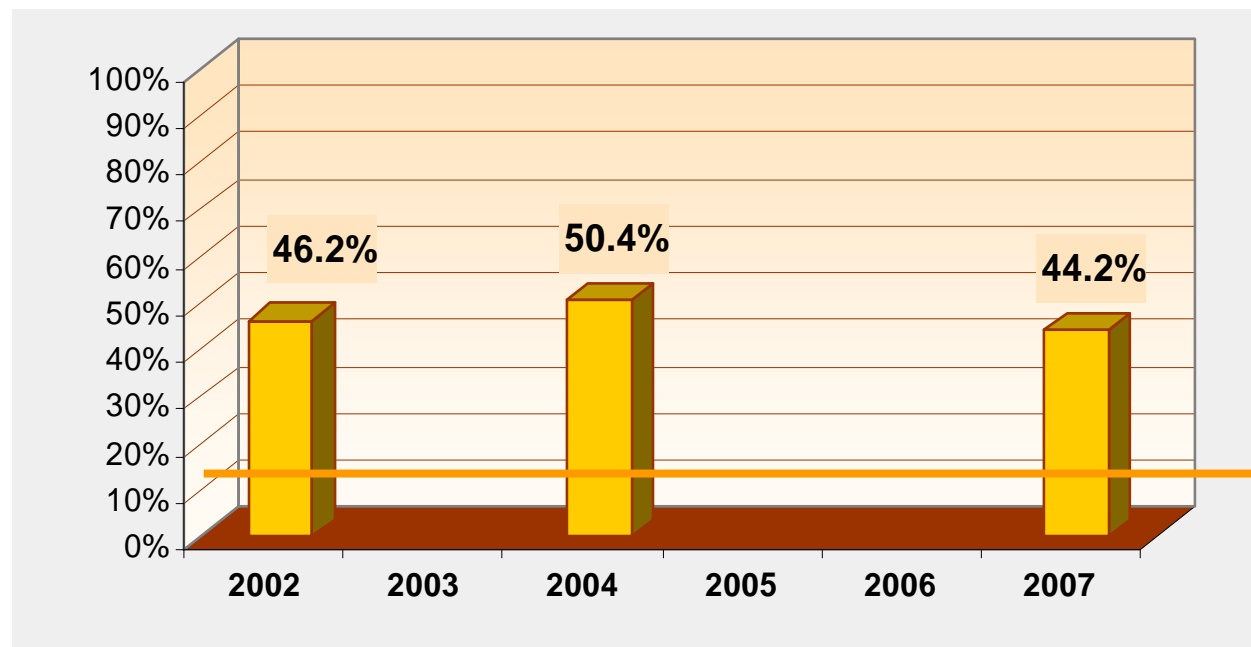
- Alcohol – Youth 1
- Other Drugs – Youth 2
- Tobacco – Youth 3



Substance Abuse – Youth

**Percentage of Carroll County 12th Graders Who
Drank Alcohol in the Past 30 Days**

Improvement Objective: 11% or less

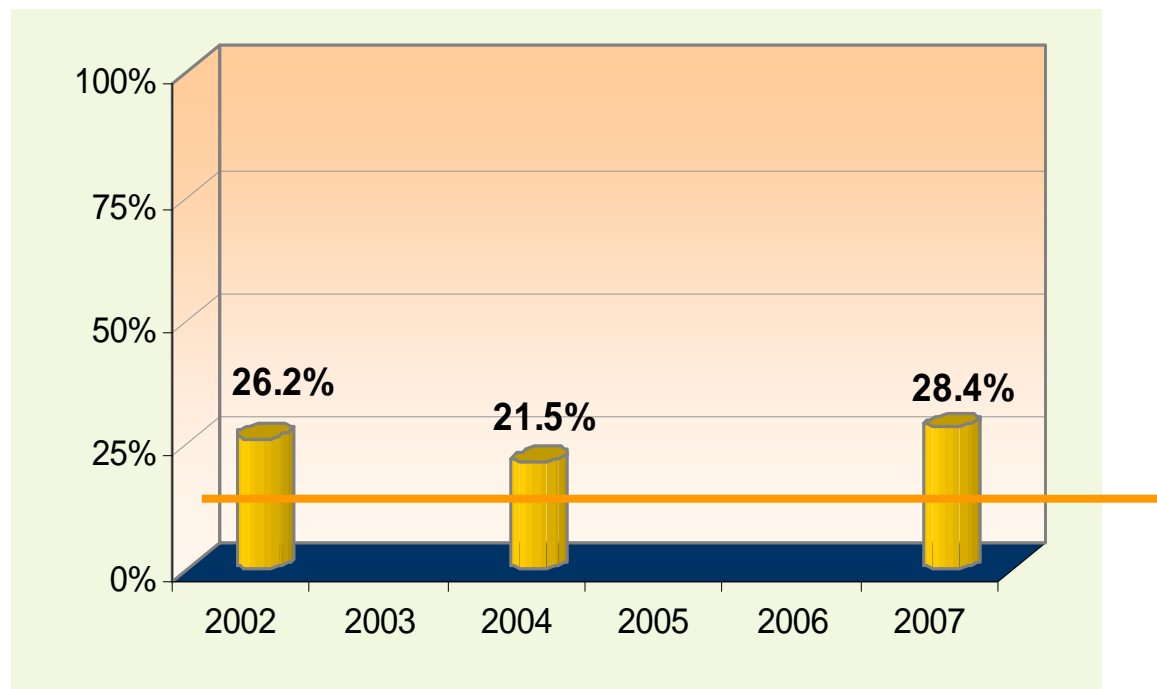


DATA SOURCE: Maryland Adolescent Survey

Substance Abuse – Youth

**Percentage of Carroll County 12th Graders Who Used Drugs
Other Than Alcohol or Tobacco in the Past 30 Days**

Improvement Objective: 11% or less

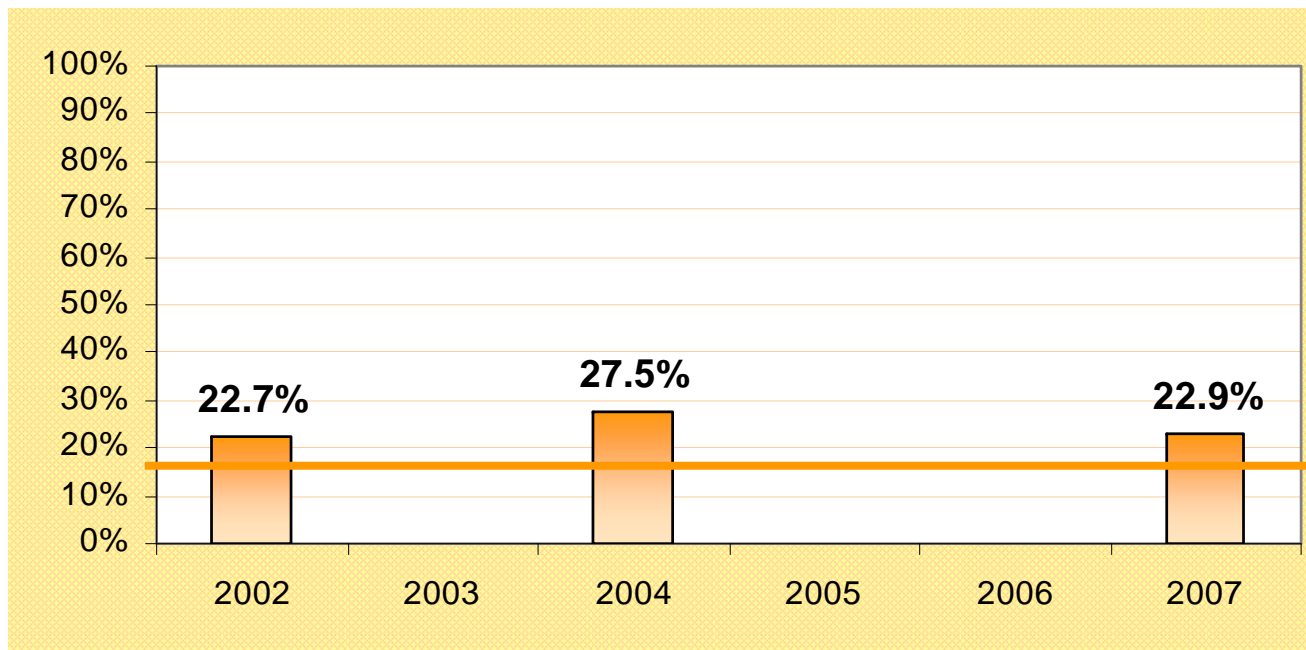


DATA SOURCE: Maryland Adolescent Survey

Substance Abuse – Youth

**Percentage of Carroll County 12th Graders Who
Used Cigarettes in the Past 30 Days**

Improvement Objective: 16% or less



DATA SOURCE: Maryland Adolescent Survey

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health PREVENTION & WELLNESS Data Charts

Updated April 2009

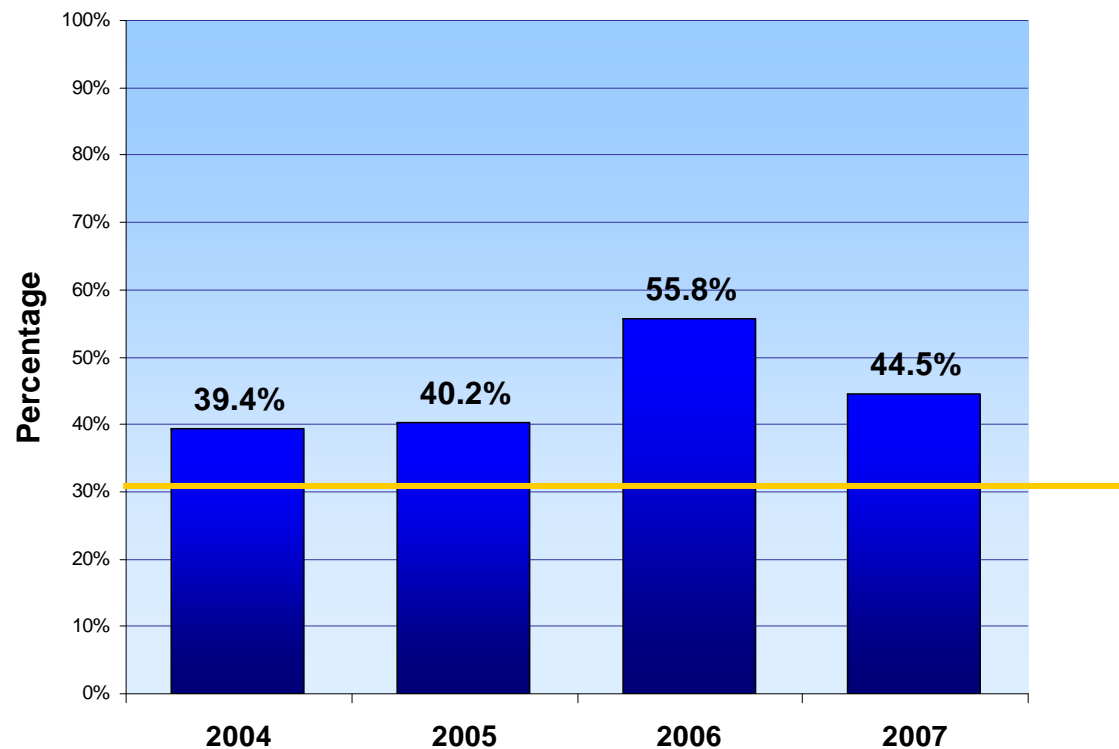
- Physical Activity: Adults 1
- Nutrition: Fruits & Vegetable – Adults 2
- Nutrition: Fruits & Vegetables – Youth 3
- Nutrition: Obesity – Adults 4
- Nutrition: Diabetes 5
- Tobacco-Free Living: Smoking – Adults 6
- Tobacco-Free Living: Smoking – Youth 7
- Safety: Motor Vehicle Deaths 8
- Safety: Motor Vehicle Injuries 9



Prevention & Wellness – Physical Activity

Percent of Adults in Carroll County Who Exercise 30 Minutes or More At Least 5 Times Per Week

Improvement Objective: 30%

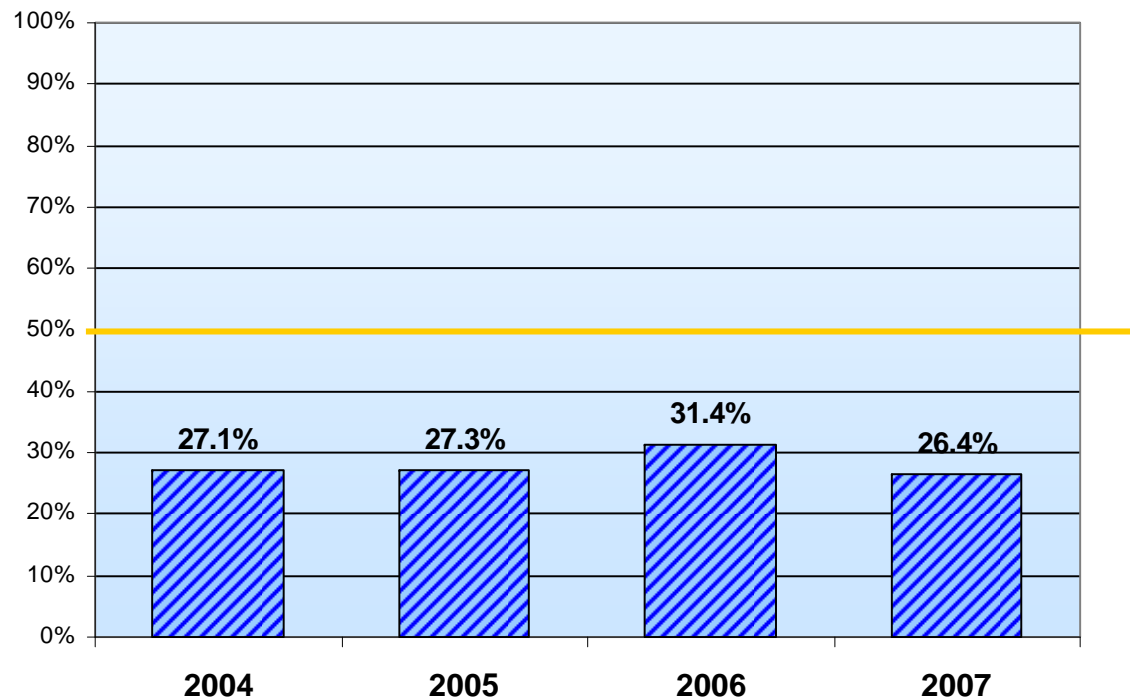


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Prevention & Wellness - Nutrition

**Percent of Adults in Carroll County Who Consume
Fruits & Vegetables At Least 5 Times Per Day**

Improvement Objective: 50%



DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Prevention & Wellness - Nutrition

Percent of Carroll County Youth Who Consume Fruits & Vegetables At Least 5 Times Per Day

Improvement Objective: 50%

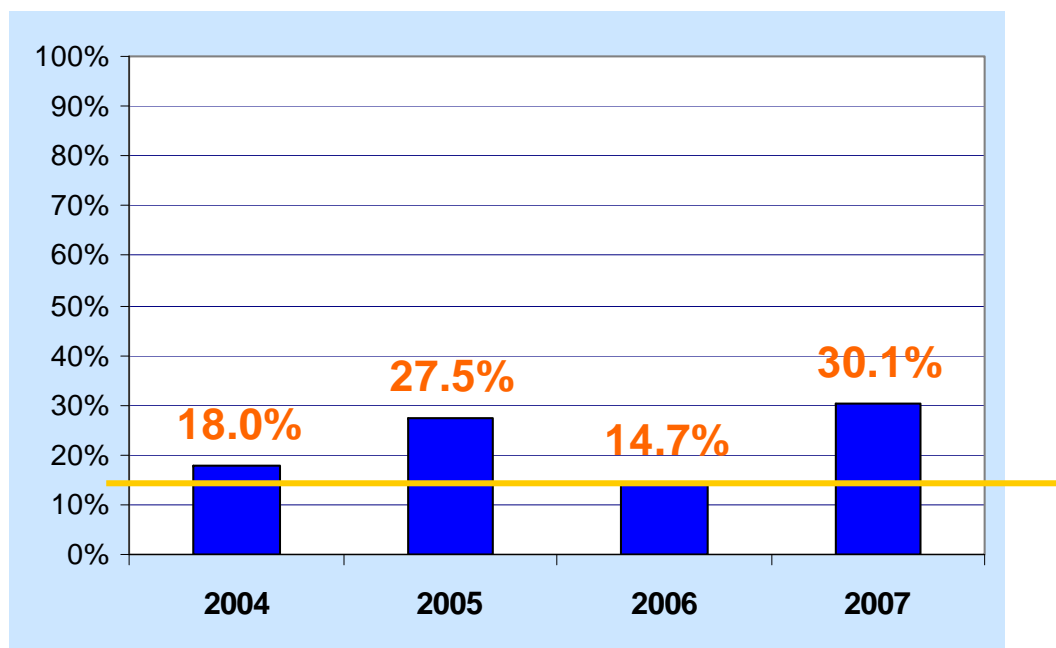
Carroll County did not participate in this study.

DATA SOURCE: Maryland Youth Behavioral Risk Factor Surveillance System (YRBS)

Prevention & Wellness - Nutrition

**Percent of Adults in Carroll County Who Are Obese
(Body Mass Index of 30 and Over)**

Improvement Objective: 15% or less

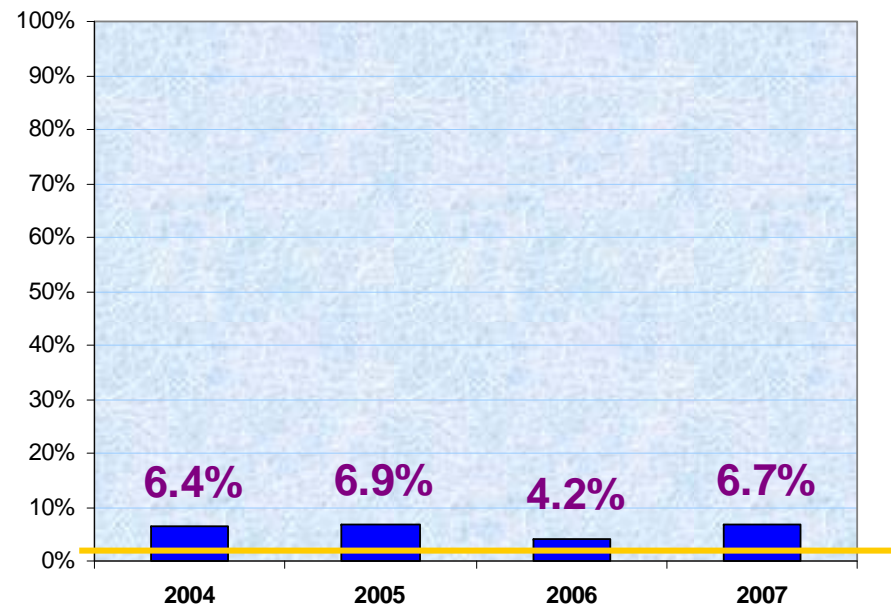


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Prevention & Wellness - Nutrition

Percentage of adults who have ever been told they have diabetes by a physician

Improvement Objective: 2.5% or Less

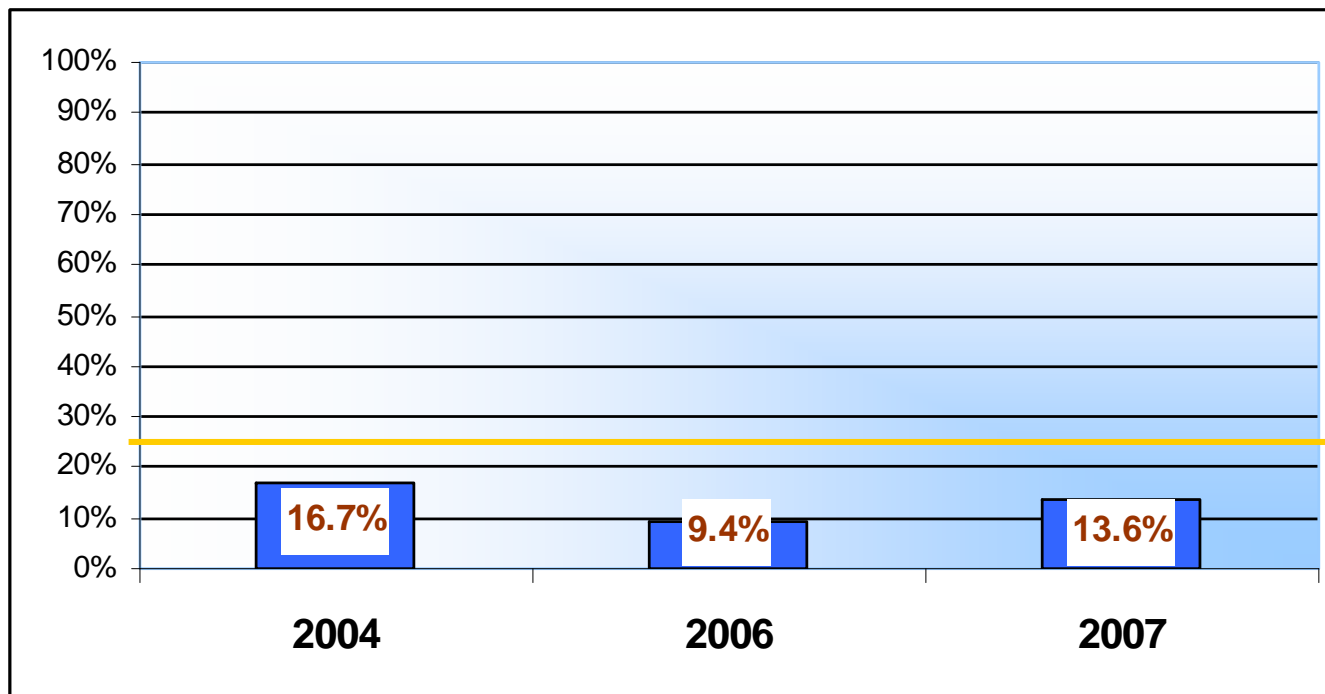


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Prevention & Wellness – Tobacco-Free

Percentage of Carroll County Adults
Who Smoke Every Day

Improvement Objective: 25% or Less

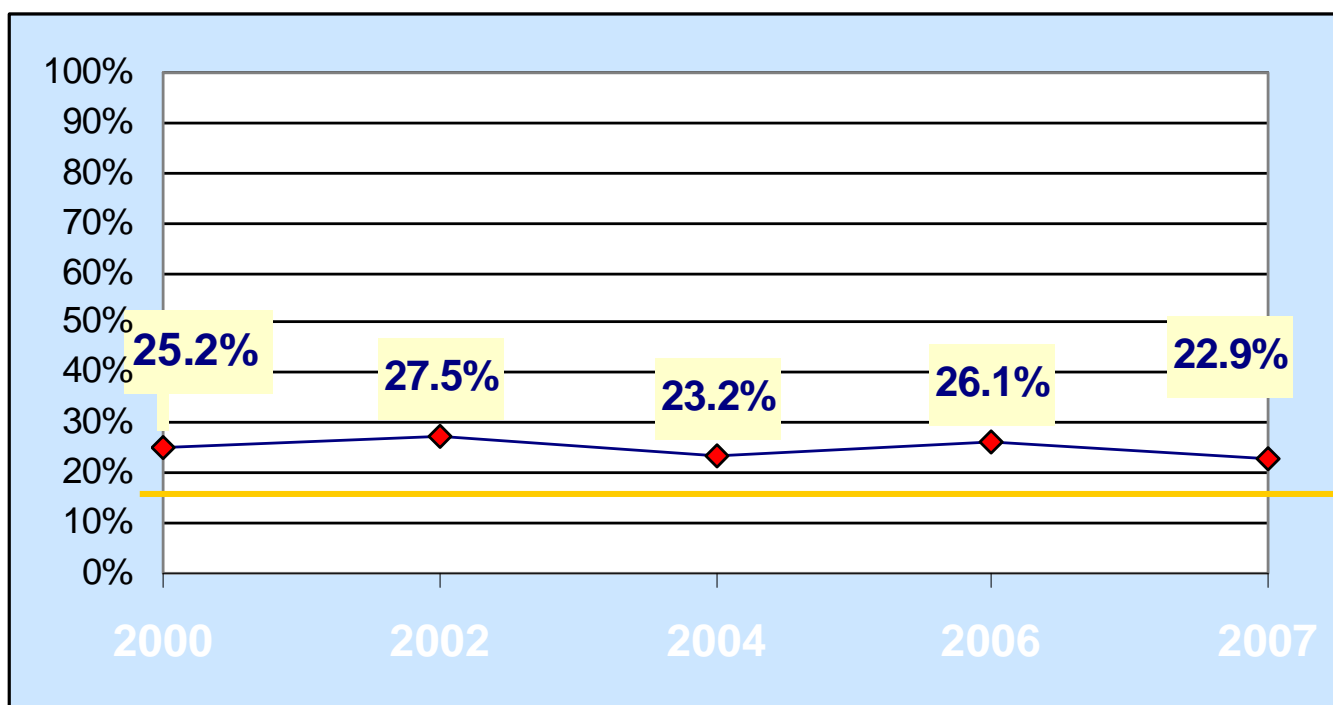


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Prevention & Wellness – Tobacco-Free

Percent of Carroll County 12th Graders Who Smoked Cigarettes in the Past 30 Days

Improvement Objective: 16% or Less



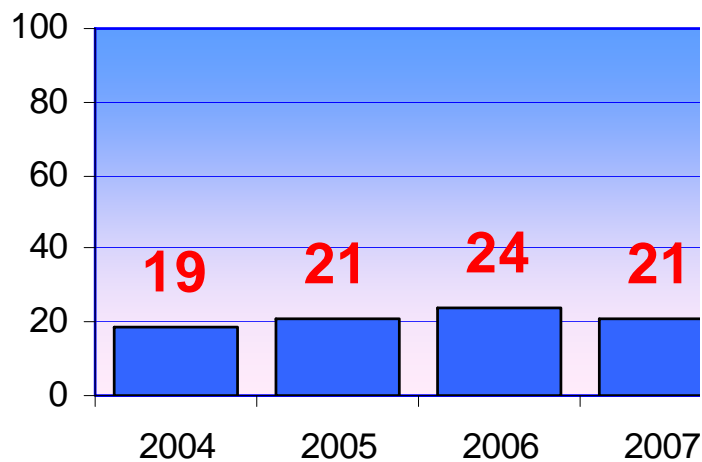
DATA SOURCE: Maryland Adolescent Survey

Prevention & Wellness - Safety

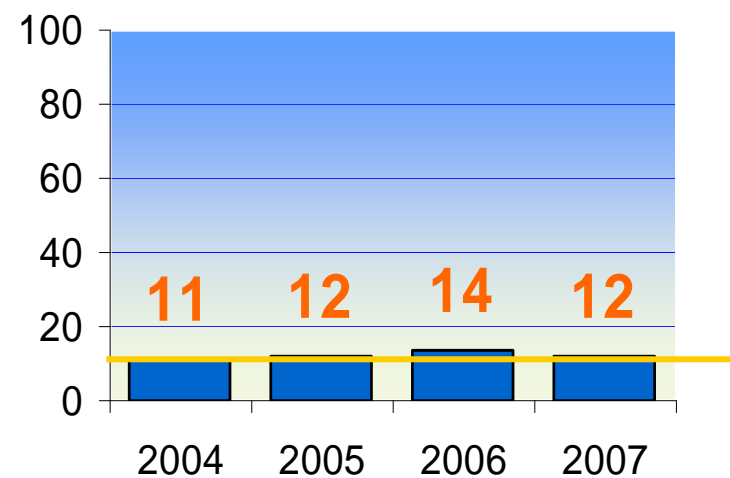
Carroll County Motor Vehicle Deaths

Improvement Objective: 9 per 100,000 or less

**A. Number of deaths from
motor vehicle crashes**



**B. Motor vehicle deaths
Rate per 100,000**

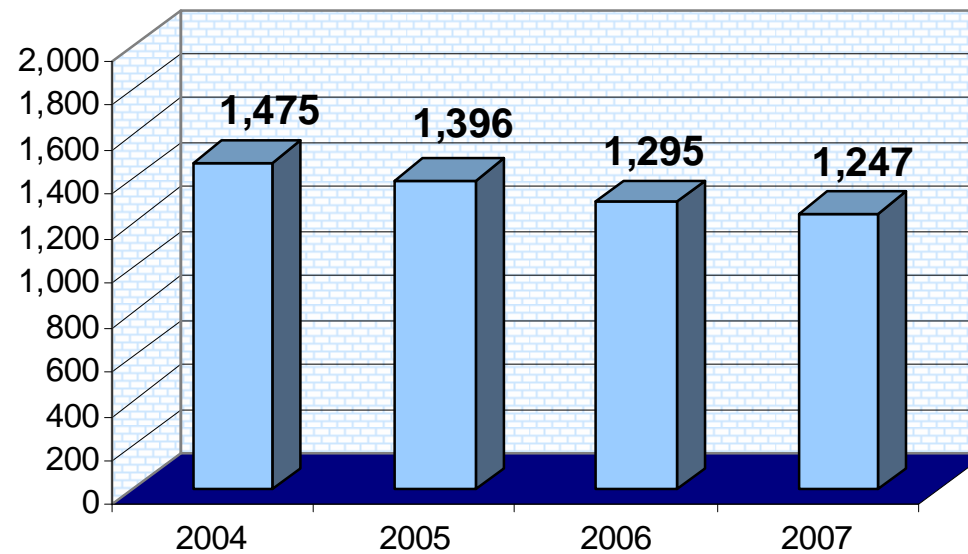


DATA SOURCE: University of MD School of Medicine National Study Center

Prevention & Wellness - Safety

Injuries in Carroll County in Motor Vehicle Crashes

Improvement Objective: 1,000 per 100,000 or less



Carroll County rate per 100,000 (1998-2007): 736.9

DATA SOURCE: University of MD School of Medicine National Study Center

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health
POSITIVE YOUTH & FAMILY DEVELOPMENT
Data Charts - Updated July 2009

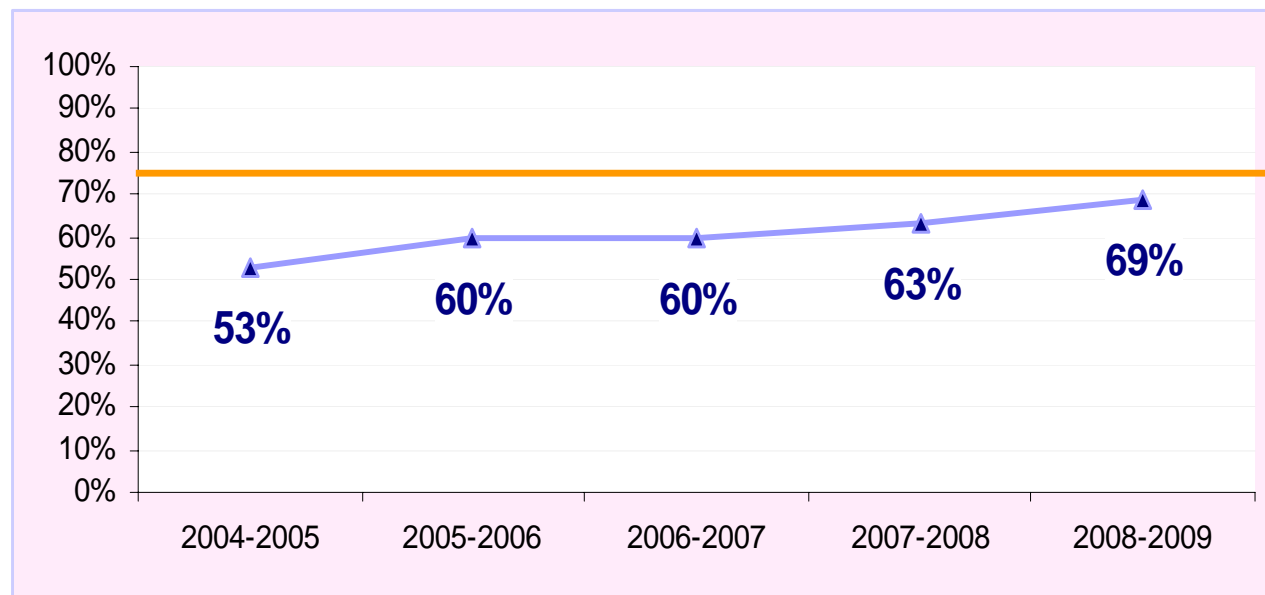
1. Children Ready to Learn: Full Readiness Entering Kindergarten
2. Children Safe in Families & Communities: Juvenile Violent Offenses
3. Children Safe in Families & Communities: Juvenile Nonviolent Offenses
4. Children Safe in Families & Communities: Child Abuse / Child Neglect
5. Stable & Economically Independent Families: Out-of-Home Placement



Positive Youth & Family Development – Children Enter School Ready to Learn

**Percentage of Kindergarten Students Who Have Reached Full Readiness
on the Work Sampling Kindergarten Assessment**

Improvement Objective: 75% fully ready by 2008

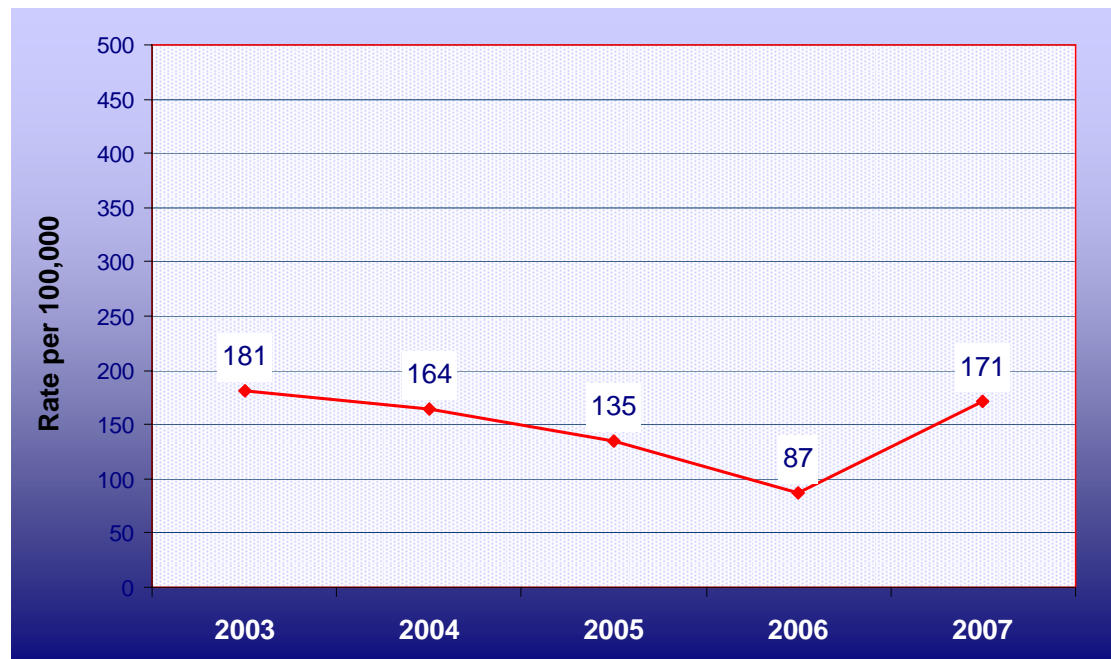


DATA SOURCE: Kindergarten Assessment – Maryland State Department of Education

Positive Youth & Family Development - Children Safe in Families & Communities

Juvenile violent offense arrest rate, ages 10-17

Improvement Objective: Downward Trend

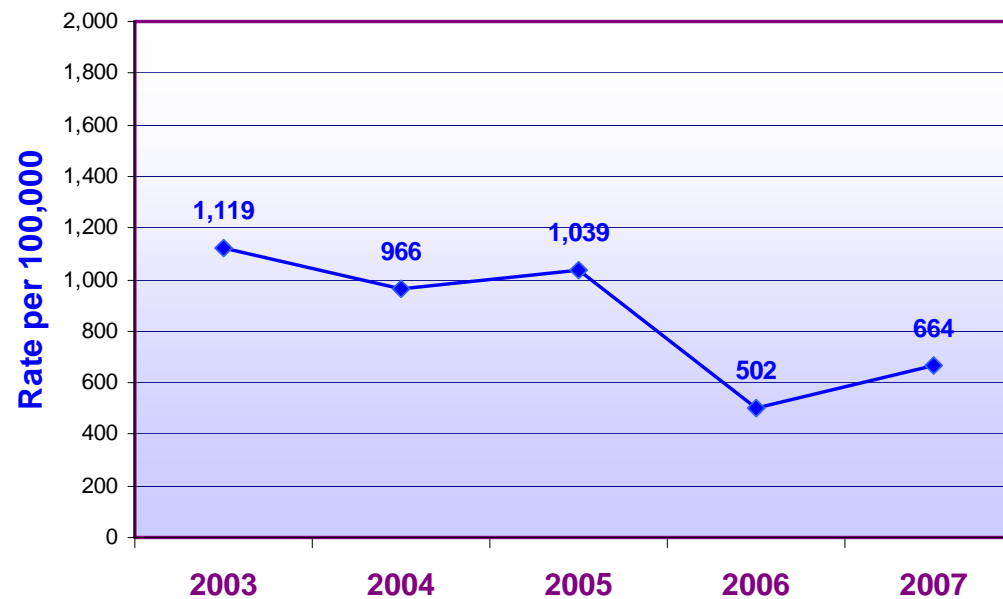


DATA SOURCE: Maryland State Police Uniform Crime Report

Positive Youth & Family Development - Children Safe in Families & Communities

Juvenile non-violent offense arrest rates ages 10-17

Improvement Objective: Downward Trend

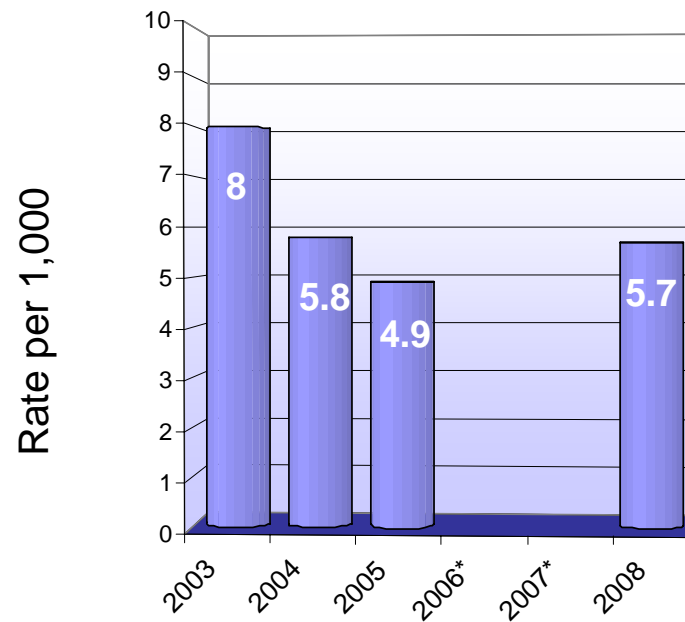


DATA SOURCE: Maryland State Police Uniform Crime Report

Positive Youth & Family Development - Children Safe in Families & Communities

Child Abuse or Neglect Investigations Ruled as Indicated or Unsubstantiated

Improvement Objective: Downward Trend



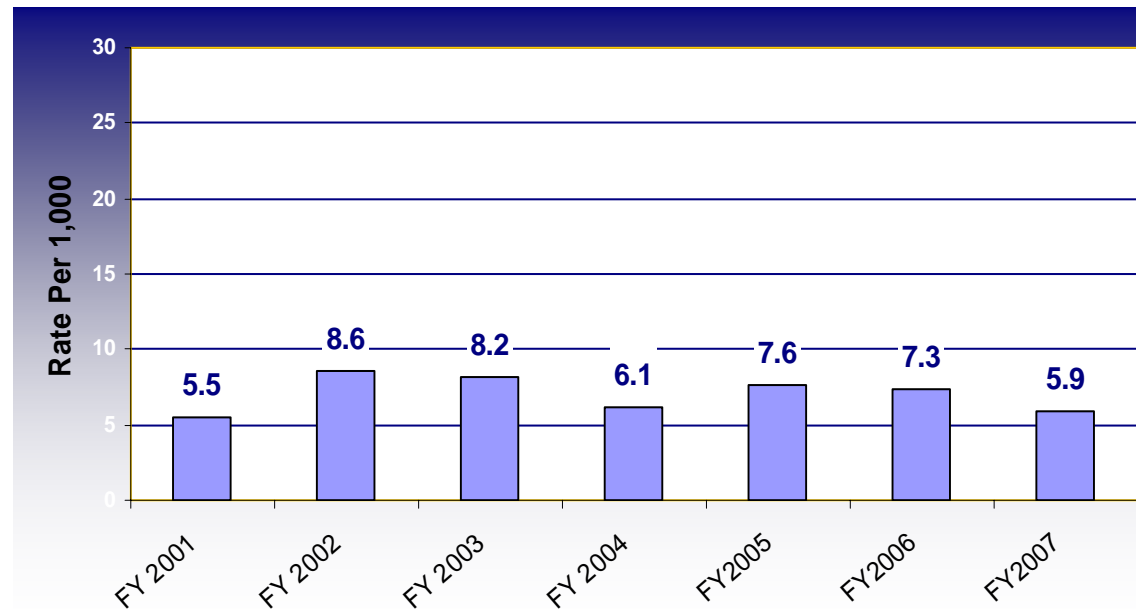
DATA SOURCE: MD Governor's Office for Children (OCFY)

* 2006 and 2007 Data not available

Positive Youth & Family Development – Stable & Economically Independent Families

Out-of-Home Placement

Improvement Objective: Downward Trend



DATA SOURCE: Maryland Governor's Office for Children (OCFY) –
SSA Foster Care and Adoption Child Tracking System

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health **MENTAL HEALTH Data Charts**

Updated April 2009

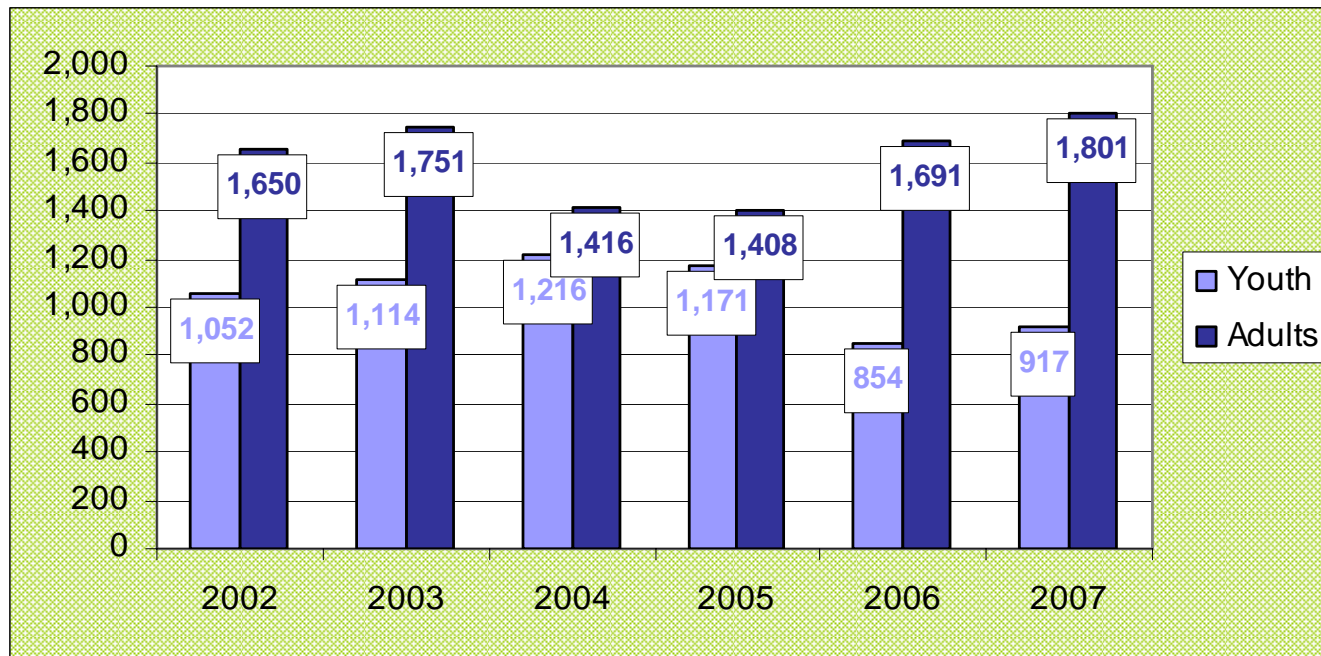
- Psychiatric Services 1
- Interventions for Suicidal Thoughts 2



Mental Health – Psychiatric Services

Number of public counseling and psychiatric services rendered for youths and adults in Carroll County

Improvement Objective: Developmental

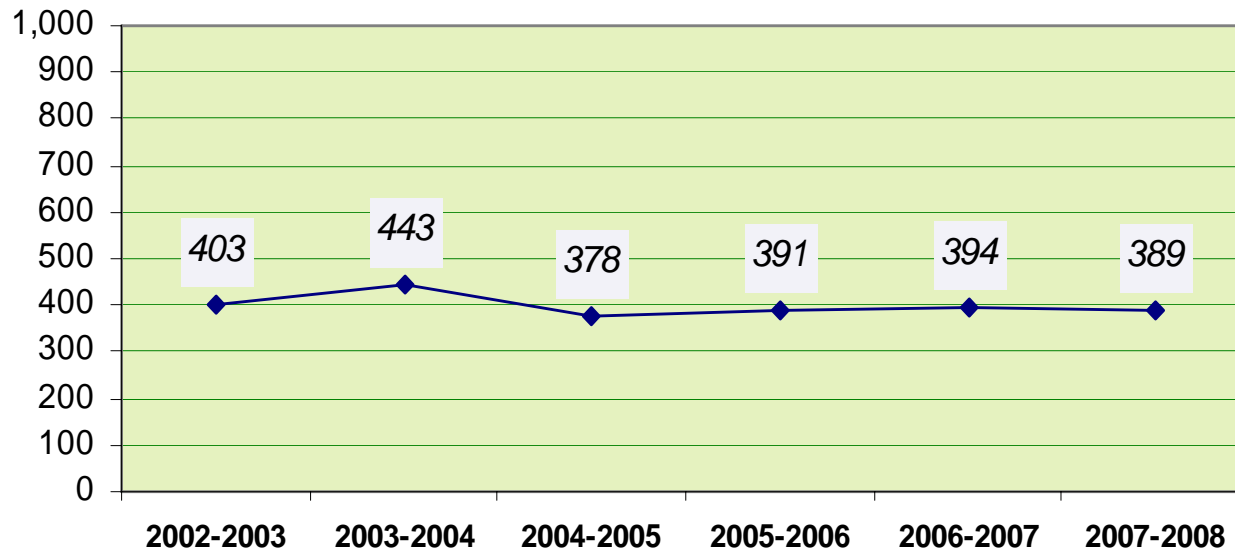


DATA SOURCE: Carroll County Core Service Agency Crystal Report of APS Health Care Data

Mental Health – Youth

Number of Carroll County Public Schools Interventions for Suicidal Thoughts

**Improvement Objective: 1% or less – suicide attempts
by students in grades 9 - 12**



DATA SOURCE: Carroll County Public Schools Student Services Annual Report

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health **INTERPERSONAL VIOLENCE Data Charts**

Updated April 2009

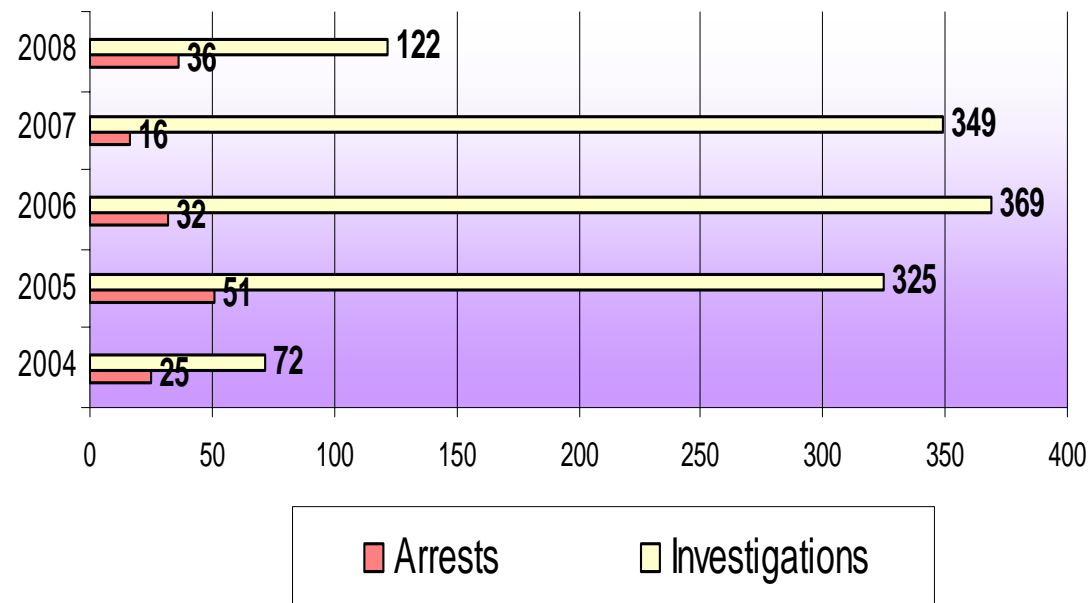
1. Child Abuse Investigations and Arrests
2. Weapons Violations at Carroll County Public Schools
3. Juvenile Arrests for Assault
4. Cases Filed for Domestic Violence and Peace Orders
5. Aggravated Assaults and Forcible Rapes



Interpersonal Violence – Youth

Number of child abuse investigations and arrests in Carroll County

Improvement Objective: 11.1 cases or less per 1,000 children under 18

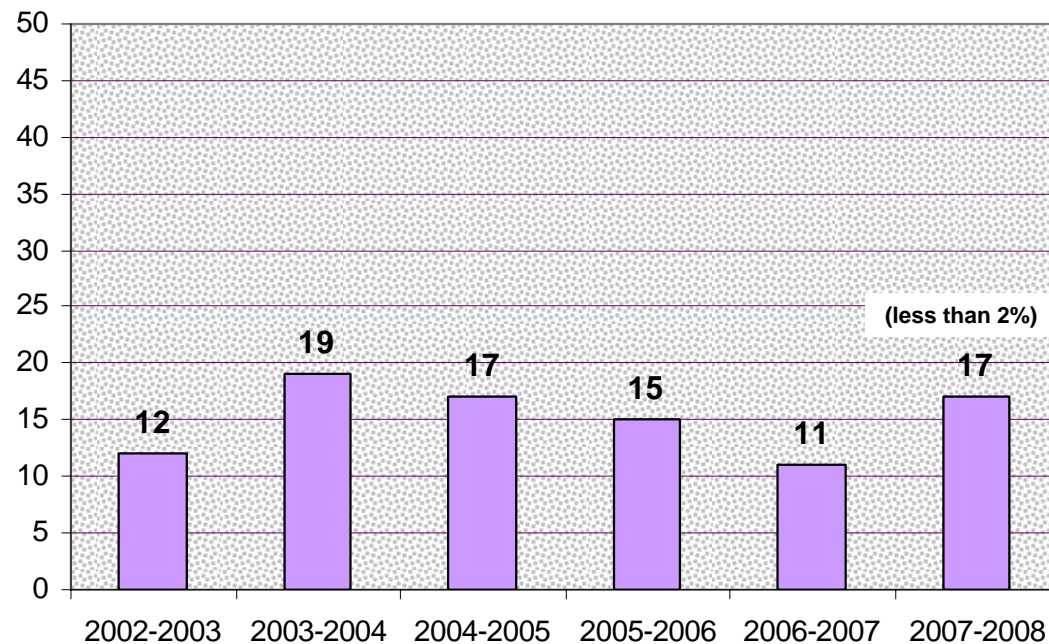


DATA SOURCE: Carroll County Sheriff's Department Annual Report

Interpersonal Violence – Youth

Number of Weapons Violations at Carroll County Public Schools

Improvement Objective: 6% or less of students in grades 9 - 12



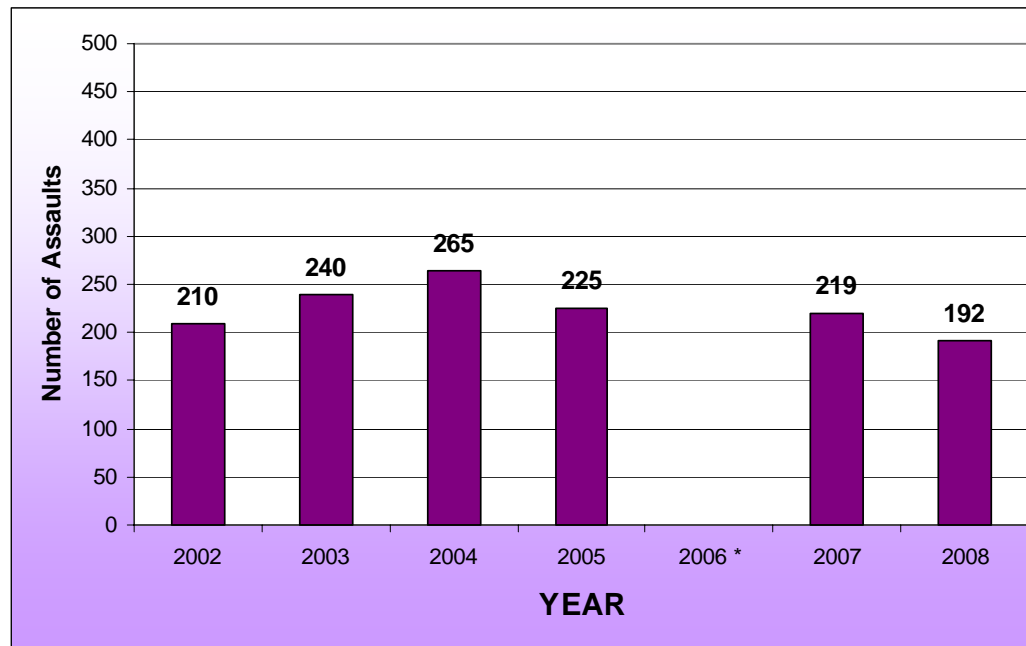
NOTE: Data is for all grades. The 17 occurrences in 2007-2008 represent less than 2% of the total CCPS student population.

DATA SOURCE: Carroll County Public Schools Annual Student Services Report

Interpersonal Violence – Youth

Number of Juvenile Arrests for Assault in Carroll County (includes both physical and sexual assaults)

Improvement Objective: 33.3% or less of all students 9th - 12th grade who report physical fighting in the previous 12 months (YRBS)



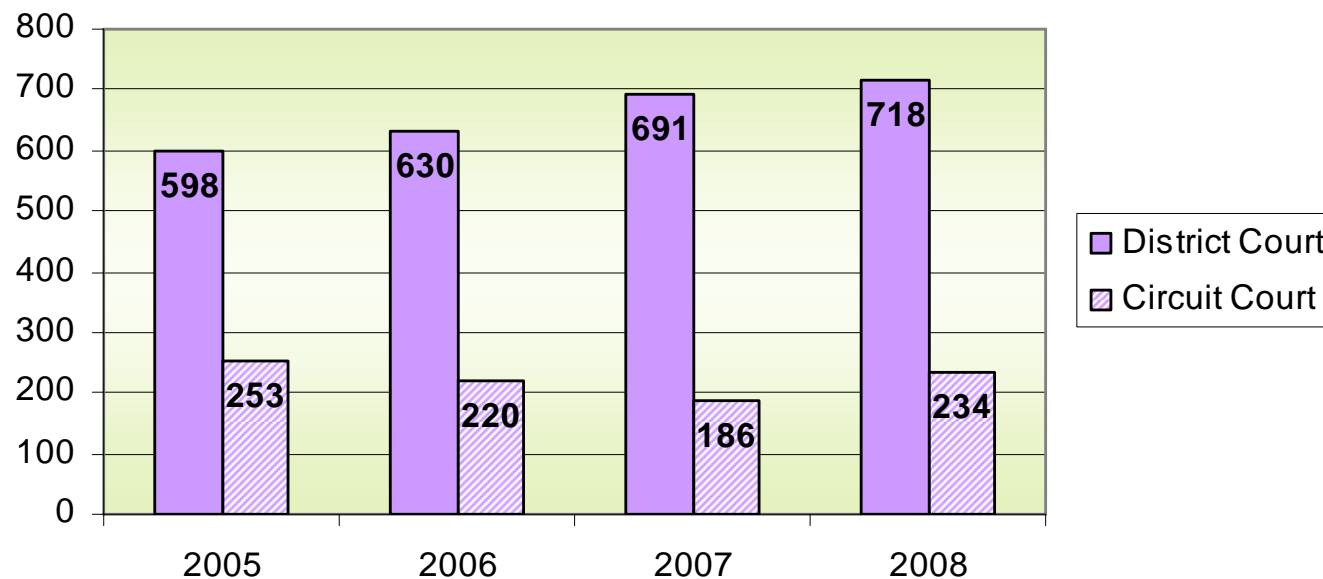
DATA SOURCE: Carroll County Department of Juvenile Services

* 2006 data not available

Interpersonal Violence – Adults & Families

Number of cases filed with the court system in Carroll County for domestic violence and peace orders (Circuit and District Courts, combined)

Improvement Objective: 3.6 physical assaults or less per 1,000 persons age 12 and older

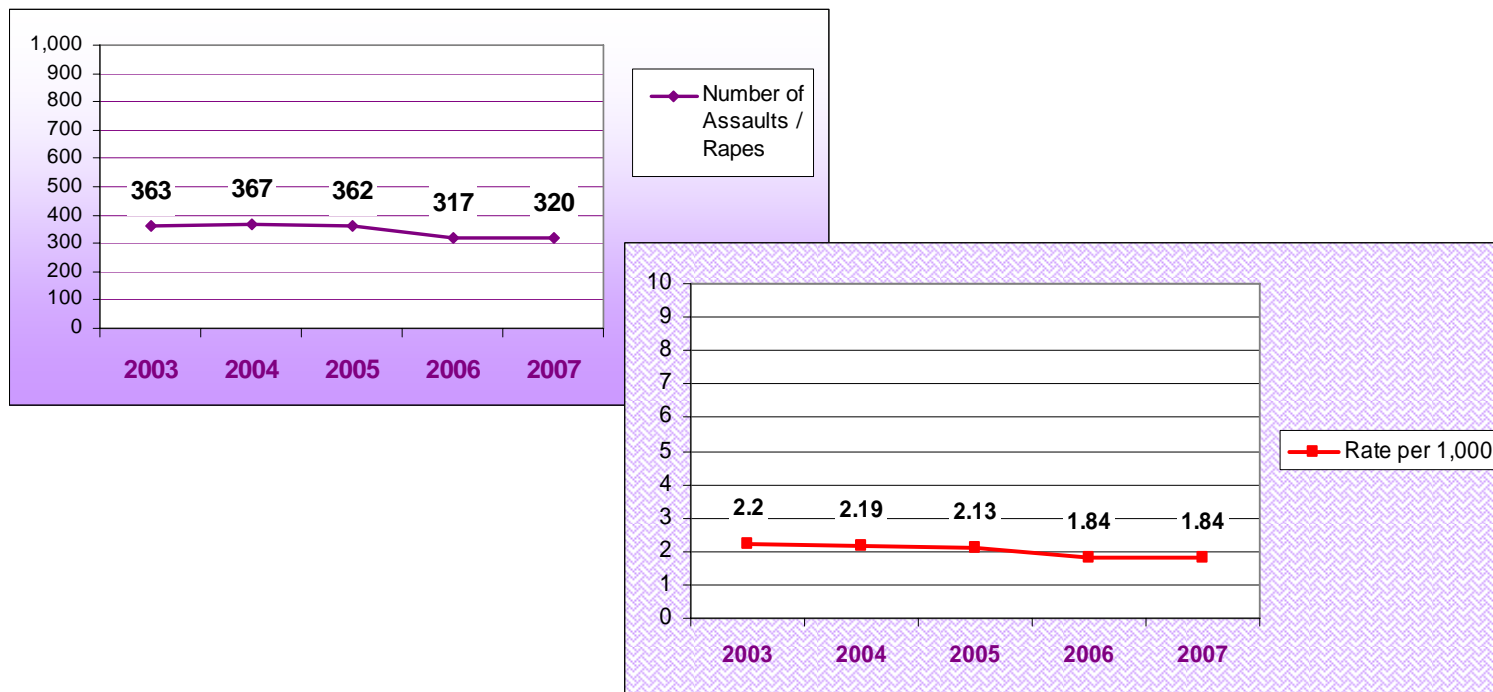


DATA SOURCE: Carroll County District and Circuit Court and Carroll County Sheriff's Office Annual Report

Interpersonal Violence – Adults & Families

Aggravated Assaults and Forcible Rapes in Carroll County

Improvement Objective: 0.7 cases per 1,000 - persons age 12 and over



NOTE: Data not available for persons age 12 and over. Data is for persons age 20 and over.

DATA SOURCE: Uniform Crime Report, Maryland State Police

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health

HEART HEALTH Data Charts

Updated April 2009

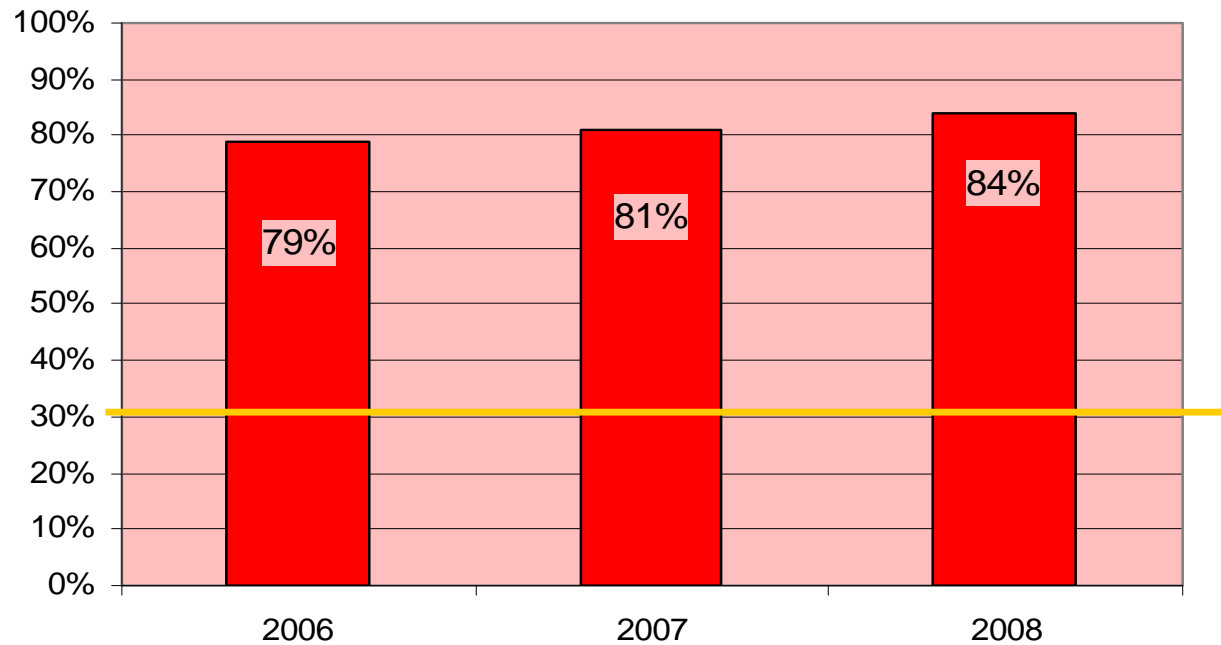
- Physical Activity 1
- Cardiovascular Disease: Deaths 2
- Cardiovascular Disease: High Blood Pressure 3
- Stroke 4



Heart Health – Physical Activity

**Percentage of students participating in Project ACES
physical activity challenge who met the goal of 60
minutes of activity per day**

Improvement Objective: 30%

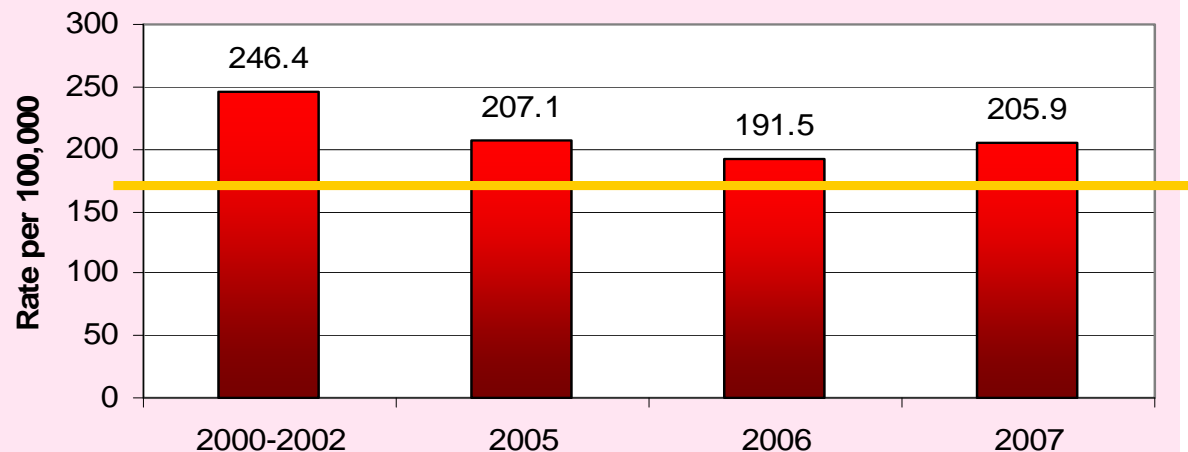


DATA SOURCE: Carroll County Health Department

Heart Health – Cardiovascular Disease

Rate of Deaths From Diseases of the Heart

Improvement Objective: 166 per 100,000

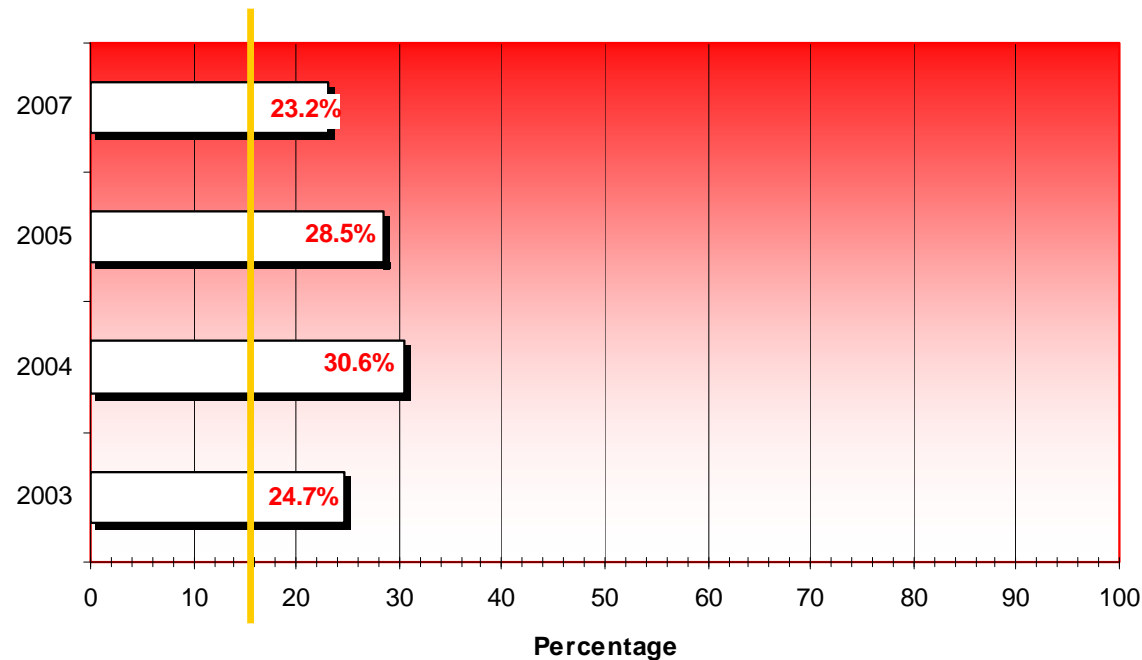


DATA SOURCE: Maryland Vital Statistics

Heart Health – Cardiovascular Disease

Percentage of people told by a health care professional
that they have high blood pressure

Improvement Objective: 16% or less

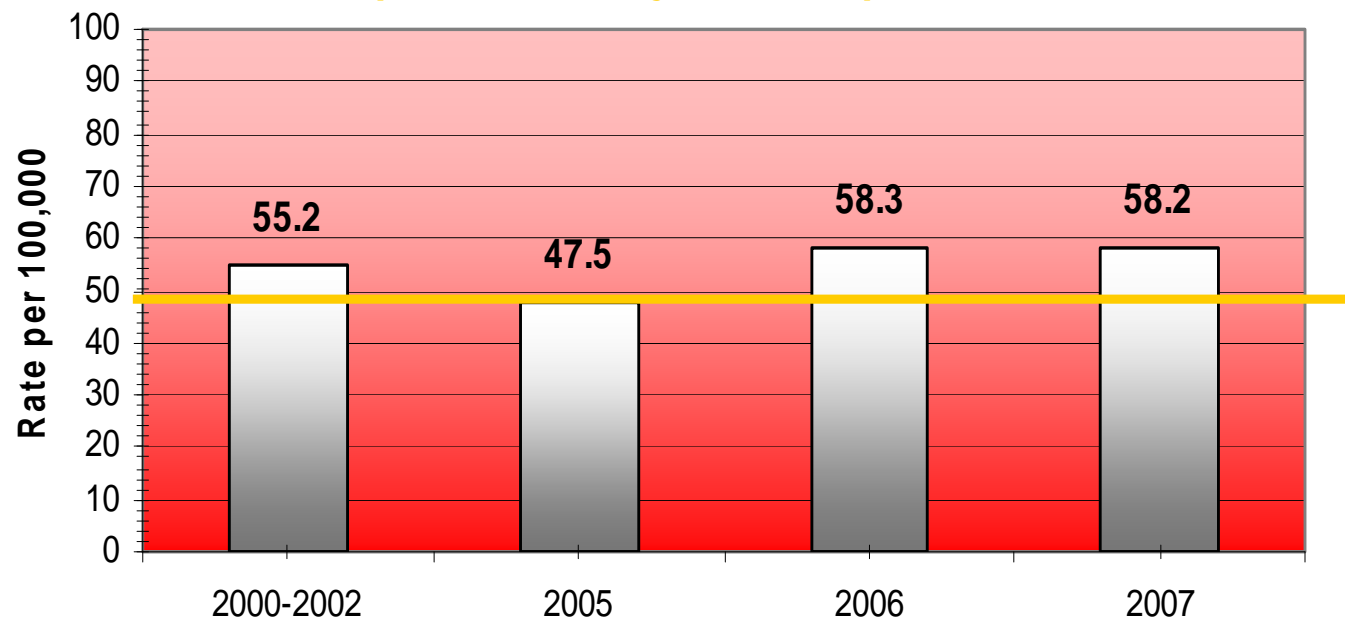


DATA SOURCE: Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)

Heart Health – Stroke

Deaths from Cerebrovascular Disease (Stroke Mortality Rate)

Improvement Objective: 48 per 100,000



DATA SOURCE: Maryland Vital Statistics

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health**GROWTH Data Charts**

Updated April 2009

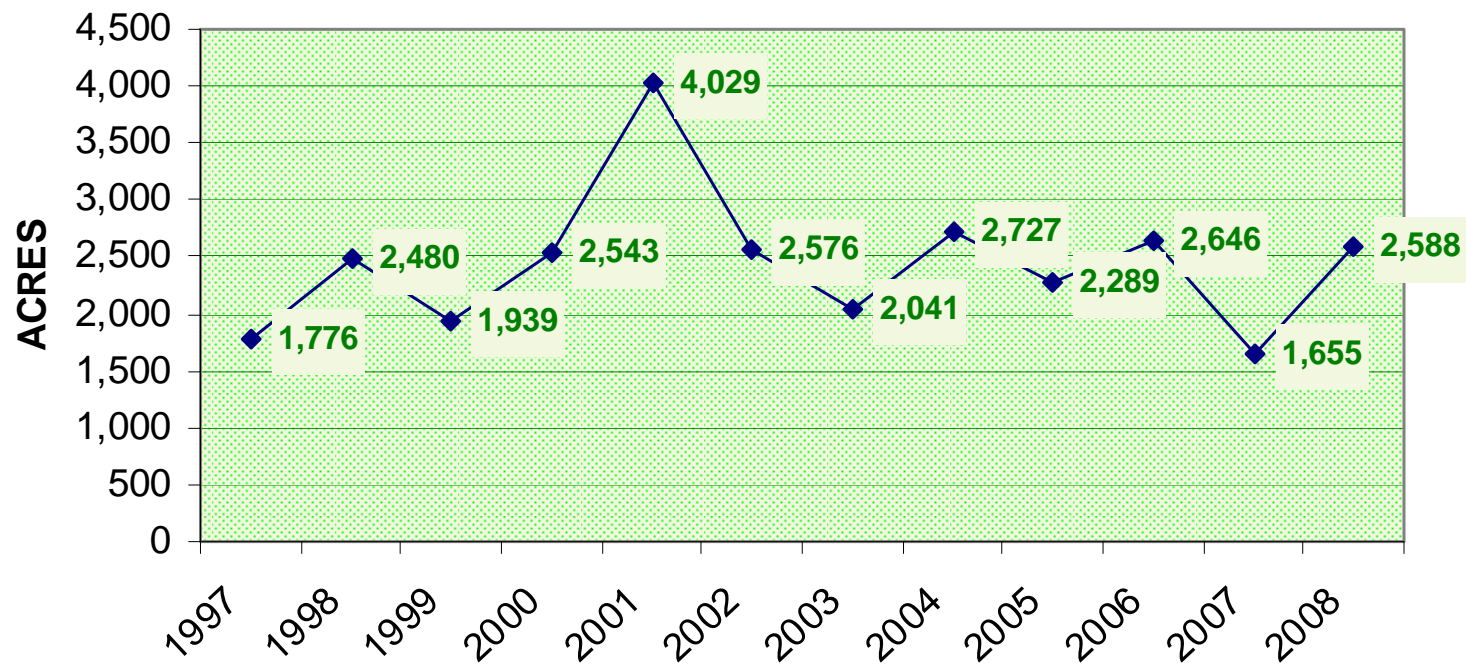
- Land Preservation: New Acres Per Year 1
- Land Preservation: Total Acres 2
- Recycled Waste: Percentage of Total 3



Growth – Land Preservation

New acres put in land preservation

Improvement Objective: 100,000 Acres in Preservation



DATA SOURCE: Carroll County Department of Planning / Agricultural Land Preservation Program

Growth – Land Preservation

Total Carroll County acres currently in land preservation

Improvement Objective: 100,000 Acres in Preservation



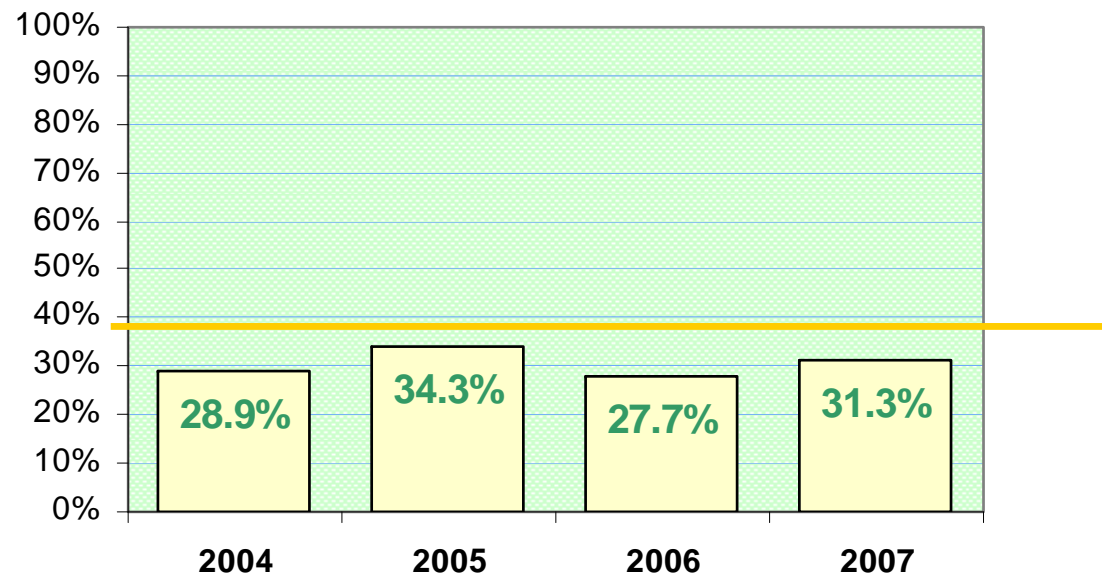
DATA SOURCE: Carroll County Department of Planning / Agricultural Land Preservation Program

Growth – Development

Percentage of Waste Recycled Maryland Recycling Act Materials
(compostables, glass, metals, paper, plastic, and miscellaneous recyclables)

Improvement Objective: At Least 38% of All Waste Recycled

Recycling Rate



NOTE: Materials able to be recycled changed from 2005 to 2006

DATA SOURCE: Carroll County Department of Public Works / Solid Waste Management

HEALTHY CARROLL VITAL SIGNS: Measures of Community Health

WATER SUPPLY Data Charts

Updated April 2009

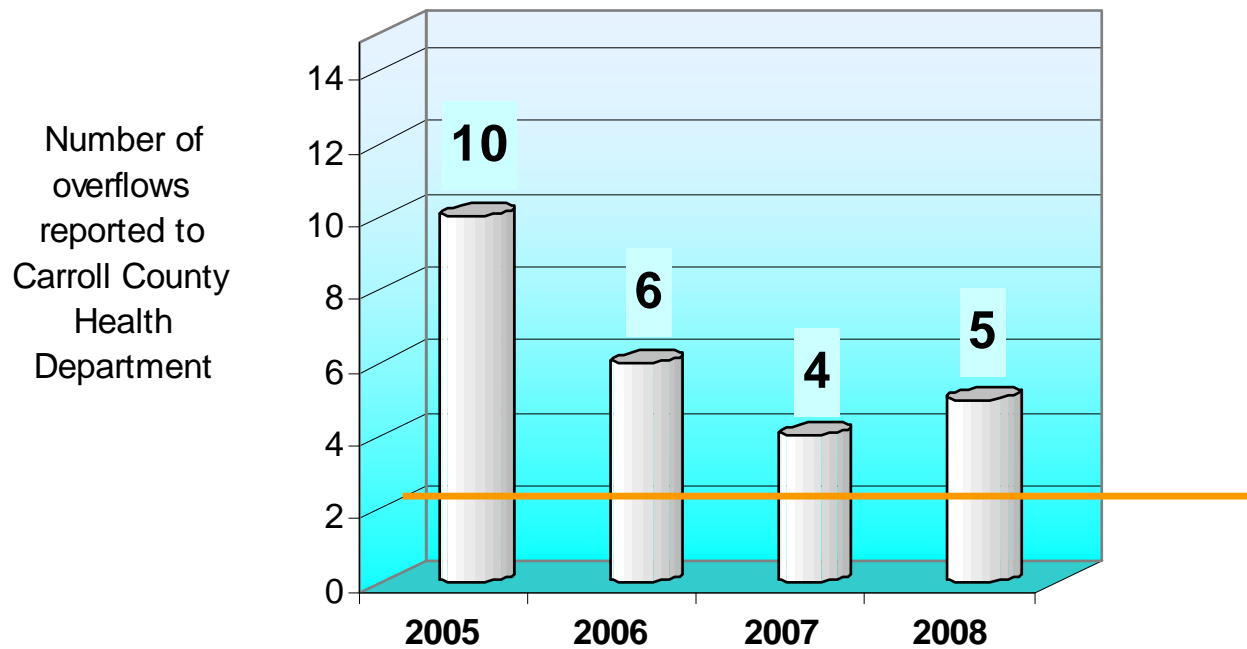
Water Safety: Sewage Overflows	1
Recreation / Quality: Fish Kills	2
Recreation / Quality: Stream Miles Assessed	3
Supply: Water Use per Household	4



Water Supply – Safety / Quality

Public Sewage Overflows Per Year in Carroll County

Improvement Objective: 2 or less per year

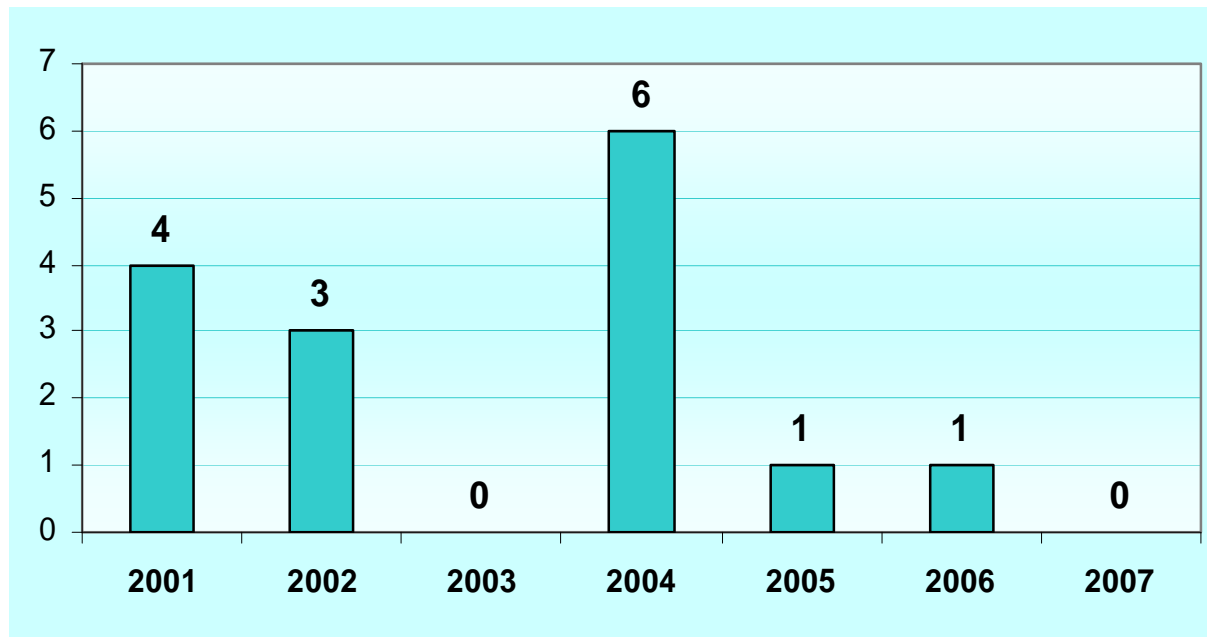


DATA SOURCE: Carroll County Health Department

Water Supply – Recreation/ Quality

Number of Fish Kills Reported

Improvement Objective: Developmental

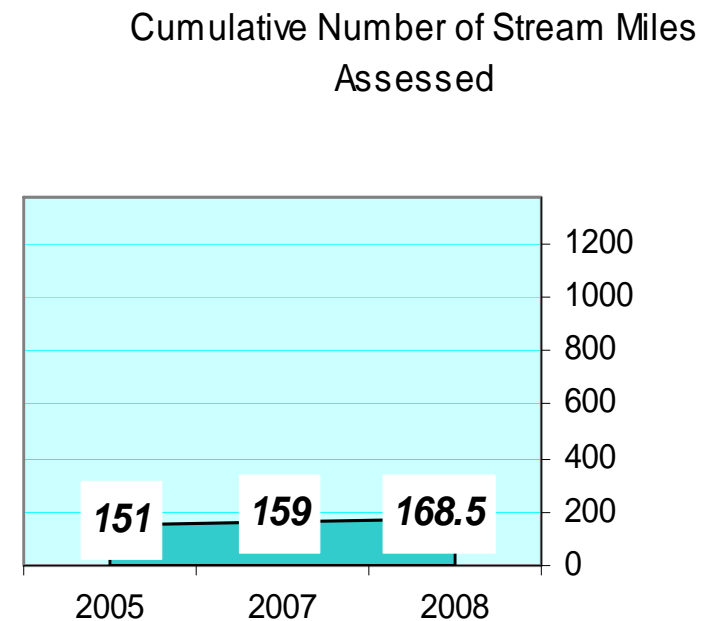
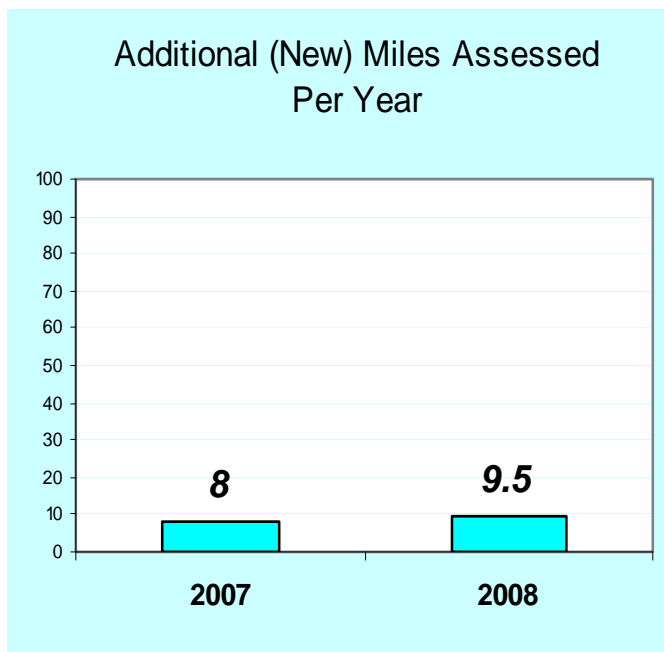


DATA SOURCE: Maryland Department of the Environment

Water Supply – Recreation/ Quality

Stream Miles Assessed (Cumulative Total)

Improvement Objective: Developmental

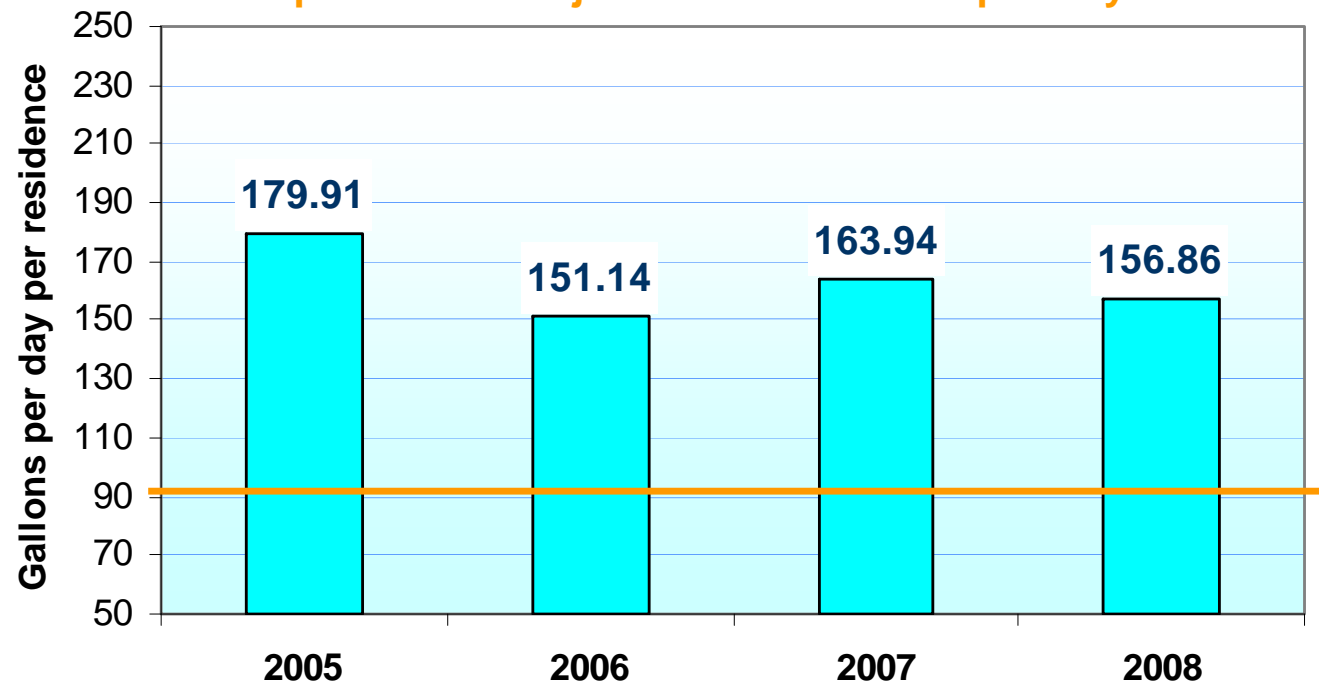


SOURCE: Carroll County Department of Planning/ Office of Environmental Compliance

Water Supply – Usage

Average Daily Water Use Per Household

Improvement Objective: 90.9 Gallons per Day



SOURCE: Carroll County Bureau of Accounting

COMMUNITY BENEFIT NARRATIVE REPORT
for
Chester River Hospital Center
Community Benefit Report FY2009



BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet rely in large part on the VHA, CHA, and Lyon software community benefits reporting experience, which was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) how hospitals determined the needs of the communities they serve, (2) initiatives undertaken to address those needs, and (3) evaluations undertaken regarding the effectiveness of the initiatives.

Reporting Requirements

Narrative Reporting Instructions: (please note that all of Chester River Hospital Center's information is in Times New Roman text)

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Chester River Hospital Center is licensed for 53-beds for fiscal year 2009.

2. Describe the community your organization serves. The narrative should address the following topics: (*The items below are based on IRS Schedule H, Part V, Question 4*).

- Describe the geographic community or communities the organization serves;

Chester River Hospital Center (CRHC) serves the communities of Kent County, and upper Queen Anne's County. CRHC also serves portions of southern Cecil County and northern Caroline County. This is a rural area populated by active farmers and small, close-knit communities. Transportation is often a barrier for access to health care services.

- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

The approximate service area populations for Chester River Hospital Center is 40,000 people, with 19.6% of the residents of Kent County (which has a total population of 20,000) are 65 years of age or older; this is 65% higher than Maryland's percentage and higher than other rural areas in the state by almost a quarter. This makes Kent County having one of the oldest populations in Maryland. And approximately 19% of the residents of Kent County are African-American. There is a small, but rapidly growing Hispanic population, too. Thirty percent of the population is classified as low income, with 15% without insurance. A spring 2008 study conducted for Kent County Health Department indicated that Kent County had high rates of hypertension, high cholesterol, obesity, smoking and diabetes. Alcohol abuse and mental health diagnoses occur at rates higher than the state average, too.

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (*based on IRS Schedule H, Part V, Question 2*).

The following are examples of how community health needs might have been identified:

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
- Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
- Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
- Analyzed utilization patterns in the hospital to identify unmet needs;
- Surveyed community residents, and if so, indicate the date of the survey;
- Used data or statistics compiled by county, state, or federal government;
- Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);

To identify the health needs of the community it serves, Chester River Hospital Center (CRHC) has used the needs assessments developed by the local Kent County Health Department, last conducted in 2008, which was a collaboration that included CRHC along with other local organizations. The needs assessment incorporated surveys of community residents; data and statistics compiled by state and local governments; and included information gathered by consultation of Kent County Health Department, eleven primary care physicians and the Local Management Board (LMB).

b. In seeking information about community health needs, did you consult with the local health department? Yes, Chester River Hospital Center consulted with the local health department to determine community health needs. A community health needs assessment was conducted by the Mid-Atlantic Association of Health Care Centers for the Kent County Health Department in March-April of 2008. It was a collaborative effort and some of the other organizations that contributed included: Choptank Community Health System; Kent County Department of Social Services; Chesapeake College; Chester River Hospital Center; and Kent County Public Schools. This assessment enabled Kent County to examine the health needs and concerns of its residents. The full report can be viewed online at <http://www.kentcountylmb.com/news.htm>.

4. Please list the major needs identified through the process explained question #3. Chester River Hospital Center identified the following major health care needs of the community: alcohol and substance abuse rates are significantly higher than the state average; hypertension, stroke and cancer rates are higher than the state; and, 40% of adults had unmet dental health needs. Kent County also leads the state for deaths related to Alzheimer's, a disease which is most closely associated with aging.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? The senior Administration of Chester River Hospital Center, along with the Board in support of FQHC addresses these issues.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how? Yes. Chester River Hospital Center offers free prostate cancer screening during the month of September. And, our clinical staff also educates the community

through free seminars and support groups about diabetes, heart disease, breast cancer and other cancers.

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

To date the Chester River Hospital Center has not completed an evaluation or assessment to determine the effectiveness of current community benefit initiatives.

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

- a. Name of initiative:
- b. Year of evaluation:
- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or
- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

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

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

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

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

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

Cardiology – although there are two cardiologists on the medical staff at Chester River, which is an appropriate number according to our medical staff development plan, during FY 2009 we had cardiology coverage for the emergency department less than 1/2 the time. We transfer emergency cardiology cases primarily to Washington Hospital Center.

Pulmonology – our one pulmonologist left our rural community and returned in April 2009 on a half-time basis. While we recruit to replace this position, emergency patients are transferred, primarily to Shore Health, Christiana or University of Maryland Medical Center.

Orthopedics – although there's an adequate number of orthopedic surgeons on the medical staff based on our medical staff development plan, we do not have continual emergency department coverage in this area; in Fiscal Year 2009 we lacked coverage 13% of the time. Orthopedic trauma cases are generally transported directly to Shock Trauma, bypassing our hospital. Emergency cases may be transferred to Union Hospital in Elkton. Inpatients are visited by our orthopedic surgeons following admission and patients who are discharged from the Emergency Department are directed to follow up with orthopedic physicians in their private practice.

9. If you list Physician Subsidies in your data, please provide detail.

Chester River Hospital Center started a hospitalist program August 2008 to better serve the community. During FY2009 CRHC also contracted additional physicians for on-call coverage. And, a subsidy for obstetrics services, since there was only one OB/GYN serving the community for half of FY2009.

To Be Attached as Appendices:

1. Describe your Charity Care policy (*taken from IRS Schedule H, Part V, Question 3*):
 - 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. **(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 (**Appendix 2**).
2. Describe the hospital's mission, vision, and value statement(s) (**Appendix 3**).
- a. Attach a copy of the statement (**Appendix 4**).



APPENDIX 1

PAGE: 1 of 3

Description of Chester River Hospital Center's Charity Care Policy:

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

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

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

Signage is posted in the Emergency Department, registration and Business Office areas to notify patients of our patient financial assistance programs.

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

Chester River Hospital Center uses the following guidelines to determine eligibility for uncompensated care (taken from our Charity Care Policy):

1. Patients shall be eligible for financial assistance provided they meet the necessary criteria for both the services provided and their ability to pay. Income guidelines are based on 200% of the Federal Poverty Income Guidelines.
2. Financial Assistance will be considered for those patients who live in the geographical service area of Chester River Hospital Center. This includes the following counties: Kent and Queen Anne's.

3. Patients who apply for financial assistance, who live outside of our geographic area may be eligible for “one time” assistance.
4. Financial Assistance will be granted without regard to age, race, creed or sex.
5. The application for financial assistance should be made as soon as possible in the admission process; however, an application may be taken at any time on open accounts.
6. The Credit and Collections Officer, Business Office Manager and/or Director of Patient Financial Services will determine if a patient is eligible for financial assistance. In making this determination, 200% of the current Federal Poverty Income Guidelines will be used as a base guide.
7. If it is determined that the patient may be eligible for other third party coverage, including Maryland Medical Assistance, that determination must be made before our internal financial assistance policy can be considered.
8. Approval for financial assistance is granted for six months. After that time limit has expired, a new application must be submitted for continuation of assistance.
9. Patients are NOT ELIGIBLE for financial assistance if they do not comply with their insurance coverage requirements and restrictions. This includes services that should have been performed at another provider location, but the patient chooses to have services rendered at Chester River Hospital Center.
10. Financial Assistance will not cover elective or non-emergent services, such as cosmetic surgery, dental procedures or other services as deemed non-covered by Chester River Hospital Center.
11. Financial Assistance will not cover any account that has been referred to a collection agency or referred for legal action.

Chester River Hospital has the following procedure(s) in place:

1. Patients presenting with no insurance will be given an application at the point of registration, or any time when requested.
2. Patients admitted to Chester River Hospital Center without proof of insurance will be referred to an outside agency to determine eligibility for any federal, state or other assistance program. If they are deemed to be ineligible for outside assistance, internal financial assistance is offered.
3. Patients must complete the application and return it within 30 days and provide any or all of the following information:
 - a. Most recent tax return
 - b. Two most recent pay check stubs, if employed
 - c. If not employed, proof of income
 - d. Two bank statements, if self employed
 - e. Documented household expenses
 - f. Letter documenting circumstances if income is slightly above guidelines or unable to document income

- g. Letter of denial from Maryland Medical Assistance
- 4. Applications will be processed no more than 14 days after receipt of completed application and supporting documentation.
- 5. The application and supporting documentation will be reviewed by the Credit and Collections Officer and the Business Office Manager for approval. The Director of Patient Financial Services will review any application with questionable documentation or for amounts over \$5,000.00.
- 6. The Credit and Collections Officer will notify the patient by mail of the decision made with regard to financial assistance and will document the reason for approval or denial. If approved, the Credit and Collections Officer will write off all eligible accounts with the appropriate code.
- 7. The Credit and Collections Officer will continue to review eligible accounts and complete the write-off for a period of one year.
- 8. If a patient does not agree with a denial of financial assistance, they may appeal to the Director of Patient Financial Services who will review the documentation and may request additional information to assist in making the determination. If the Director agrees with the initial determination, the patient may request a final review by the Chief Financial Officer of Chester River Hospital Center.



APPENDIX 1

PAGE: 1 of 3

SUBJECT: Patient Financial Assistance

SERVICE: Patient Financial Services - Registration

MANUAL: Patient Financial Services

POLICY:

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

PURPOSE:

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

GUIDELINES:

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

1. Patients shall be eligible for financial assistance provided they meet the necessary criteria for both the services provided and their ability to pay. Income guidelines are based on 200% of the Federal Poverty Income Guidelines.
2. Financial Assistance will be considered for those patients who live in the geographical service area of Chester River Hospital Center. This includes the following counties: Kent and Queen Anne's.
3. Patients who apply for financial assistance, who live outside of our geographic area may be eligible for "one time" assistance.
4. Financial Assistance will be granted without regard to age, race, creed or sex.

5. The application for financial assistance should be made as soon as possible in the admission process; however, an application may be taken at any time on open accounts.
6. The Credit and Collections Officer, Business Office Manager and/or Director of Patient Financial Services will determine if a patient is eligible for financial assistance. In making this determination, 200% of the current Federal Poverty Income Guidelines will be used as a base guide.
7. If it is determined that the patient may be eligible for other third party coverage, including Maryland Medical Assistance, that determination must be made before our internal financial assistance policy can be considered.
8. Approval for financial assistance is granted for six months. After that time limit has expired, a new application must be submitted for continuation of assistance.
9. Patients are NOT ELIGIBLE for financial assistance if they do not comply with their insurance coverage requirements and restrictions. This includes services that should have been performed at another provider location, but the patient chooses to have services rendered at Chester River Hospital Center.
10. Financial Assistance will not cover elective or non-emergent services, such as cosmetic surgery, dental procedures or other services as deemed non-covered by Chester River Hospital Center.
11. Financial Assistance will not cover any account that has been referred to a collection agency or referred for legal action.

PROCEDURE:

1. Patients presenting with no insurance will be given an application at the point of registration, or any time when requested.
2. Patients admitted to Chester River Hospital Center without proof of insurance will be referred to an outside agency to determine eligibility for any federal, state or other assistance program. If they are deemed to be ineligible for outside assistance, internal financial assistance is offered.
3. Patients must complete the application and return it within 30 days and provide any or all of the following information:
 - a. Most recent tax return
 - b. Two most recent pay check stubs, if employed
 - c. If not employed, proof of income
 - d. Two bank statements, if self employed
 - e. Documented household expenses
 - f. Letter documenting circumstances if income is slightly above guidelines or unable to document income
 - g. Letter of denial from Maryland Medical Assistance
4. Applications will be processed no more than 14 days after receipt of completed application and supporting documentation.

5. The application and supporting documentation will be reviewed by the Credit and Collections Officer and the Business Office Manager for approval. The Director of Patient Financial Services will review any application with questionable documentation or for amounts over \$5,000.00.
6. The Credit and Collections Officer will notify the patient by mail of the decision made with regard to financial assistance and will document the reason for approval or denial. If approved, the Credit and Collections Officer will write off all eligible accounts with the appropriate code.
7. The Credit and Collections Officer will continue to review eligible accounts and complete the write-off for a period of one year.
8. If a patient does not agree with a denial of financial assistance, they may appeal to the Director of Patient Financial Services who will review the documentation and may request additional information to assist in making the determination. If the Director agrees with the initial determination, the patient may request a final review by the Chief Financial Officer of Chester River Hospital Center.

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

APPROVED BY AND DATE: Chief Executive Officer
December 2008

ORIGINAL DATE: December 2008

REVIEW CYCLE: Three Years

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

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



APPENDIX 3

Description of Chester River Health System's Mission, Vision and Values:

Chester River Hospital Center's Mission, Vision and Values Statement was created with input from the Board of Directors, Medical Staff and senior management team during the development of the Chester River Health System's strategic plan which was adopted in December 2002. It was based in large part on the environmental assessment and feedback from a strategic planning retreat.

Prior to this current statement, each of the three members of Chester River Health System (Chester River Hospital Center, Chester River Home Care & Hospice and Chester River Manor) had their own mission statements. The Strategic Planning Committee concluded that as the health system developed, evolved and became more integrated it was important to have a system-wide Mission, Vision and Values Statement.

The mission statement clearly communicates to internal and external constituencies why the organization exists and what important purpose it intends to achieve and includes the purpose of each of the three entities. The vision statement frames strategy direction by stating what the organization's aspirations are for the future planning horizon which was identified as five to ten years. The key vision concepts in this statement (which is attached as Appendix 5) are the following components which were further defined in the strategic plan document: model, rural, integrated, health services and upper Eastern Shore counties. The values statement is the underpinning of the entire strategic direction and plan, describing the character and the culture of the organization. The specific values identified as critical to the success of Chester River are compassion, respect, excellence, collaboration, responsibility and integrity.

The Mission, Vision and Values Statement will be reviewed and likely revised during the next strategic plan exercise which is expected to begin within the next twelve months.



APPENDIX 4

Mission Statement

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

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

Vision Statement

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

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

Values Statement

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

Reporting Requirements

Narrative Reporting Instructions:

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

129 Licensed Beds and 8600 inpatient admissions (including births).

2. Describe the community your organization serves. The narrative should address the following topics: *(The items below are based on IRS Schedule H, Part V, Question 4).*

- Describe the geographic community or communities the organization serves;
- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

See attachment "Profile of Charles County"

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done *(based on IRS Schedule H, Part V, Question 2).*

The following are examples of how community health needs might have been identified:

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
 - Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
 - Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
 - Analyzed utilization patterns in the hospital to identify unmet needs;
 - Surveyed community residents, and if so, indicate the date of the survey;
 - Used data or statistics compiled by county, state, or federal government;
 - Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);
- b. In seeking information about community health needs, did you consult with the local health department?

Civista Medical Center, in partnership with the Charles County Department of Health, conducts a Needs Assessment of Charles County every five (5) years. The data included in this report was collected in 2006 and is scheduled to be repeated in FY 2011. Additionally, The Charles County Community Foundation, in cooperation with Civista Medical Center, Charles County Department of Health, The United Way of Charles County and the Charles County Government conducted a Priority Needs Assessment for Charles County in 2008. In April 2009, the Charles County Local Management Board conducted a Needs Assessment. The Maryland Physician data is from the Maryland Health Commission's 2007 report. The data from all of these reports is shared with all of the members of Partnerships for a Healthier Charles County of which Civista is a member.

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

- 1. Leading causes of death (Highest mortality among African Americans)**
 - a. Malignant Neoplasm**
 - b. Diseases of the Heart**
- 2. Rising infant mortality rate**
- 3. Rising obesity rates**
- 4. Physician shortages in 83 specialties**

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

Civista Medical Center's Community Benefit Program consists of the following decision makers:

- The Board of Director's**
- Executive Management Team**
- Community Benefits Leadership Team (Health Promotions, Finance)**
- Community Benefits Reporters**

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

Civista Medical Center sponsors the following community initiatives:

- 1. Free cancer screening and education programs for prostate, breast, cervical and colorectal cancer; with outreach targeted to the uninsured and African American populations; Participation in the Tobacco Education Program**
- 2. Prenatal clinic**
- 3. WE CAN! (Ways to Enhance Children's Activity and Nutrition) program for 8-13 year olds**
- 4. Physician recruitment efforts**

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of

major Community Benefit program initiatives.

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

- a. Name of initiative:
- b. Year of evaluation:
- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or
- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Assessment of the success of initiatives will be provided with the 2011 Charles County needs Assessment Survey.

- 1. Prostate Cancer Screening September 2009: Focused outreach on areas of county that have a high African American population; Partnership with traditionally African American Groups such as the Bel Alton Alumni Association and Delta Zeta Sorority; Evaluation provided by the Charles County Department of Health**
- 2. Prenatal Clinic – ongoing: Civista provides the only prenatal clinic for uninsured and underinsured pregnant women; Clinical services, education and follow up are provided by Civista Medical Center staff and physicians. Clinic providers participate on the Charles County Fetal Infant Mortality Board for review and evaluation of outcomes.**
- 3. WE CAN! Childhood Obesity Program initiated in FY 2009; Free family education program for 8-13 year olds and their families; New initiative; Data is currently being collected and will be evaluated in partnership with the Charles County Department of Health.**
- 4. Physician Recruitment – Recruitment of physicians to Charles County concentrating in the high priority areas of the 83 specialties lacking; Physician recruiter retained by Civista; Evaluation by number of physicians successfully recruited and placed.**

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

See Attachment “Shortages by Region”

According to the Maryland Health Commission, 83 physician specialties are in shortage in the Southern Maryland area. Of particular lack in Charles County is Obstetrics and Gynecology. In early 2008, only 5 OB/GYN physicians were providing care at Civista– 3 of whom are employed by Civista Medical Center. The rising infant mortality rate in Charles County raised the recruitment of OB/GYN practitioners to priority one. To date, one additional physician has been added. Recruitment efforts for, Orthopedics, General Surgery, Infectious Disease has produced additional physicians. Ongoing efforts to recruit include for Neurology, Oncology, Primary Care, General Surgery, Orthopedics, ENT, and Gastroenterology.

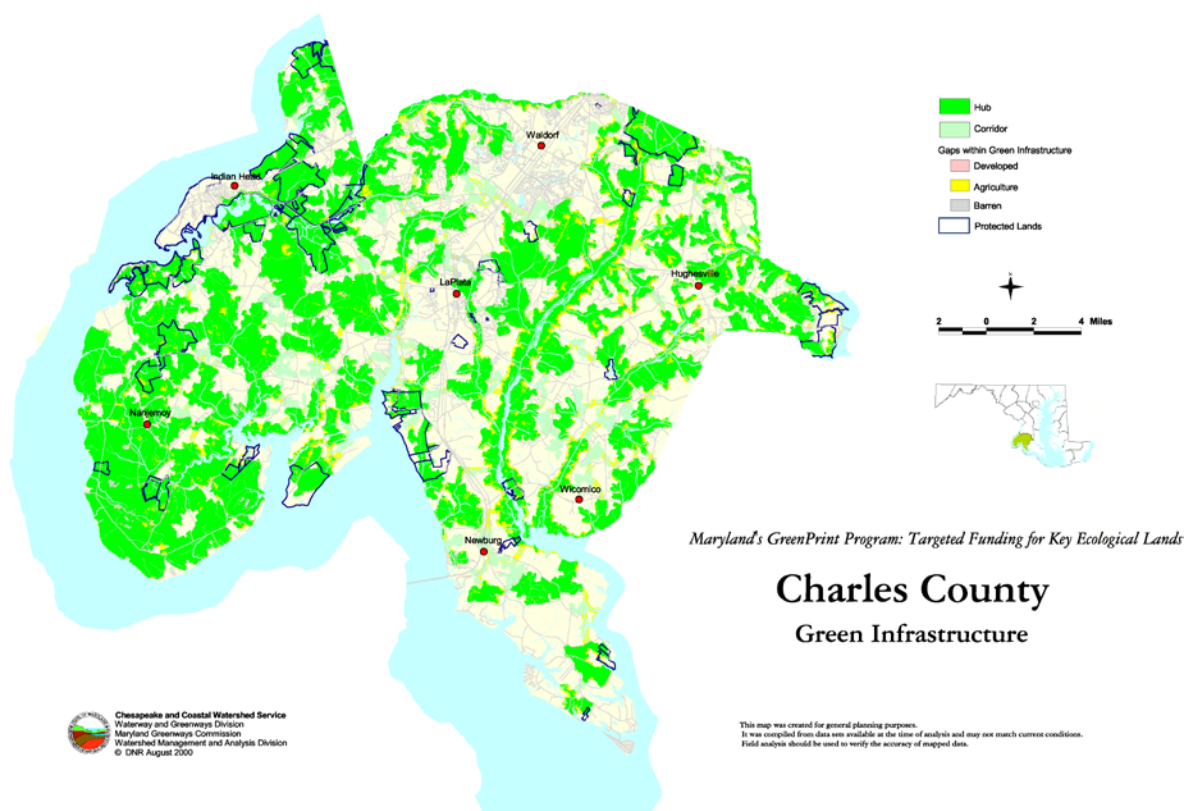
9. If you list Physician Subsidies in your data, please provide detail.

Attachment "2009 Workforce Development Costs"

Profile of Charles County

Charles County is mostly a rural county located on the Southern Maryland Peninsula, bordered by Prince George's County to the north, Calvert County to the east, and St. Mary's County to the south. Charles sits about 15 miles south of the Washington Capitol Beltway, 18 miles from Washington, D.C, and 54 miles southwest of Baltimore.

The northern part of the county is the “development district” where commercial, residential and business growth is focused, so that the remainder of the county can retain its rural character. The major communities of Charles County are La Plata, the county seat; Port Tobacco, Indian Head, and the planned community of St. Charles. The main commercial cluster is Hughesville-Waldorf-White Plains.



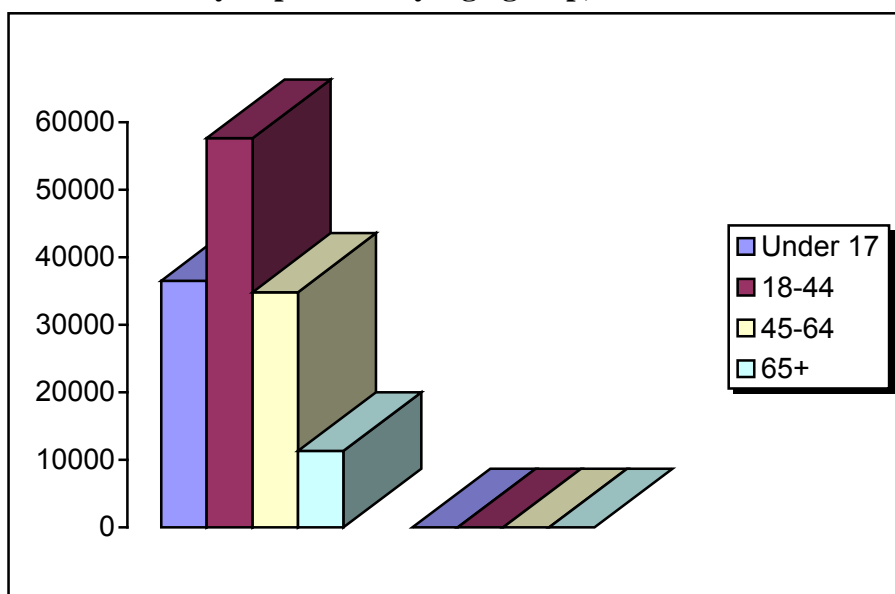
Source: 2003 dnr.maryland.gov

There are three nursing homes in Charles County, two are located in La Plata and one is located in Waldorf. In addition to the nursing homes there are two adult day care centers one in La Plata and one in Waldorf. These facilities provide care for the elderly citizens of Charles County, assisting family members by providing day time activities for those elderly citizens still in the home families. The County has one 98-bed hospital—Civista, located in the county's seat, La Plata.

Demographics

Charles County continues to experience rapid growth, expanding its population from 47,678 to 120,546 in the 2000 census. Current U.S. Census estimates are that the population now exceeds 140,444. This magnitude of growth can be seen in the change in population density, with an increase of 15% in the period from 2000 to 2005. While there are only 307 people per square mile over the total area of Charles County, there are 821 people per square mile of developed land. The population density is concentrated mainly in the northern end of the County. The census describes a population that is young, with a medium age of 35 years, and approximately 26% is under the age of 17, 41% is between the ages of 18-44, 25% is between the ages of 45-64; and 8% of the county's population 65 or over.²

Charles County Population by Age-group, 2006



Source: Maryland DHMH 2005 Vital Statistics Report

The average household size is 2.85 with the average family size 3.23. The marital status of the county for males is 15,962 never married, 28,913 now married, 1,467 separated, 924 widowed, and 5,680 divorced. For females 17,792 never married, 28,699 now married, 1,796 separated, 4,018 widowed, 5,563 divorced. All numbers refer to residents 15 years and over.¹³

In 2006 the types of households in Charles County included 54% married couples, 23% other families, 19% people living alone, and 4% other nonfamily households. The geographic mobility of residents in Charles County showed that 86% had been in the same residences, only 7% had moved to another residence in the county, 4% moved out of the county, 3% moved to another state, and 1% moved out of the country.¹³

Population:

Charles County Population Data

Population Data	Charles County	Maryland
Population, 2000	120,546	5,296,486
Population, 2006	140,416	5,615,727
Male, 2006	48.7%	48.4%
Female, 2006	51.3%	51.6%

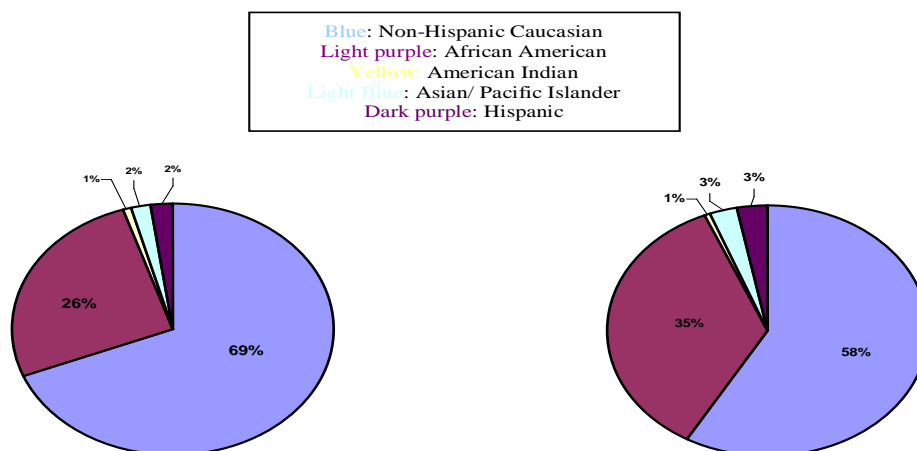
Source: 2006 Maryland Vital Statistics Report and US Census Bureau:
2006 American Community Survey

The minority population in the United States as well as Maryland continues to grow each year. In 2004, more than 32% of the total US population was racial or ethnic minorities. In 2004, the minority population in Maryland made up 39.6% of the population.¹

In 2004, racial and ethnic minorities made up 39.4% of the total county population. Charles County ranks fifth among the 24 Maryland jurisdictions in terms of the largest minority population. The county minority population is also significantly higher than the minority population in the other Southern Maryland jurisdictions: Calvert County with 16.3% and St Mary's County with 19%.¹

And the minority population within the county continues to grow each year. In 2005, the Charles County minority population comprised 41.5% of the total population (Refer to graph below). It remained the fifth highest percentage among the Maryland jurisdictions, but it exceeded the Maryland state average percentage of 40.3%.²

Race of Charles County Population, 2000 versus 2005



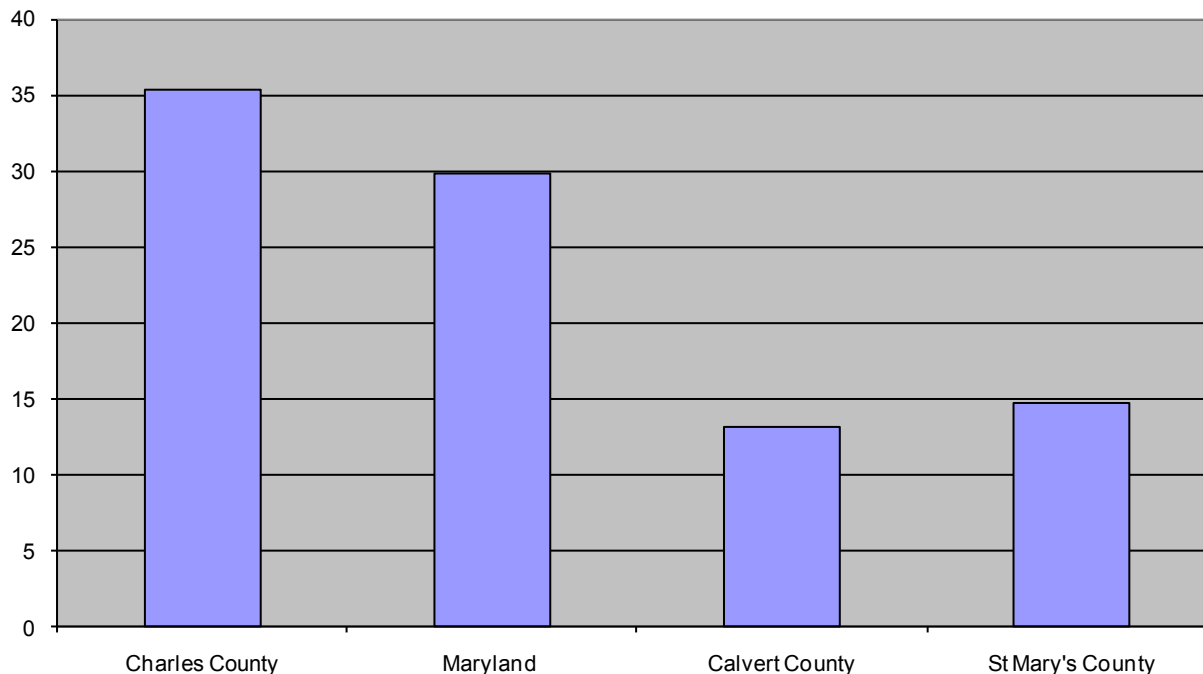
2000

2005

Source: Maryland Department of Health and Mental Hygiene. 2005 MD Vital Statistics Report.

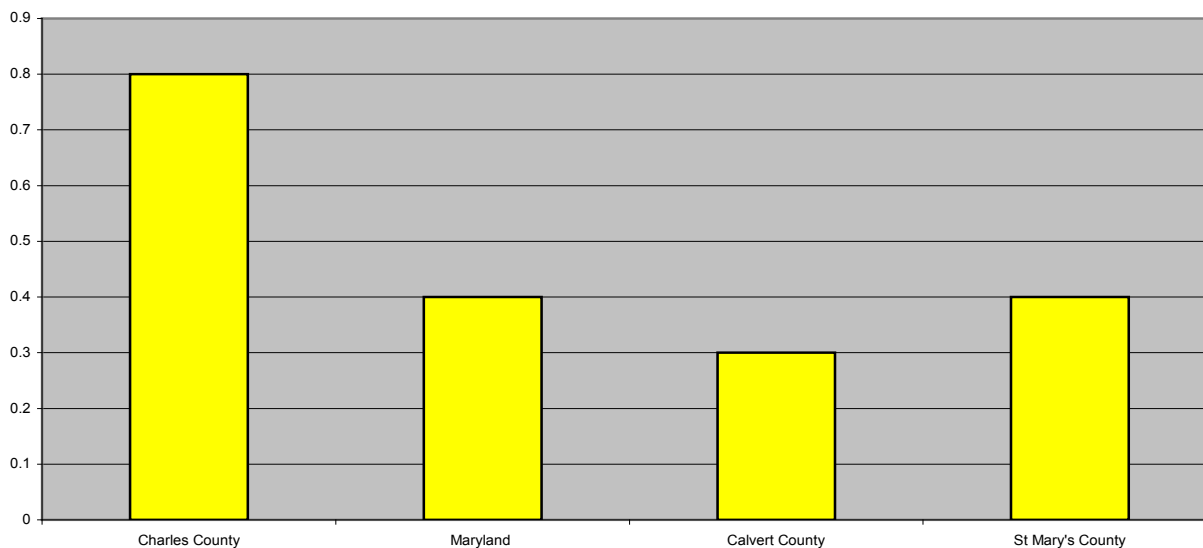
The African American population is the largest minority group within the state of Maryland as well as Charles County. African American comprised 75% of the Maryland minority population and approximately 85% of the Charles County minority population.

The African American population continues to grow within the county population. In 2005, they accounted for 35.4% of the total county population. This is the 4th highest percentage among the 24 Maryland jurisdictions. This percentage is much higher than the percent for the other Southern Maryland jurisdictions: Calvert County: 13.1% and St Mary's County: 14.8%. These differences are statistically significant ($p > .05$). It is also greater than the Maryland state average of 29.9%, though the difference is not statistically significant ($p < .05$).¹

2005 African American Population: Percent of Total Population

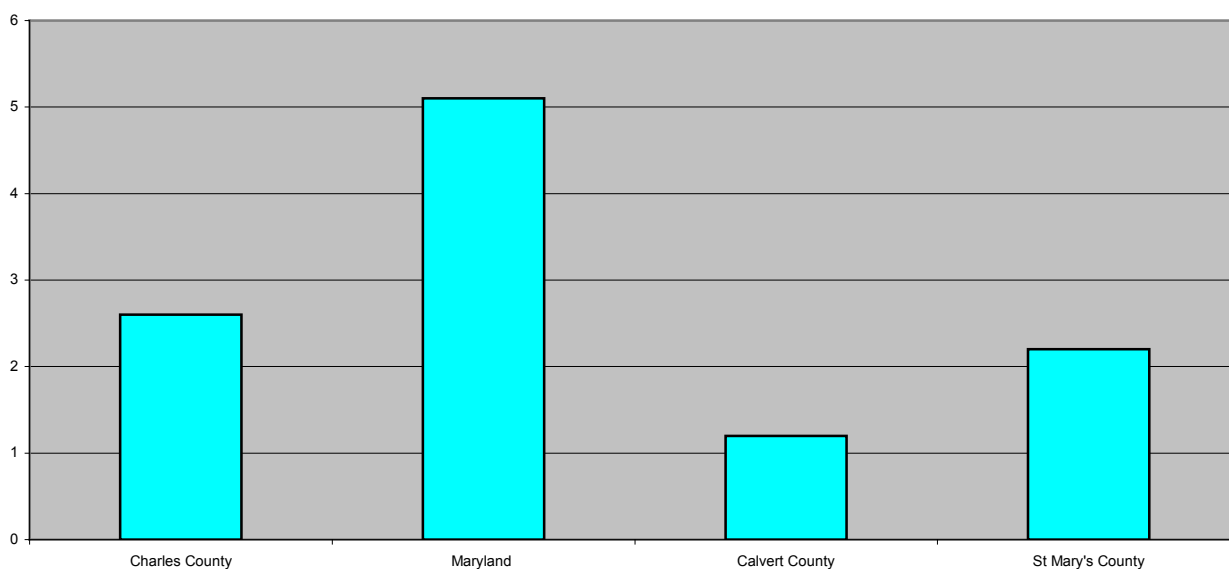
Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Though the American Indian/ Alaskan Native population makes up a very small percentage of the total county population, Charles County has the highest proportion of this minority than any of the jurisdiction in the state of Maryland. American Indians and Alaskan Natives make up 0.8% of the total county population. This is double the Maryland state average of 0.4%. It is also much higher than the other Southern Maryland jurisdictions: Calvert County: 0.3% and St Mary's County: 0.4%.¹

2005 American Indian/Alaskan Native Population: Percent of Total Population

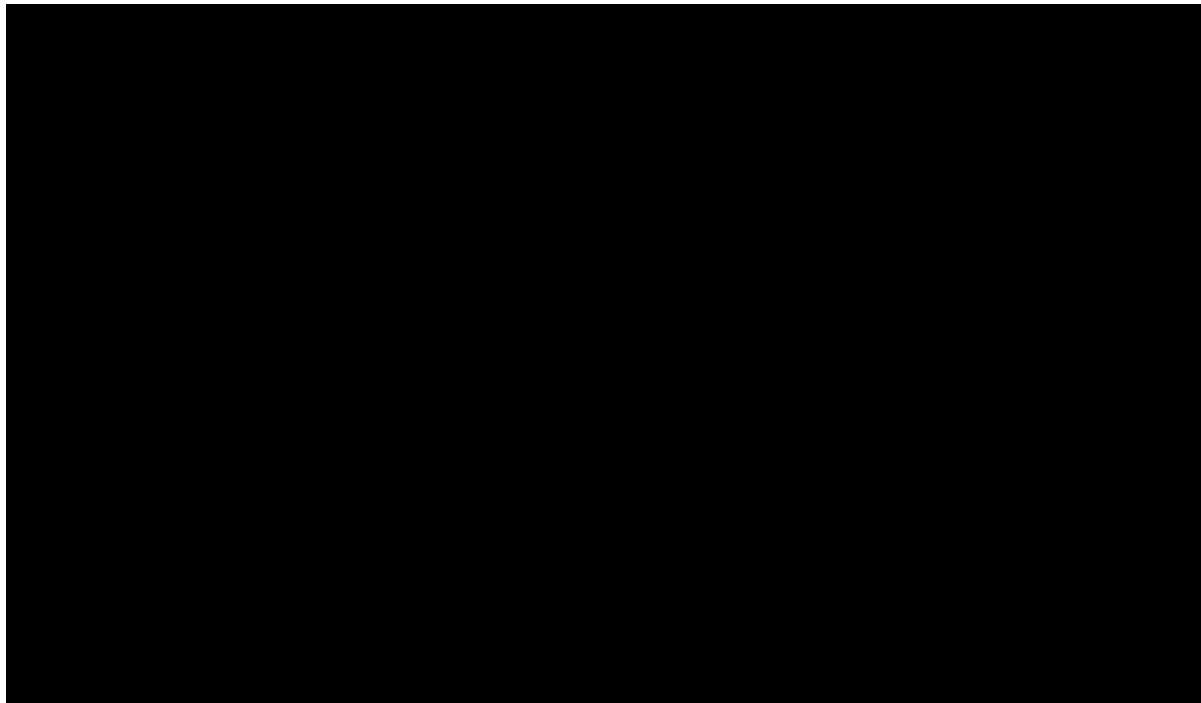
Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

The presence of Asians and Pacific Islander continues to increase within Charles County as well. According to the 2005 Maryland Vital Statistics Report, Asians and Pacific Islanders made up 2.6% of the total Charles County population. This is the seventh highest percentage among the Maryland jurisdictions. This is the greatest percentage among the Southern Maryland jurisdictions: Calvert County: 1.2% and St Mary's County: 2.2%. It is however less than the Maryland state average of 5.1%, which may be skewed by the large presence of Asians and Pacific Islanders in large Maryland counties.¹

2005 Asian/Pacific Islander Population: Percent of Total Population

Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

The Hispanic and Latino population is becoming a significant minority within Charles County. This minority now comprises 3.1% of the total county population. This percentage is the seventh highest among the Maryland jurisdictions; however, this is lower than the Maryland state average of 5.7%, which is high due to larger counties such as Montgomery County where Hispanics make up 13.6% of the total county population. The Charles County Hispanic population is the largest among the Southern Maryland jurisdictions: Calvert County 2.0% and St Mary's County 2.3%.¹



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

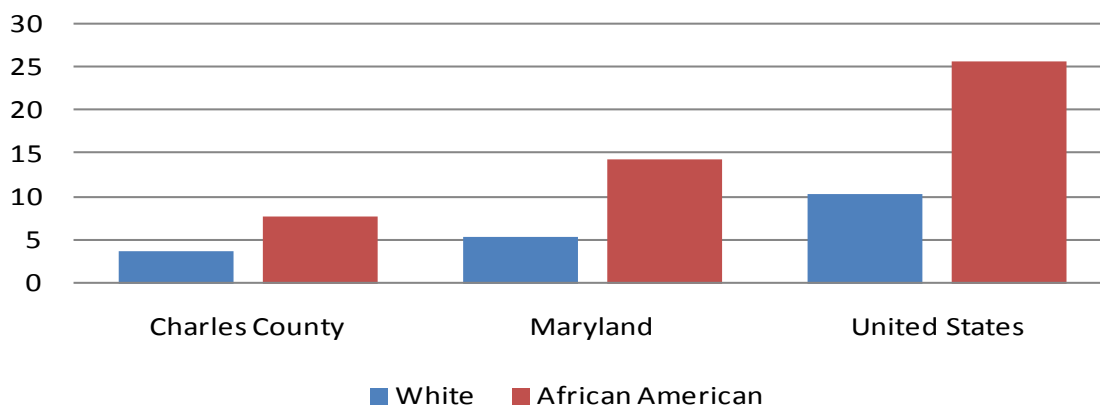
Socio-economic Characteristics:

Employment and economic indicators for the county are strong. In 2006 the employed population for 16 years and older was 108,609. The commute to work includes 56,379 vehicles driven alone, 8,084 vehicles used for carpooling, 5,459 individuals use public transportation (excluding taxicabs), 546 individuals walk, 348 individuals use other means, and 2,421 individuals work from home.¹³

Income:

In 2006, the mean household income was \$95,033.¹³ Charles County has a rate of 6.4% of all families who were living below the poverty level in 2006. African Americans were twice as likely to report that they were below the poverty level as Whites in the county. However, the rates of poverty in Charles County are significantly lower than the Maryland average rate and the United States rate. Poverty rates for Asians, American Indian/ Alaskan Native, and Hispanics could not be calculated due to small sample sizes.³

Percent Below Poverty Level in past 12 months, 2005



Source: 2005 American Community Survey, US Census Bureau

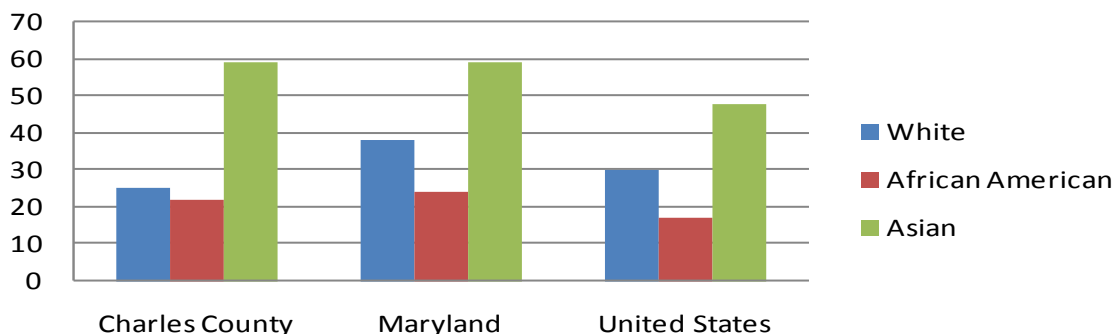
Economic Indicators	Charles County	Maryland
Average Household Income, 2006	\$95,033	\$83,367
Persons below poverty, 2006	6.4%	7.8%
Homeownership rate, 2006	79.2%	69.4%
In labor force, 2006	73.5%	69.2%

Source: 2006 Maryland Vital Statistics Report and US Census Bureau:
2006 American Community Survey

Educational Attainment:

Within Charles County, the number of individuals with a bachelor's degree or higher in the White and African American populations is less than the Maryland average. The percentage of college educated African American residents in Charles County is higher than the United States average and only slightly below the Maryland state average. For the Asian population, the Charles County percentage is exactly the same as the Maryland state average and higher than the United State average. Educational attainment statistics were not available for the American Indian/Alaskan Native and Hispanic populations due to small samples sizes.³

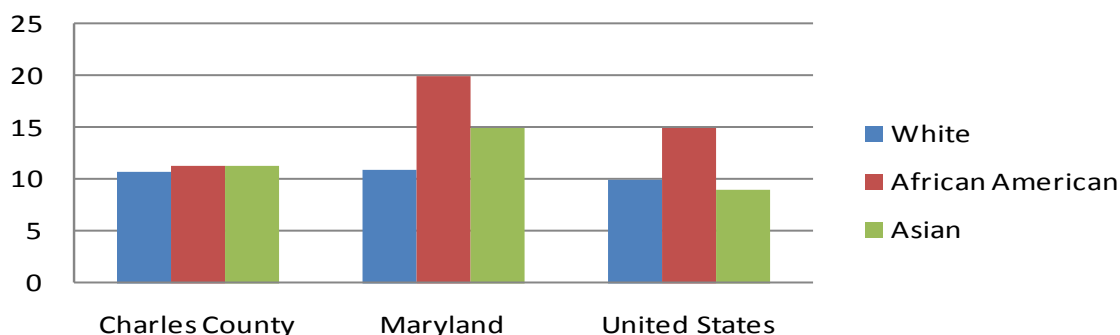
Percent of Bachelors Degree or higher within Racial and Ethnic Groups, 2005 (Ages 25 and over)



Source: 2005 American Community Survey, US Census Bureau

There are no visible racial disparities in the percentage of individuals who have less than a high school diploma. The percentage for Whites, African Americans, and Asians was approximately 11 percent.³ The rate among the White population was similar on a county, state, and national level. The rate for the African American population was less on a county level than the state and national averages. The rate for the Asian population was less than the national average though slightly higher than the state average.

Percent with Less than High School Diploma within Racial and Ethnic Groups, 2005 (Ages 25 and over)



Source: 2005 American Community Survey, US Census Bureau

Mortality:

All Cause Mortality:

From 1999-2003, Charles County like most jurisdictions within Maryland, has a lower all-cause mortality rate than the Maryland state average rate and the national rate. However, mortality rates are higher for African Americans than Whites in every Maryland jurisdiction as well as the state, and the nation.⁴

The Charles County African American all-cause mortality rate is the 4th lowest among the Maryland jurisdictions. It is actually lower than the White all-cause mortality rate for several Maryland jurisdictions such as Somerset County and Baltimore City.

When comparing the White and African American rates on a county level, there are no statistically significant differences in the all-cause mortality rates. The percent excess in the African American all-cause mortality rate compared to the White all-cause mortality rate in Charles County is the smallest in the state. The African American death rate is only 4.1% greater than the White death rate. This is significantly smaller than the Maryland state average excess of 30.8%.

Leading Causes of Death

Cause of Death	Charles County Number, 2006	Charles County Number, 2004-2006	Charles County Rate 2004-2006*	Maryland Number, 2006	Maryland Number, 2004-2006	Maryland Rate 2004-2006*
All Causes	841	2568	862.2	43491	130426	789.0
Cancers	202	662	215.7	10336	30831	186.6
Diseases of the Heart	199	599	211.6	11191	34026	205.7
Accidents	46	126	33.5	1424	4187	25.0
Chronic Lower Respiratory Diseases	46	127	46.3	1827	5618	34.9
Cerebrovascular Diseases	34	128	46.8	2358	7535	45.9
Diabetes mellitus	31	95	32.3	1230	4025	24.5
Septicemia	17	65	21.0	964	3105	18.9
Influenza & Pneumonia	17	68	25.8	1091	3429	20.8
Certain conditions originating in the perinatal period	17	39	**	365	1101	**
Alzheimer's Disease	12	41	17.1	908	2767	16.9
Intentional self-harm (suicide)	12	39	9.9	485	1441	8.5

*All rates calculated per 100,000 population

**Rates not available

Source: 2006 Maryland Vital Statistics Report

Diseases of the Heart:

From 1999-2003, Charles County had lower heart disease death rates for African Americans and for Whites than the Maryland state average rate and the United States rate. The Charles County African American heart disease mortality rate was the 11th lowest in the state. On the county

level, the Charles County African American heart disease death rate was higher than the White heart disease death rate, though there was not a statistically significant difference ($p < .05$).⁴

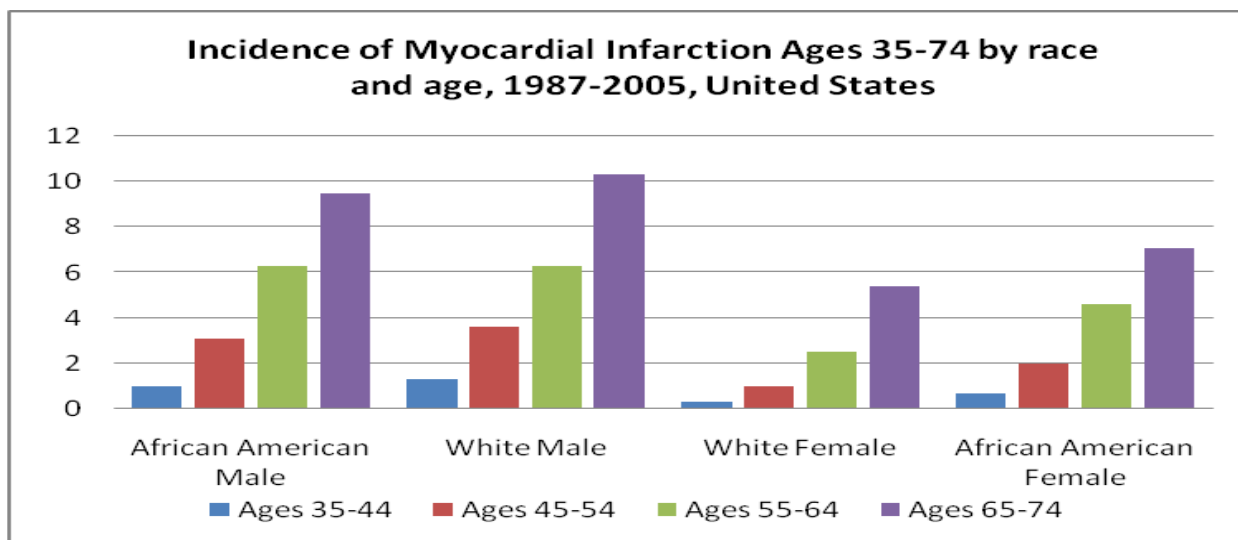
Heart disease is the leading cause of death in the state of Maryland and the second leading cause of death in Charles County. According to the 2005 Maryland Vital Statistics Report, the age-adjusted average death rate for diseases of the heart in Charles County from 2003-2005 was 224.2 per 100,000, which is slightly higher than the Maryland state average rate of 218 per 100,000.²

For Maryland African Americans, the mortality rate from diseases of the heart is much higher than the mortality rate for any other racial group in Maryland. In 2005, the African American age-adjusted death rate for diseases of the heart was 253.3 per 100,000 compared to 200.9 per 100,000 for Caucasians. When comparing by gender, African American males have the greatest death rates from heart disease. The 2005 age-adjusted death rate for black males was 301.6 per 100,000, while the 2005 age-adjusted death rate for white males was 244.1 per 100,000. African American females are also at an increased risk of death from heart disease. The 2005 age-adjusted death rate for diseases of the heart for black females was 216.2 per 100,000, which was significantly higher than the 2005 age-adjusted death rate for white females at 166.3.²

Historically the death rates for African Americans have been higher for heart disease than Caucasians. The heart disease death rates have been slowly decreasing over the past decade for both races, but there is still a racial disparity in the heart disease death rates between blacks and whites. The difference in the death rates for blacks and whites is actually increasing over the years. This is true regardless of gender. The biggest difference in rates can be seen when comparing the male populations.

Using data from the 2005 Maryland Health Services Cost Review Commission, Ambulatory and Hospital Discharge Data and the 2005 Maryland Vital Statistics Report, relative risks for hospitalization and mortality from heart disease were calculated between Maryland African American males/White males and Maryland African American females/White females. African American males were 1.18 times more likely to be hospitalized for heart disease than white males, and 1.24 times more likely to die from heart disease than white males. African American females were 1.51 times more likely to be hospitalized for heart disease than white females, and 1.30 times more likely to die from heart disease than white females.¹

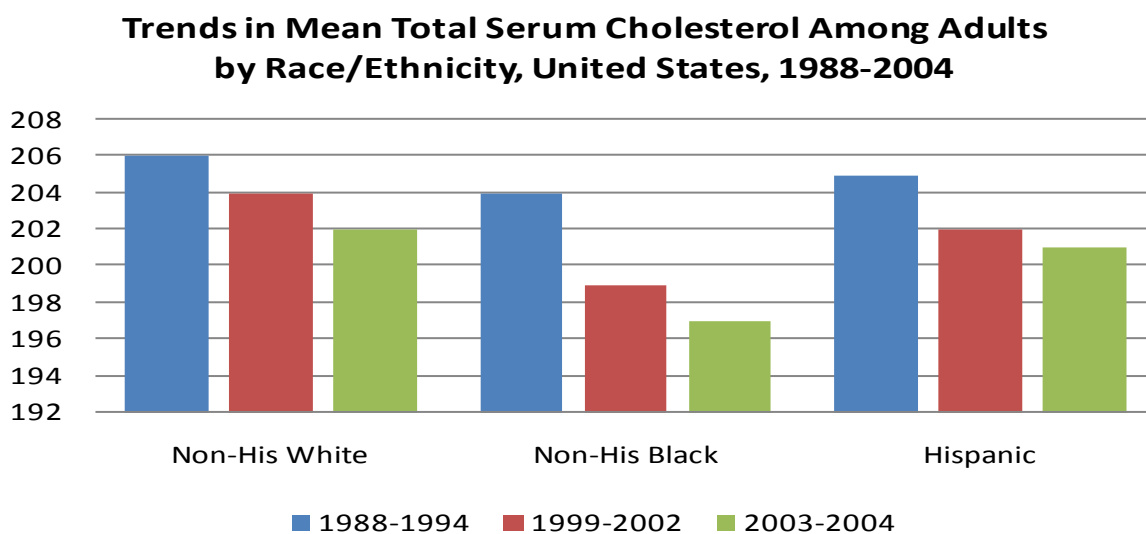
Higher mortality rates for heart disease in African Americans are in part related to the fact that the disease occurs more frequently in African Americans. The following figure shows that incidence (the rate of new cases) of heart attack (myocardial infarction) is higher in African Americans than in Whites in the United States.



Source: American Heart Association, *Heart Disease and Stroke Statistics 2007 Updated*.

Analogous Maryland data on incidence of heart disease are not available. Prevalence data for heart attack in the BRFSS shows that prevalence is similar between African Americans and Whites. However, prevalence data can be misleading regarding disparity in disease occurrence. If a disease has higher incidence in a minority group and also has poorer survival in that group, prevalence may be similar. That is despite higher rates of new disease, and lower rates of survival in the minority group. Therefore, similar disease prevalence for a condition where minorities have higher mortality is not reassuring.

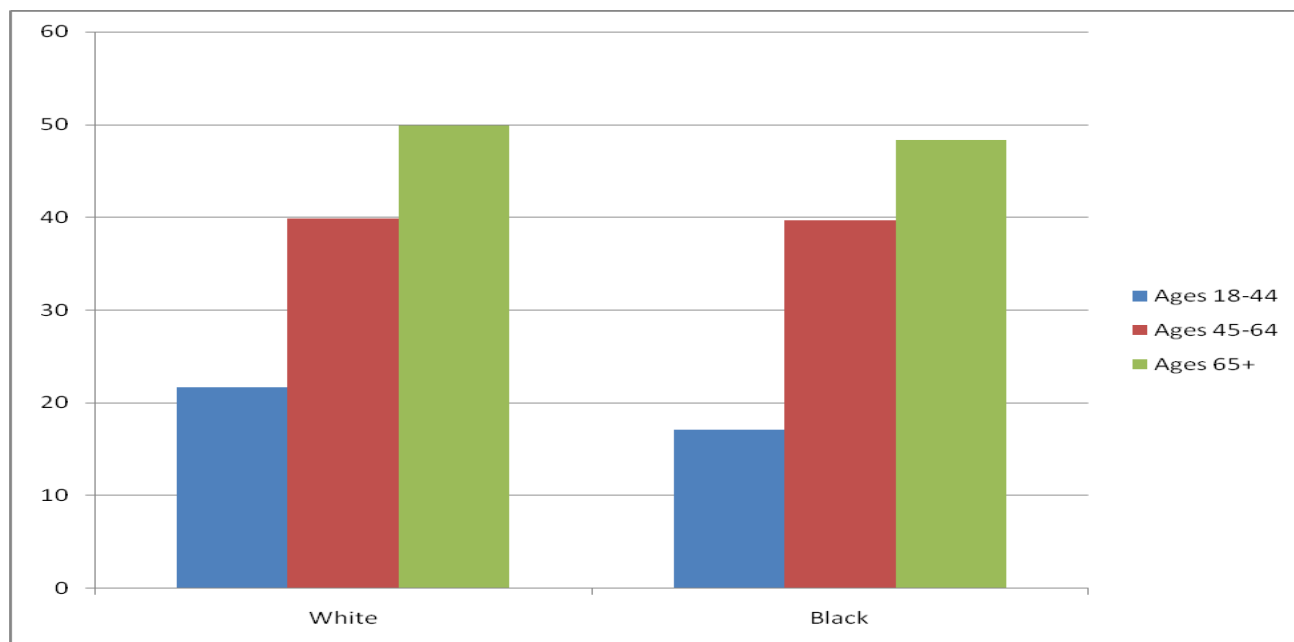
Higher occurrence of heart disease reflects differences in risk factors for heart disease. African Americans have higher rates of hypertension (high blood pressure) and diabetes than whites. Survey data in the U.S. does not show a difference in cholesterol levels.



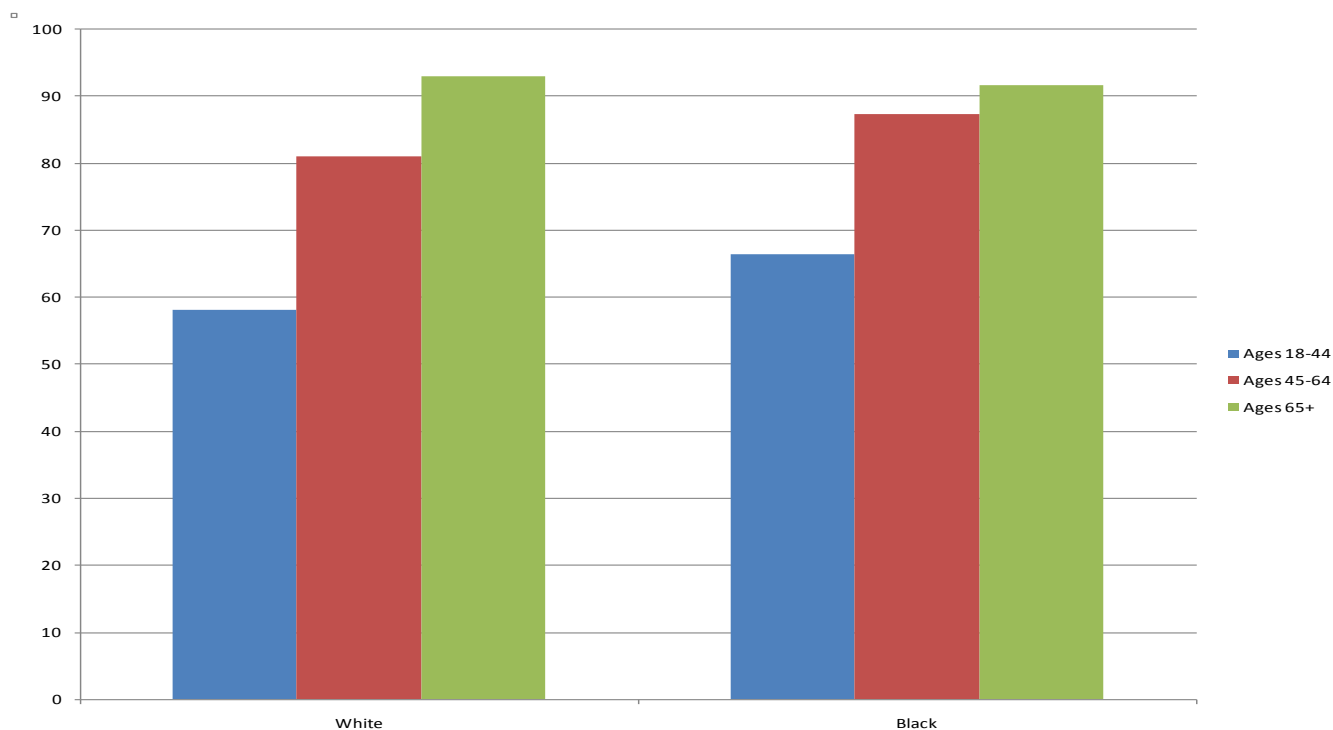
Source: American Heart Association, *Heart Disease and Stroke Statistics 2007 Updated*.

BRFSS survey data in Maryland does not show a difference in the number of adults reporting a diagnosis of high cholesterol between African Americans and Whites. Rates of cholesterol testing are also similar for the two groups.⁵

Prevalence of High Cholesterol by Race, Maryland BRFSS, 2001 and 2003 pooled



Percent with Cholesterol Test in Last 2 Years, Maryland BRFSS, 2001 and 2003 pooled

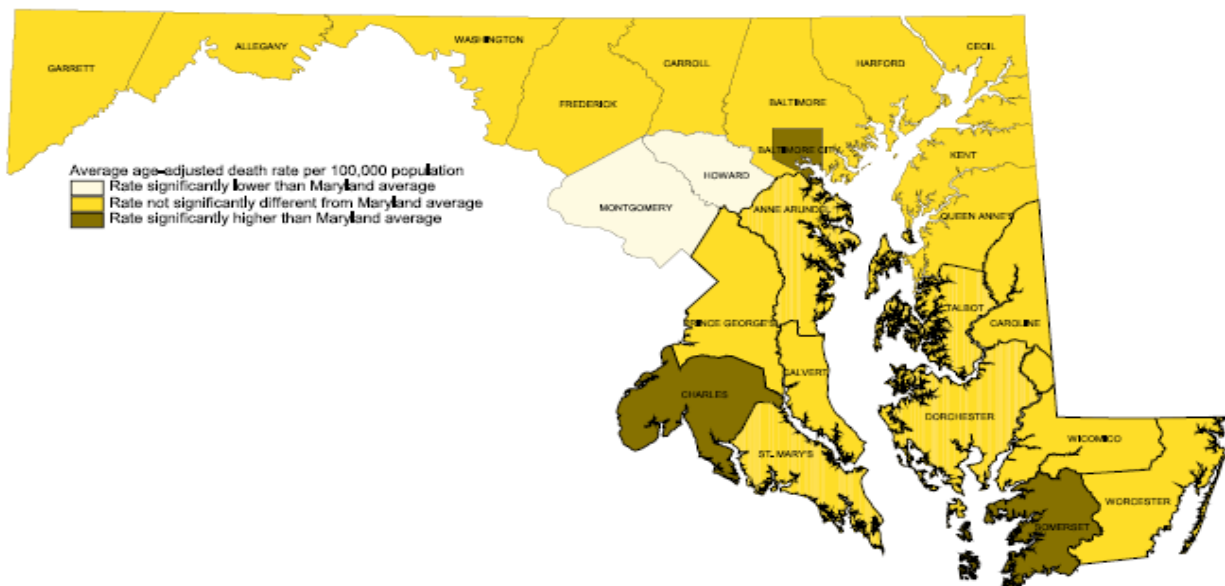


Cancer:

Cancer is the second leading cause of death in both the U.S. and in Maryland. The age-adjusted cancer death rates have been declining for both Whites and African Americans in Maryland, although African Americans have experienced a steeper decline in rates than Whites. Progress has been made in reducing the cancer disparity. In 1996, African Americans had 28 percent higher cancer mortality rates than Whites, while in 2005 the age-adjusted cancer mortality rate for African Americans in Maryland was 12 percent higher than for Whites. The difference between African American and White cancer mortality rates in 2000 was 44 deaths per 100,000, while in 2005 the difference was 22 deaths per 100,000. This represents a 50% reduction of the cancer mortality disparity in Maryland from 2000 to 2005.¹

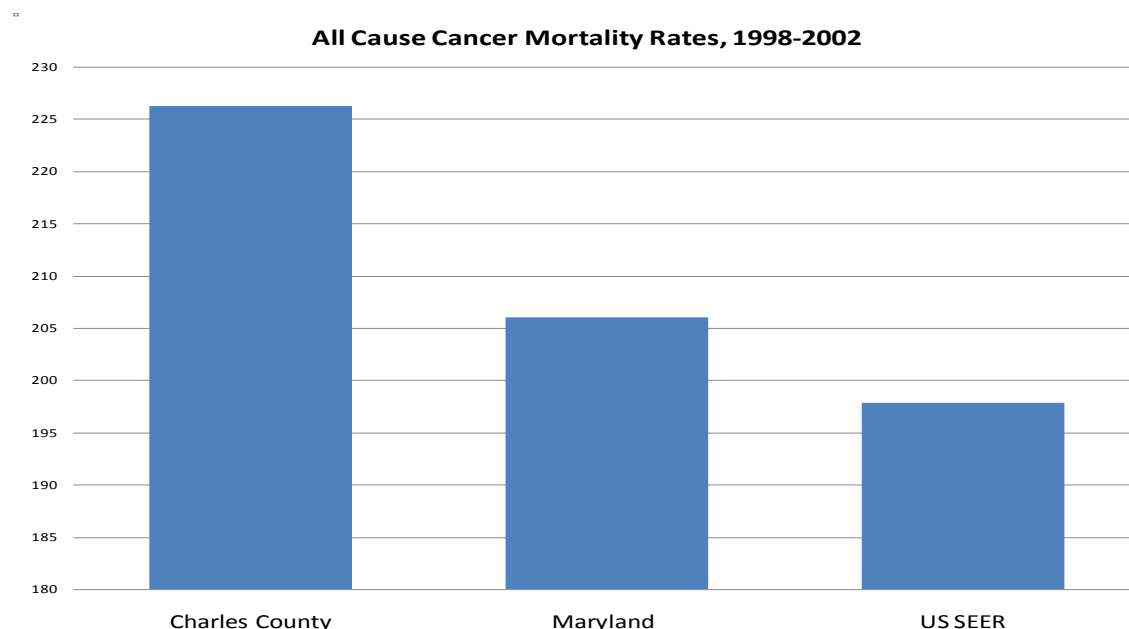
The same patterns of decline in cancer mortality rates have been seen in Charles County. In 2004, cancer was the leading cause of death in Charles County. The age-adjusted death rate for overall cancer from 2003-2005 in Charles County was 222.4 per 100,000.² This rate exceeds the state overall cancer death rate of 190 per 100,000. For 1998-2002, lung and bronchus cancer incidence in Charles County is 66.9 per 100,000 and mortality is 59.9 per 100,000. On a county level, both the incidence and mortality rates for overall cancer and lung/bronchus cancer have decreased since the previous cancer report data. The county incidence rate for lung/bronchus cancer has dropped below the State incidence (68.0); however, the county mortality rate has remained slightly higher than the state mortality (58.1) rate for lung/bronchus cancer.⁶

Comparison of County Age-adjusted Death Rates* for Malignant Neoplasms with the Maryland State Average, 2003-2005.



When comparing cancer mortality among racial groups, there was a reversed disparity for cancer mortality between the periods of 1999-2003. The White cancer mortality rate (approximately

230 per 100,000) is slightly higher than the African American cancer mortality rate (approximately 225 per 100,000), though the difference is not statistically significant.⁴ The White cancer mortality rate exceeds the state average rate and is one of the highest among all of the Maryland jurisdictions. The African American cancer mortality rate is the sixth lowest among the Maryland jurisdictions and is well below the Maryland and national rates.



Source: 2005 Maryland Vital Statistics Report

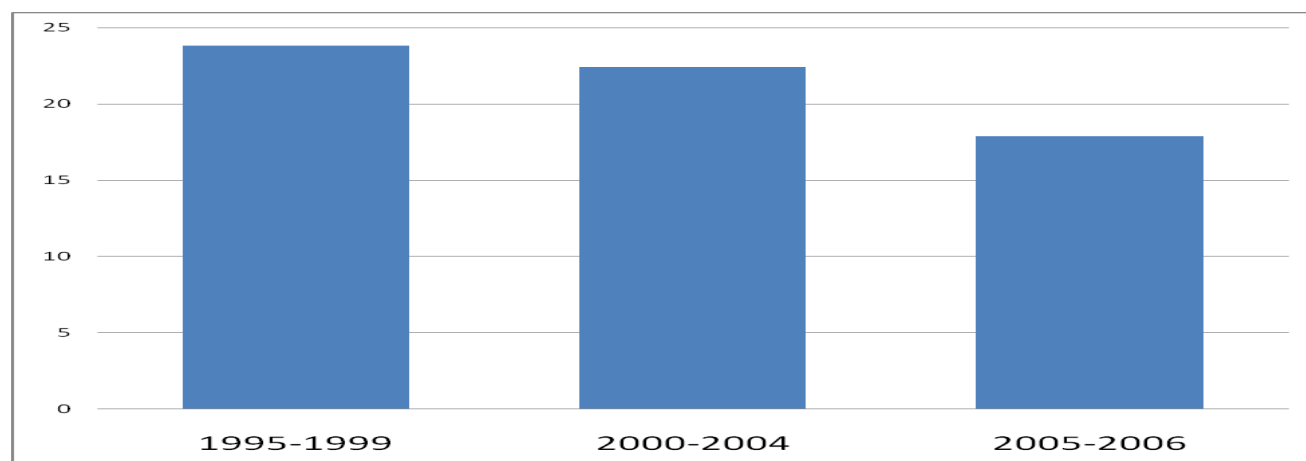
Cigarette smoking is a well-known risk factor for many types of cancer. Among the Maryland jurisdictions, Charles County had the 6th lowest rate of tobacco use by minority youth in 2000 and dropped to the 4th lowest rate in the state in 2002. Charles County ranked 13th in 2000 and 15th in 2002 for highest rates of tobacco use by minority adults. In 2000, the state rates for tobacco use among minority youth and minority adults was less than the county rates; however, the county rates fell below the state rates by 2002.⁷

Prevalence of Any Tobacco Use by Minority Under-age Youth and Minority Adults, Statewide and Charles County, 2000 vs. 2002

Year	Youth	Adults
State – 2000	18.8%	20.6%
State – 2002	16.8%	19.1%
Charles – 2000	21.8%	21.8%
Charles – 2002	16.6%	18.5%

Source: 2002 CRF Tobacco Use in Maryland

Prevalence of Current Smoking, Charles County, Maryland BRFSS, 1995-2006



Site-Specific:

A table is presented below with the site-specific incidence and mortality rates for Charles County and the state of Maryland for 2004 and the United States for 2001. Charles County is number one in the state for new cases of prostate cancer. Charles County has consistently held the highest prostate cancer incidence rate in Maryland for the last decade. The county has higher death rates for lung, prostate, colorectal, and oral cancers than the United States.

Site	2004 Charles County Incidence Rate*	2004 Maryland Incidence Rate*	2001 US Incidence Rate*	2004 Charles County Mortality Rate*	2004 Maryland Mortality Rate*	2001 US Mortality Rate*
Lung/Bronchus	469	475.3	468.8	239.6	209.9	195.6
Colorectal	54.5	55.7	51.8	27.7	23.1	20
Female Breast	121.4	132.8	134.8	32.5	28.5	25.9
Prostate	221.1	178.6	176.8	49.6	34.3	29.1
Oral	8.4	10.7	10.4	**	3.1	2.7
Melanoma of Skin	12.8	16.9	18.7	**	2.5	2.7
Cervical	8.9	8.3	7.9	**	2.8	2.7

Source: 2006 CRF Cancer Reports.

*Rates per 100,000 population.

** Rates based on cells with 25 or fewer cases are not presented.

Prostate:

Incidence:

In the United States, the African American population is at an increased risk of developing prostate cancer. Nineteen percent of, or 1 in 5, all African American men will develop prostate cancer in their lifetime.

In Maryland, health disparities among the African American population have also been observed. In 1999, the prostate cancer incidence rate among white Maryland men was 157.4 per 100,000; for African American men in Maryland, the prostate cancer incidence rate was 226.8.⁶

However, for the Southern Maryland region these differences in prostate cancer incidence rates among races have not been noticed. In 1998, the incidence rates among the white and African American populations in Southern Maryland were similar. In 1999, the prostate cancer incidence rate among the African American population was less than the rate among the white population for the Southern Maryland region.

Table 1: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1998

1998	<u>White Males</u>	<u>Black Males</u>
<i>Southern Maryland</i>	166.3	167.9
<i>Maryland</i>	121.1	187.2

Source: 2006 CRF Cancer Report

Table 2: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1999

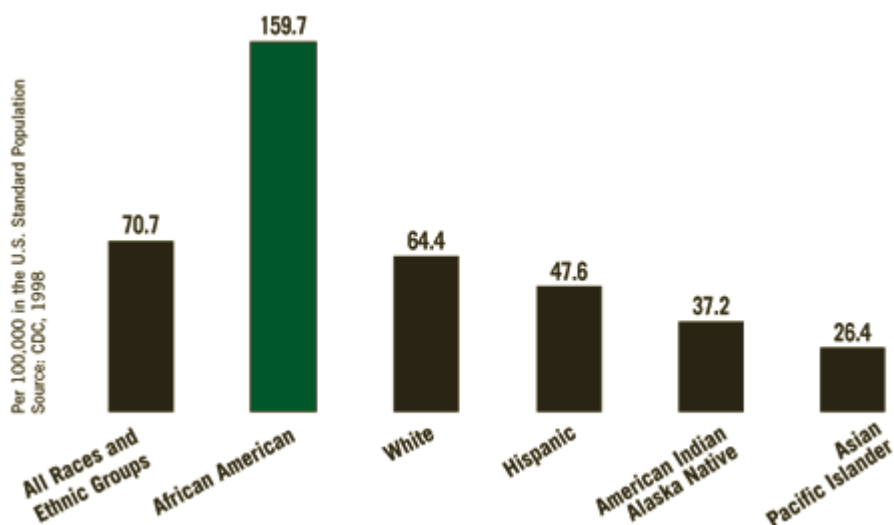
1999	<u>White Males</u>	<u>Black Males</u>
<i>Southern Maryland</i>	171.3	159.6
<i>Maryland</i>	157.4	226.8

Source: 2006 CRF Cancer Report

Mortality:

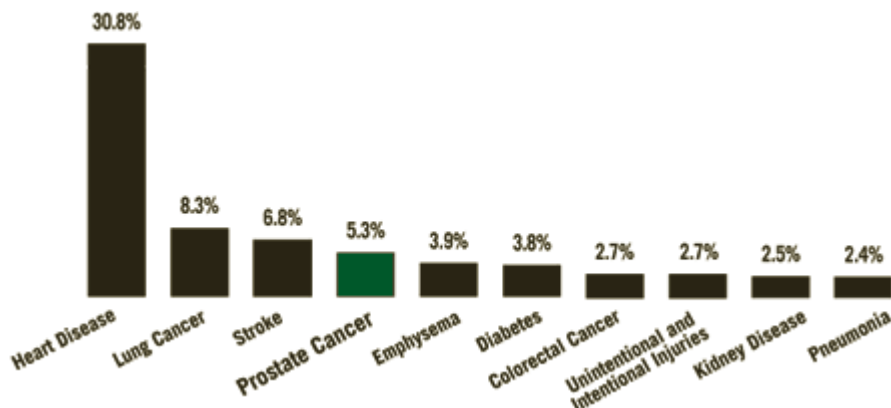
African American men are more likely to be diagnosed with prostate cancer at an advanced stage and more likely to die from the disease than white men. The death rate for prostate cancer among African American men over the age of 45 years is 159.7 per 100,000. This is statistically higher than the death rate for all races of 70.7 per 100,000.⁸

**Prostate Cancer Death Rates by Race/Ethnicity
in Men Aged 45 and Above**



African American men have a 5% chance of dying from prostate cancer; it is the fourth leading cause of death in African American men over the age of 45 years.

Top Ten Causes of Death among African American Men over Age 45

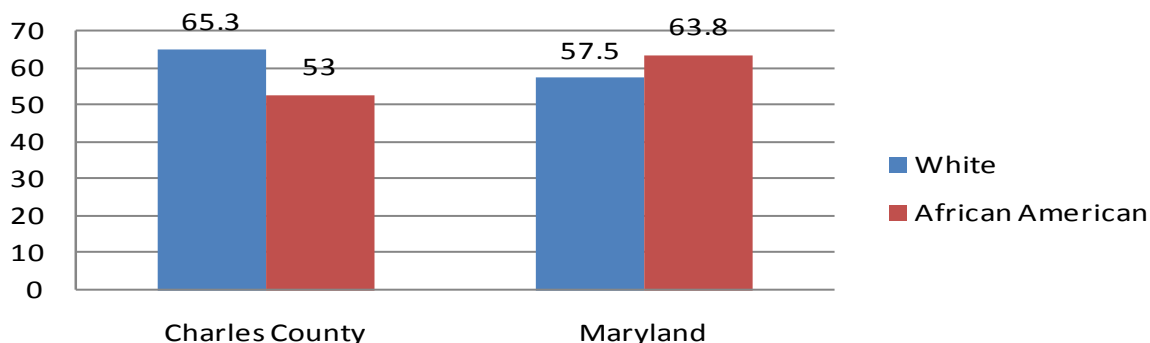


Prostate cancer mortality rates in Charles County are higher than the national mortality rates. However, they appear to be following the same trends as the state mortality rates.

Lung/Bronchus:

Lung cancer is the most fatal form of cancer, and the Charles County lung/bronchus mortality rate is the highest among all county-level cancer site death rates. Unlike the minority disparity seen on the state level, Charles County has experienced a reverse disparity with the White lung cancer death rate higher than the African American rate.

Lung/Bronchus Cancer Mortality Rates by Race, Charles County vs MD, 1999-2003

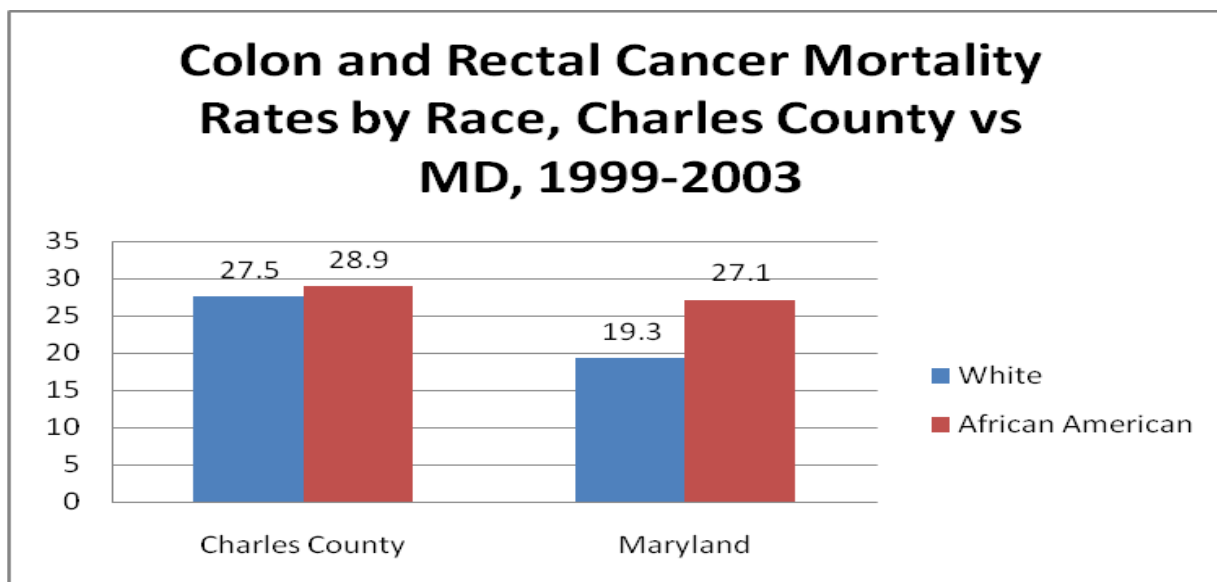


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

*Rates per 100,000 population.

Colon and Rectal Cancer:

In Maryland, there is a small disparity in terms of Colon and Rectal Cancer deaths, with African Americans experiencing high rates of mortality. However, on a county level, Charles County has not seen the same patterns. The rates for both the White and African American populations are similar. Charles County has the smallest difference in mortality between the White and African Americans than any other jurisdiction in the state.

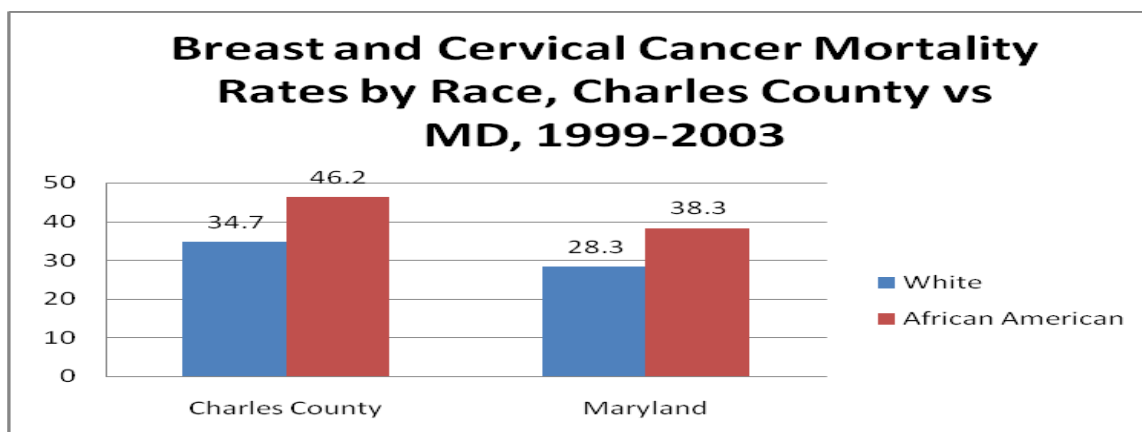


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

*Rates per 100,000 population

Breast and Cervical Cancer:

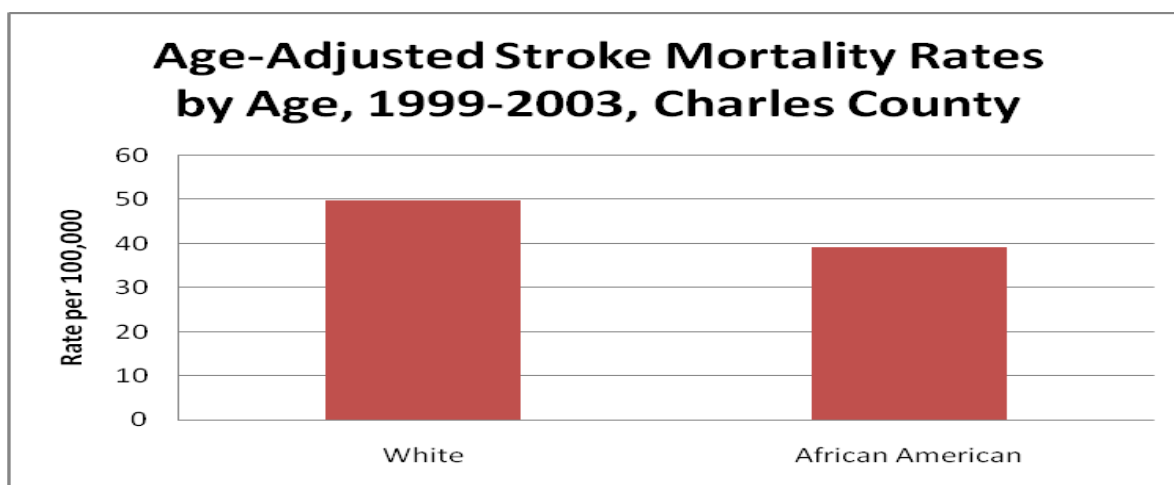
Disparities are visible between the African American and White populations on a county and state level for breast and cervical cancer mortality. The Charles County African American breast and cervical cancer mortality rate is significantly higher than the rate for the Charles County White population. The excess difference in the disparity is higher on a county level (11.5) than on a state level (10).



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities
 *Rates per 100,000 population.

Stroke:

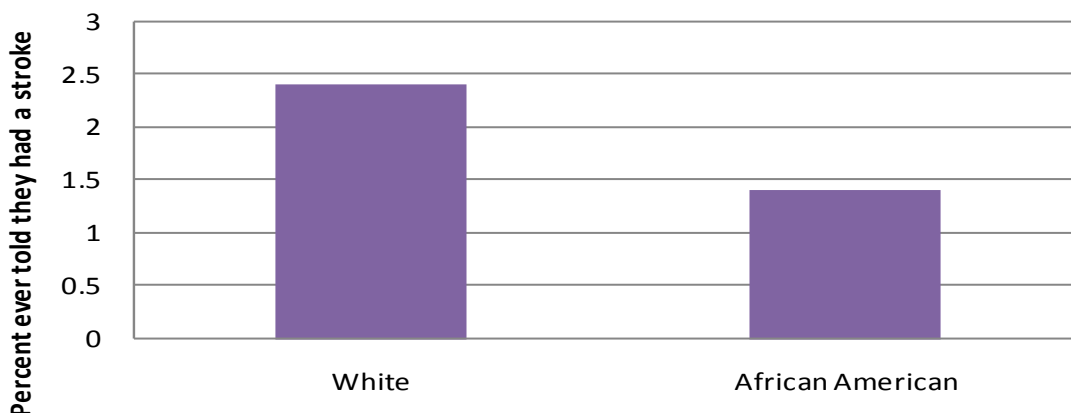
Stroke incidence and mortality are often seen at an increased rate among the African American population. This disparity has been observed on the state and national level. However, the same patterns of disparity are not observed on the county level. From 1999-2003, the Charles County White mortality rate was 27% higher than the African American stroke mortality rate and 13% lower than the Maryland statewide White stroke mortality rate. Additionally, Charles County had the lowest African American stroke mortality rate among all of the Maryland jurisdictions.¹



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Using 2003-2006 pooled data from the Maryland Behavioral Risk Factor Surveillance System, a county prevalence of stroke can be estimated. Respondents are asked if they have ever been told by a doctor that they had a stroke. Again, a reversed disparity can be seen. Approximately 2.4% of White respondents from Charles County answered “Yes” that they had been told by a doctor that they had a stroke. Only 1.4% of the African American respondents from Charles County answered “Yes” to the same question.⁵

Prevalence of Stroke by Race, Charles County, MD, BRFSS 2003-2006



High blood pressure is a risk factor for stroke. The estimated prevalence for high blood pressure can be approximated by using the Maryland Behavioral Risk Factor Surveillance System (BRFSS) data. One of the questions asks participants if they have ever been told by a doctor that they have high blood pressure. The responses for each racial group are presented in the table below. Several years of data have been included to increase the sample size and to demonstrate any trends in the prevalence of high blood pressure.

According to the self-reported data from the BRFSS, Whites have the highest levels of high blood pressure in the county. The percentage of African Americans reporting that they have high blood pressure is lower than the percentage of individuals reporting high blood pressure in the White population.⁵ This is true for all years of data presented. However, it should be noted that the percentage of respondents reporting hypertension increased from 2001-2004 to 2005 regardless of race. The estimated prevalence could not be determined for other racial groups due to small sample sizes.

Charles County BRFSS: Have you ever been told that you have High Blood Pressure? 2001-2004 and 2005	(%)	(%)
Percentage that responded "Yes"	2001-2004	2005
Charles County African Americans	31.3	34.9
Charles County Caucasians	33.6	44.7

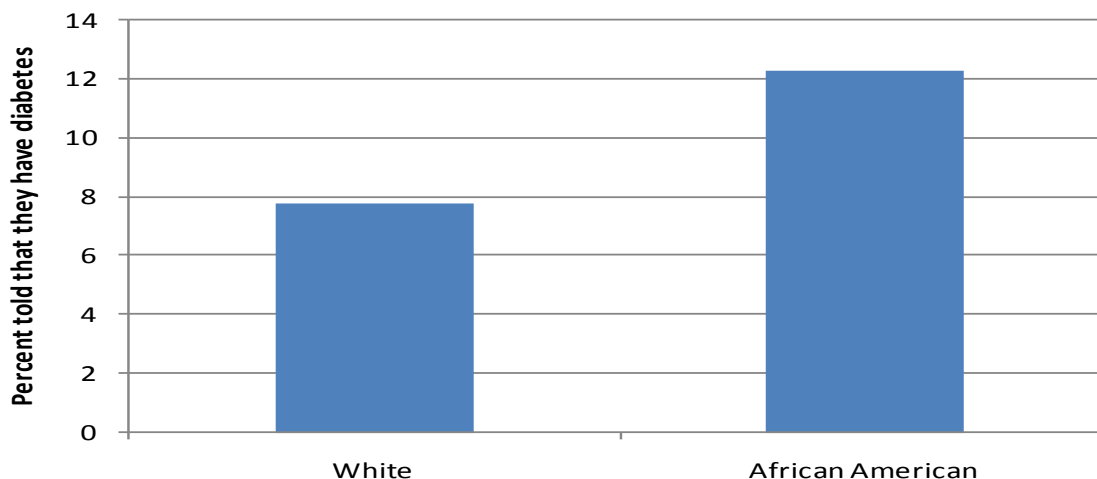
Diabetes:

Incidence:

An estimated prevalence of diagnosed diabetes can be determined on a county level using 2005-2006 Maryland BRFSS data. The data from the question, "Have you ever been told by a doctor

that you have diabetes?” was combined into a two-year period in order to increase the sample size and therefore increase the reliability of the statistics. Disparities can be seen between the African American and White population. The African American population has a significantly higher percentage of people with diabetes than the White population.

Maryland BRFSS: Diabetes Module: Have you ever been told by a doctor that you have diabetes? 2005-2006



The Center for Preventive Health Services at the Maryland Department of Health and Mental Hygiene combined five years of BRFSS data for diabetes and then weighted the responses to reflect the total Maryland and Charles County populations. The table below presents the five-year average prevalence of diagnosed diabetes for Charles County and Maryland defined by gender, race, and age from 2000-2004.

The average prevalence of diabetes in Charles County is lower than the state prevalence (4.2 vs. 6.9). The diabetic prevalence among males is significantly lower for Charles County (2.7% of the total Charles County population) than the state average prevalence of 7.3% of the total MD population. However, for females, the average prevalence is similar between Charles County and the state of Maryland (5.7% vs. 6.5%). Females in Charles County are nearly three times more likely to have been diagnosed with diabetes than Charles County males.⁹

When comparing the average diabetic prevalence by race, the percentage of diabetics within the total black population is higher than the percentage of diabetics in the total white population. The prevalence of diabetes for all races in Charles County is lower than the prevalence among all races for the state of Maryland. However, the number of African Americans in Charles County has increased in recent years. From 1998-2002, 854 African Americans were diagnosed with diabetes in Charles County; from 2000-2004, the number of African Americans with diagnosed diabetes increased to 1103 persons.⁹

When comparing the prevalence of diabetes among age groups, the highest diabetic prevalence falls within the elderly population over the age of 65 years. This is true for Charles County and for the state of Maryland, though the Charles County diabetic prevalence for this age group is below the state prevalence. The prevalence of diagnosed diabetes within the 65+ age group has increased over the past few years. The 1998-2002 five-year diagnosed diabetes prevalence for

Charles County was 12.1%, with 990 people affected. The 2000-2004 five-year prevalence has increased to 12.3%, with 1083 people affected. The prevalence estimates of diabetes within the other age groups (18-44 and 45-64) for Charles County are below the state of Maryland.⁹

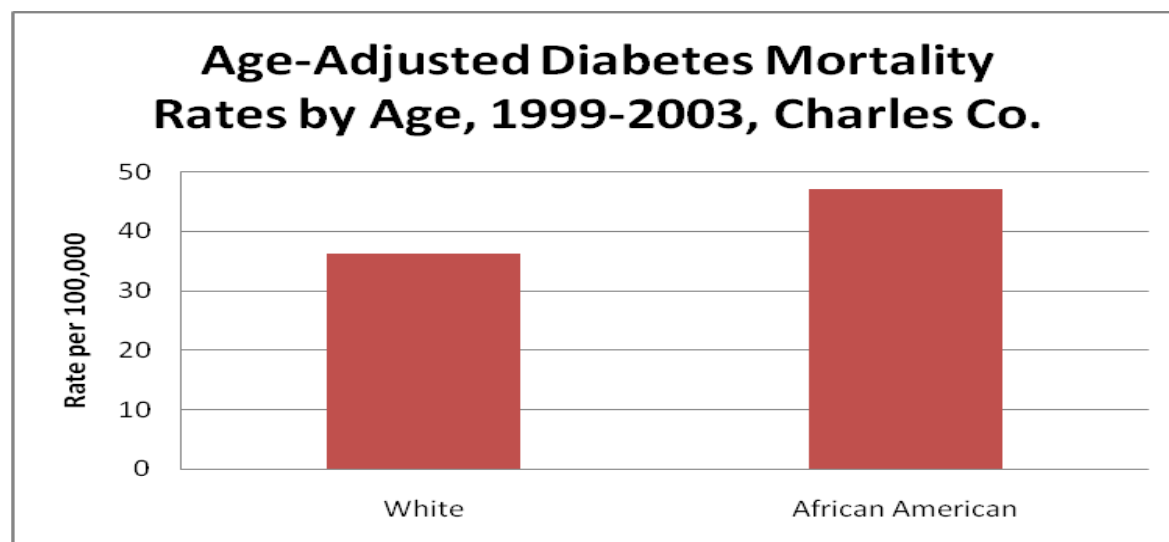
2000-2004 Five-Year Average Prevalence of Diagnosed Diabetes in Charles County and Maryland

Region	Total	Gender		Race		Age		
		Male	Female	White	Black	18-44 yrs	45-64 yrs	65+ yrs
Charles County	3716 (4.2%)	1222 (2.7%)	2493 (5.7%)	2612 (4.6%)	1103 (5.4%)	817 (1.6%)	1767 (6.5%)	1083 (12.3%)
Maryland	278713 (6.9%)	140246 (7.3%)	138467 (6.5%)	151775 (6.1%)	96598 (9.7%)	53040 (2.5%)	125652 (9.6%)	96225 (16.4%)

Source: Diabetes in Maryland. Maryland DHMH: Family Health Administration.

Mortality:

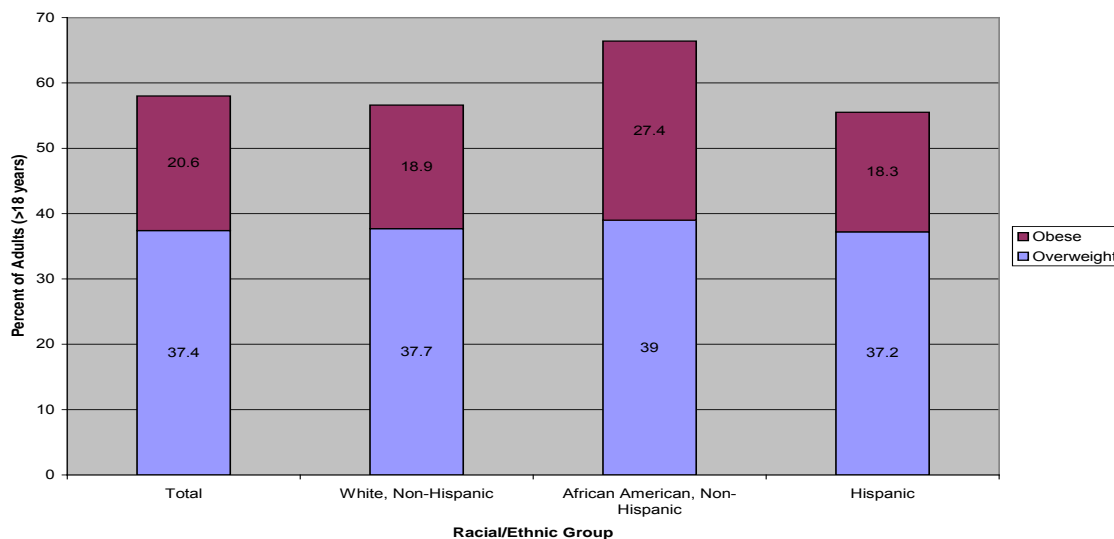
Disparities seen in Charles County for diabetes incidence are also evident in the county levels of mortality due to diabetes. The greatest mortality ratio disparity for African Americans compared to Whites in Charles County is with diabetes, where African Americans have a 30% higher death rate than Whites.¹



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

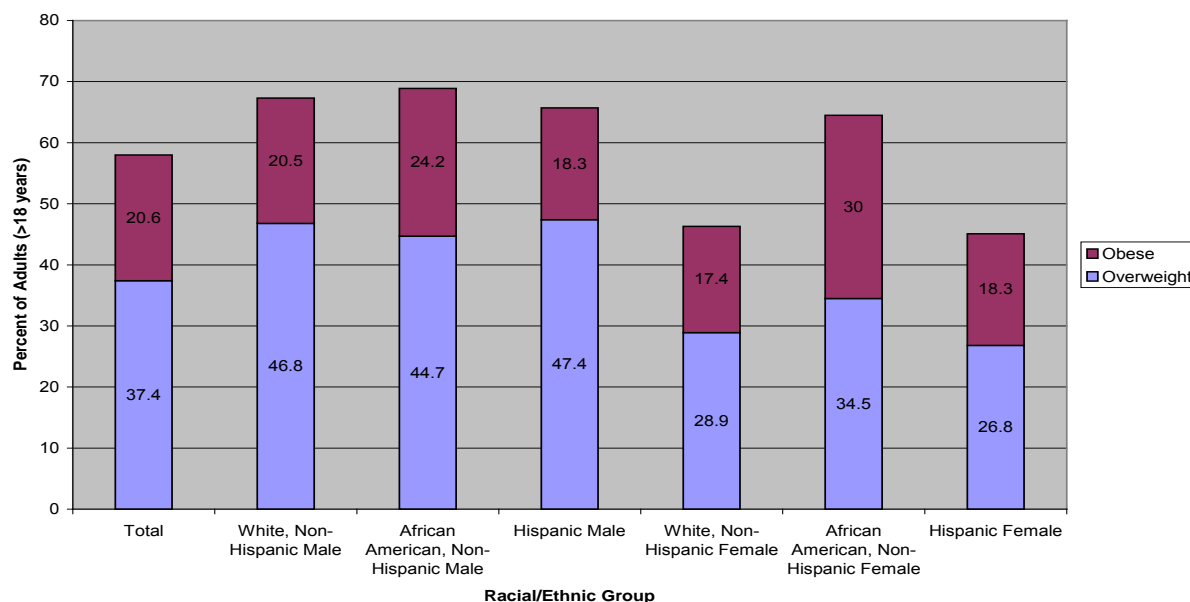
Obesity:

Obesity is a known risk factor for many chronic diseases and conditions. When comparing among racial and ethnic groups, the prevalence of overweight and obesity was higher for African American Marylanders than for White or Hispanic Marylanders. African Americans experienced higher rates of obesity than Caucasians or Hispanics.

Figure 1: Prevalence of Overweight and Obesity by Race/Ethnicity in Maryland, 2001-2003

Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

The prevalence of overweight and obesity in Maryland was higher among African American women compared to White or Hispanic women. Among males, the prevalence of overweight was comparable across racial groups; however, obesity prevalence rates were higher among African American males in Maryland than White or Hispanic males. African American women were more likely to be obese than African American men. However, white men were more likely to be obese than white women. For the Hispanic population, the obesity prevalence was the same for both men and women in Maryland.

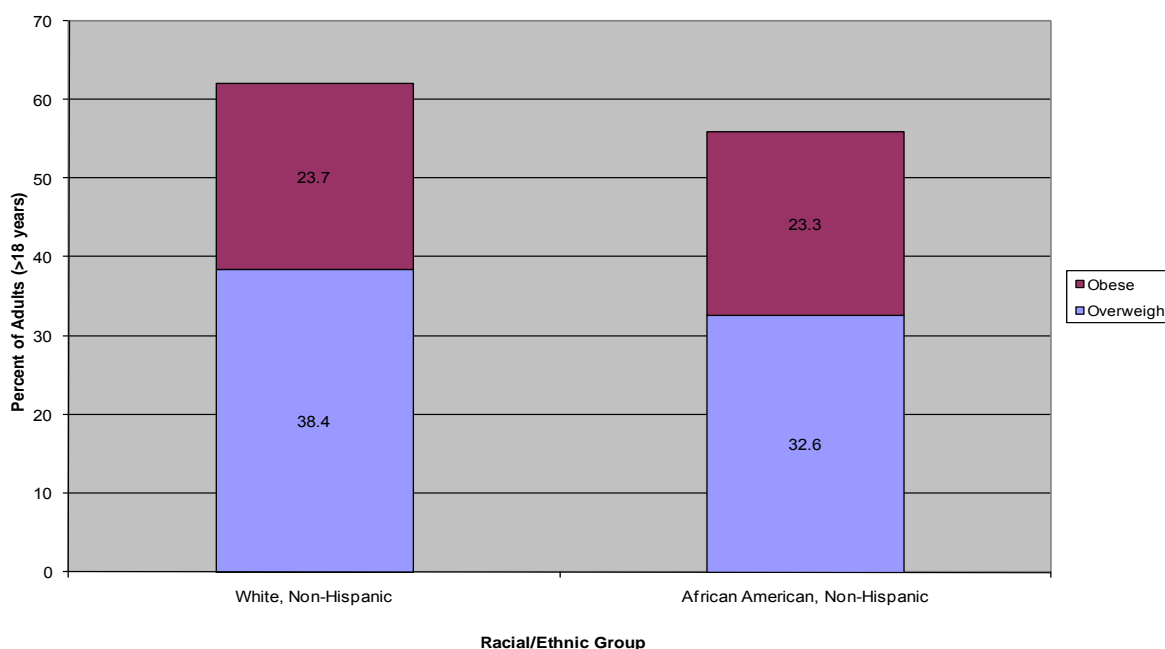
Figure 2: Prevalence of Overweight and Obesity by Race/Ethnicity and Gender in Maryland, 2001-2003

Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

Obesity prevalence rates have increased in Charles County over the last decade. Several years of data were aggregated together to increase the sample size to a more statistically stable level. Data are compared by 3 year time periods. The prevalence of obesity among Charles county adults was 15-19% during 1995-1997. By 2001-2003, the prevalence of obese adults had increased to 20-24% of the Charles county population.¹⁰

When comparing overweight and obesity rates in Charles County by race, the disparities seen on the state level are not observed. The obesity rates for the White and African American population are similar. A reversed disparity is seen when comparing rates of overweight individuals. There is a slightly higher rate in the county's White population than the African American population.⁵

Prevalence of Overweight and Obesity by Race/Ethnicity, Charles County, 2001-2004



Source: Maryland Behavioral Risk Factor Surveillance System

HIV/AIDS:

Maryland has the 19th highest total population among the 50 states and the District of Columbia. However, in 2004, Maryland was 9th in the US for the cumulative number of AIDS cases at 27,550 cases through 2004 and 4th for its cumulative AIDS incidence rate of 26.1 cases per 100,000.¹¹

For Charles County, the 2004 HIV incidence rate was 5.8 per 100,000, and the 2004 AIDS incidence rate was 6.6 per 100,000. The Charles County 2004 HIV prevalence rate was 91.3 per 100,000, and the 2004 AIDS prevalence rate was 72.2 per 100,000.¹¹

	2004 HIV Incidence Rate	2004 AIDS Incidence Rate	2004 HIV Prevalence Rate	2004 AIDS Prevalence Rate
Maryland	40.5	24.4	308.5	241.3
Charles County	5.8	6.6	91.3	72.2

Source: Maryland 2005 HIV/AIDS Annual Report

However, Charles County makes up 58% of the total HIV/AIDS cases in the Southern Maryland region. Among the increases in the incidence rates of HIV, the biggest increases have been seen in the African American population. African Americans currently make up 66% of the total HIV/AIDS cases in Southern Maryland. African Americans make up approximately 63% of the prevalent HIV cases in Charles County and 52.2% of the prevalent AIDS cases in the county.¹¹

Distribution of Gender and Race/Ethnicity among Prevalent HIV Cases on December 31, 2004

Gender:

Race:

Male	<u>Female</u>	<u>Missing</u>	<u>White</u>	<u>African American</u>	<u>Hispanic</u>	<u>Other</u>	<u>Missing</u>
63	46	1	20	69	2	0	19

Source: Maryland 2005 HIV/AIDS Annual Report

Distribution of Gender and Race/Ethnicity among Prevalent AIDS Cases on December 31, 2004

Gender:

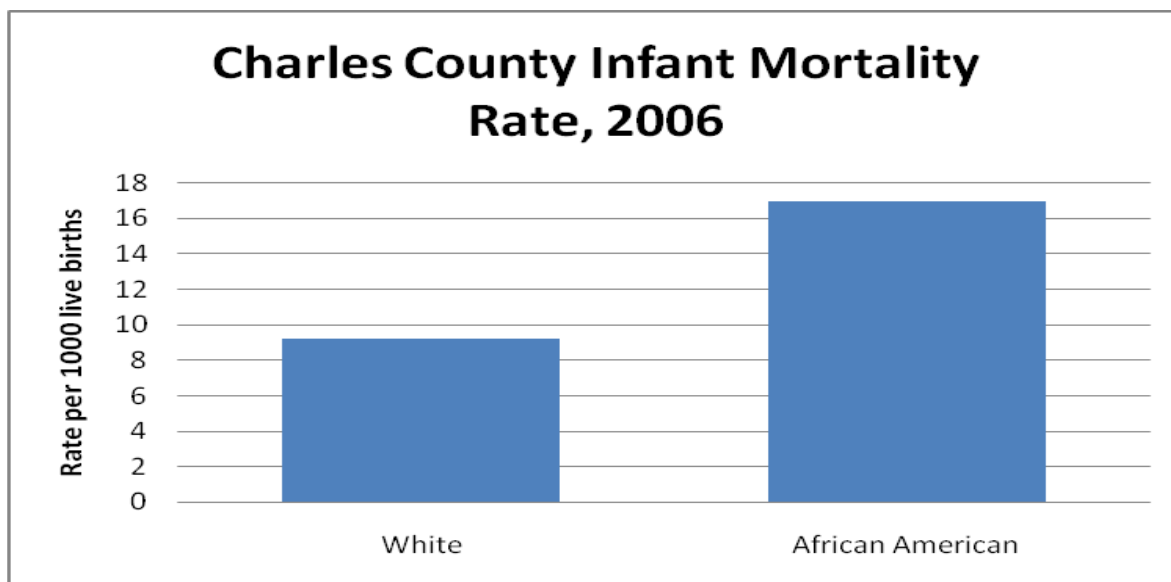
Race:

<u>Male</u>	<u>Female</u>	<u>Missing</u>	<u>White</u>	<u>African American</u>	<u>Hispanic</u>	<u>Other</u>	<u>Missing</u>
58	29	0	26	59	1	1	0

Source: Maryland 2005 HIV/AIDS Annual Report

Infant Mortality:

On a state and national level, infant mortality disproportionally affects the African American population. The same is true for Charles County. According to the 2006 Maryland Vital Statistics Report, infant mortality rates per 1000 live births are almost double for Charles County African Americans than for Charles County Whites.¹²



Source: 2006 Maryland Vital Statistics Report, DHMH

One of the hypothesized reasons for the increase in infant mortality among minorities is a lack of prenatal care. According to the 2006 Maryland Vital Statistics Report, Charles County minorities were more likely to report receiving late or no prenatal care than non-Hispanic Whites. The greatest percentage of late or no prenatal care was seen in the Asian/ Pacific Islander population.¹²

2006 BRFSS: Late of No Prenatal Care	Percent
<i>White, Non-Hispanic</i>	3.4
<i>African American</i>	6.6
<i>Asian/ Pacific Islander</i>	9.4
<i>Hispanic</i>	6.7

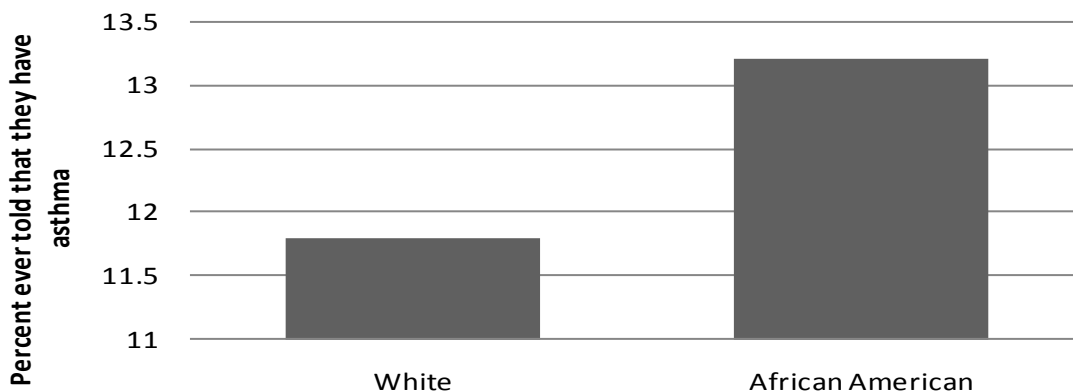
Source: 2006 Maryland Vital Statistics Report, DHMH

Asthma:

The prevalence of asthma in Maryland, from the Maryland BRFSS, is 1.2 times higher for African Americans than for Whites. Based on that, it might be expected that African American adults would experience 1.2 times as many asthma emergency department visits, asthma hospitalizations, and asthma deaths. However, African Americans experience 3.7 times as many asthma emergency visits, 2.6 times as many asthma hospitalizations, and 2.8 times as many asthma deaths. The disparity in these asthma consequences indicates that African Americans experience less treatment success in managing their asthma. Treatment success for asthma depends on access to care, quality of provider treatment planning, and the ability of patients to carry out their treatment plan at home (understanding of plan, affordability of medications and devices). It also depends on the ability to remove asthma triggers from the patient's environment. Individual differences in asthma severity and in patient responsiveness to or side effects from medications also influence treatment success. Elimination of the disparities in asthma outcomes will only occur when the disparities in asthma treatment success are eliminated.¹

Estimates on a county level from the Maryland BRFSS data find that African Americans report slightly higher rates of diagnosed asthma than the White population.

Charles County Asthma Prevalence, 2001-2004, MD BRFSS

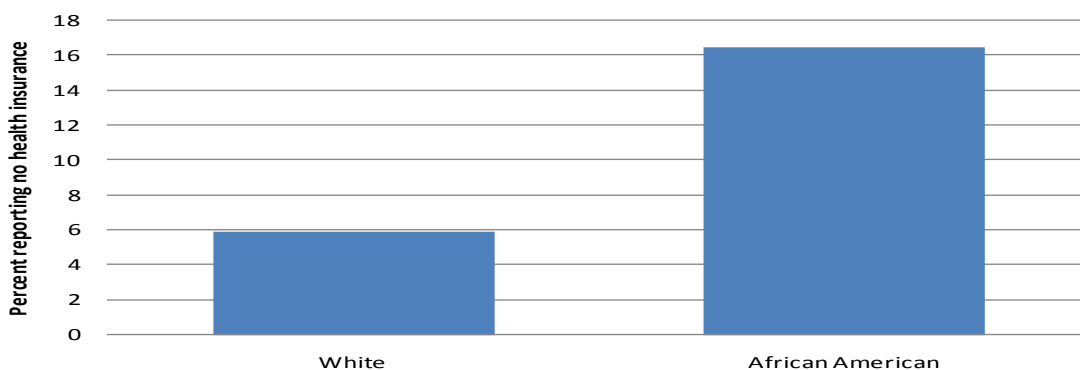


Source: 2001-2004 Maryland Behavioral Risk Factor Surveillance System

Health Insurance:

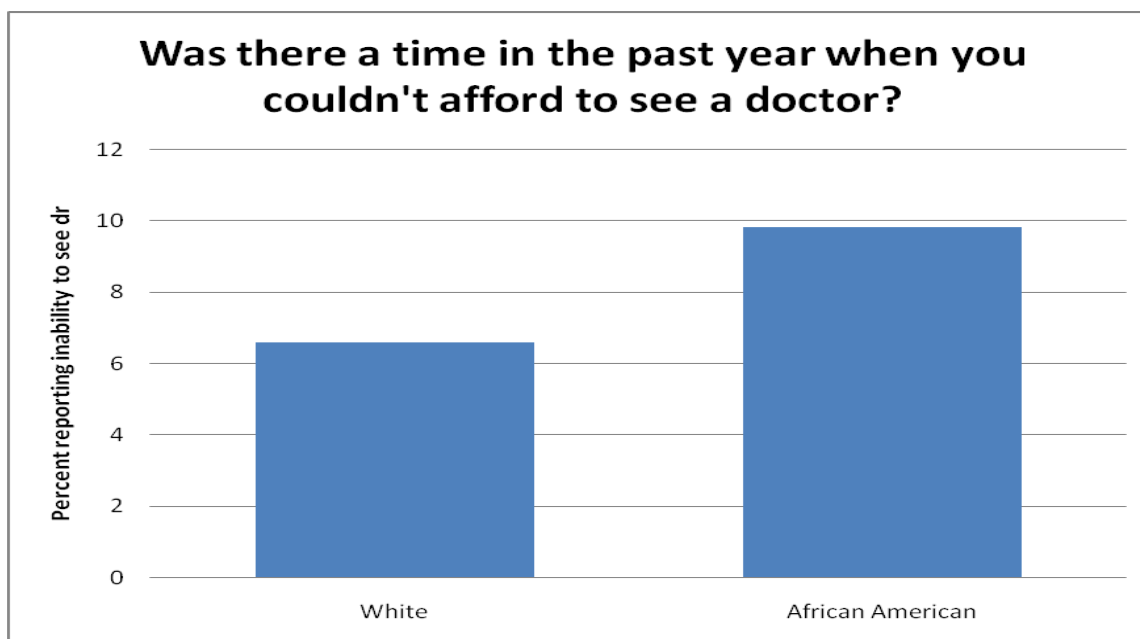
Disparities are often seen among racial groups in terms of health insurance rates. Using the 2005-2006 Maryland BRFSS data, a greater percentage of Charles County African Americans reported a lack of health insurance compared to the county's White population. The difference is more than double.⁵

Percent Reporting Lack of Health Insurance, Charles County, MD, BRFSS, 2005-2006



Source: 2005-2006 Maryland Behavioral Risk Factor Surveillance System

Using the Maryland BRFSS data from 2005-2006 for the question “Was there a time in the past year when you could not afford to see a doctor?” another disparity is observed. Slightly more African Americans reported an inability to see a doctor due to money than Whites in the county.⁵



Source: Maryland Behavioral Risk Factor Surveillance System, 2005-2006

Information on health status was asked in the 2006 Maryland BRFSS. When stratified by race, African Americans are more likely to report having “Excellent” health; however, they are also more likely to report having “Fair” or “Poor” health.⁵

“How is your health in general?”, Charles County, MD, BRFSS, 2006

<u>Health Status</u>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
<i>White</i>	20.2%	41.3%	26.1%	8.3%	4.1%
<i>African American</i>	22.5%	37.1%	24.2%	9.7%	6.5%

2008 Survey Results

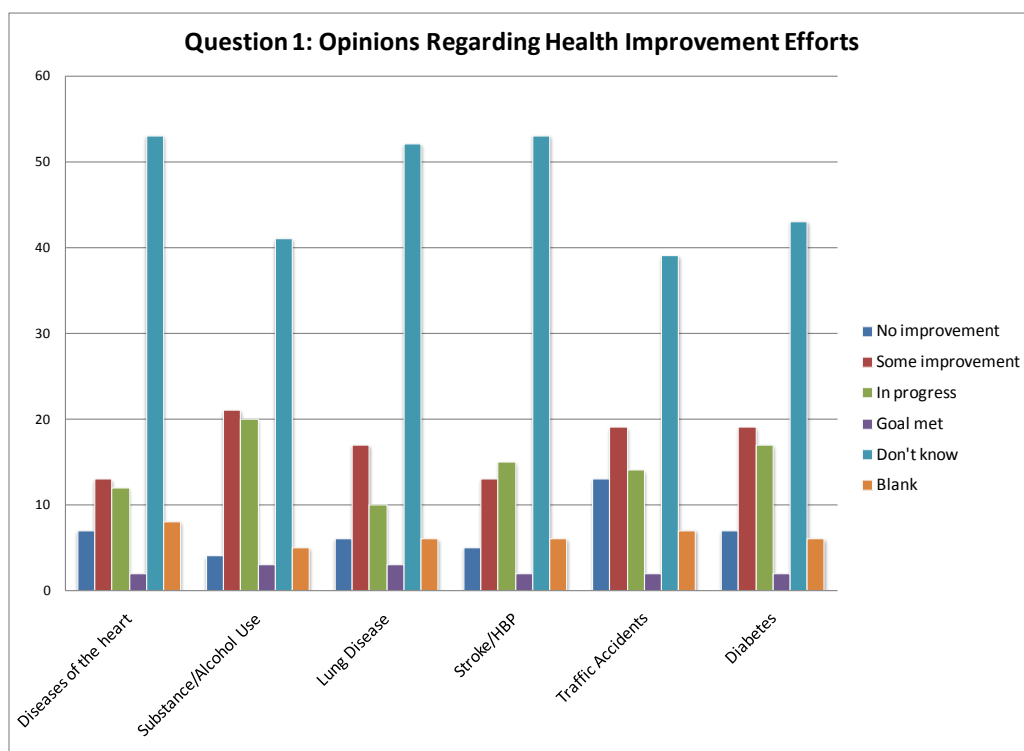
Cumulative Survey Results

As part of the latest community need profile for Charles County, a questionnaire was developed to ask health department professionals, community stakeholders, and health services clients their opinions on the status of health and health services within Charles County.

In order to identify the health achievements, obstacles, and significant problems within the county, 94 surveys were completed. These individuals represent the community's opinion on the status of health and improvements that need to be made. The results of those questionnaires are presented below.

Results

As seen from the chart below, the most common response to each question was “Don’t Know.” Traffic Accidents received the largest number of “no improvement” ratings. Substance and Alcohol Use received the largest number of “Some improvement” and “In Progress” responses. Each area received a small portion of “Goal Met” ratings. On the other hand, Heart Disease and Stroke/High Blood Pressure had the largest number of “Don’t know” responses.



Question 1: Has there been improvement in preventive health education efforts in the following areas in Charles County?

Heart disease is the second leading cause of death in Charles County. The most common response was that they did not know if any improvement had been made in preventive health education efforts for heart disease. This answer was given by 56% of the cumulative group. Among those who did comment on the status of heart disease efforts, most felt that “some

improvement” had been made or that improvements were “in progress.” This was true cumulatively as well as for each group individually.

<i>Diseases of the Heart</i>	Number	Percentage
No Improvement	7	7%
Some Improvement	13	14%
In Progress	12	13%
Goal Met	2	2%
Don't Know	53	56%
Blank	8	8%

Preventive health education efforts for substance and alcohol use have been long standing priorities at the health department. Just under half of the clients were not able to give a rating to this question and answered “don’t know.” Among those who expressed an opinion of the status of substance and alcohol use improvement efforts, most of the clients felt that “some improvement” had been made or that substance and alcohol use prevention efforts are “in progress”. This was true cumulatively as well as for each group individually.

<i>Substance and Alcohol Use</i>	Number	Percentage
No Improvement	4	4%
Some Improvement	21	22%
In Progress	20	21%
Goal Met	3	3%
Don't Know	41	44%
Blank	5	6%

Lung disease caused by smoking is the third leading cause of death in Charles County. Slightly over half of the respondents (55%) reported that they did not know if any efforts had been made to improve chronic lower respiratory disease within the county. Among those who did rate the improvement status of lung disease, many perceived that “some improvement” has been made. The results cumulatively, for clients, and for health department employees found that “some improvement” had been made. Results for the community stakeholders fared more favorably as they felt that improvements were currently “in progress.”

<i>Lung Disease Caused by Smoking</i>	Number	Percentage
No Improvement	6	6.5%
Some Improvement	17	18%
In Progress	10	11%
Goal Met	3	3%
Don't Know	52	55%
Blank	6	6.5%

Cerebrovascular disease, commonly known as stroke and high blood pressure, is the fifth leading cause of death in Charles County. Even among groups surveyed, little is known of the health education efforts within the county for stroke and high blood pressure. More than half of the

group answered that they “Don’t know” about if there has been improvements in this field. Among those who rated the health education efforts, the most common response was that improvements are “in progress.” This was true cumulatively, for clients, and for stakeholders. The most common answer for health department employees was that “some improvement” has been made.

<i>Stroke/High Blood Pressure</i>	Number	Percentage
No Improvement	5	5%
Some Improvement	13	14%
In Progress	15	16%
Goal Met	2	2%
Don’t Know	53	57%
Blank	6	6%

Injuries, death, and hospitalizations due to traffic accidents continue to increase in Charles County. Among those rating this area, the responses were evenly distributed between “no improvements”, “some improvement”, and “in progress.” This is true cumulatively and for clients. The most common response among stakeholders as well as health department employees is that “some improvements” have been made.

<i>Traffic Accidents</i>	Number	Percentage
No Improvement	13	14%
Some Improvement	19	20%
In Progress	14	15%
Goal Met	2	2%
Don’t Know	39	42%
Blank	7	7%

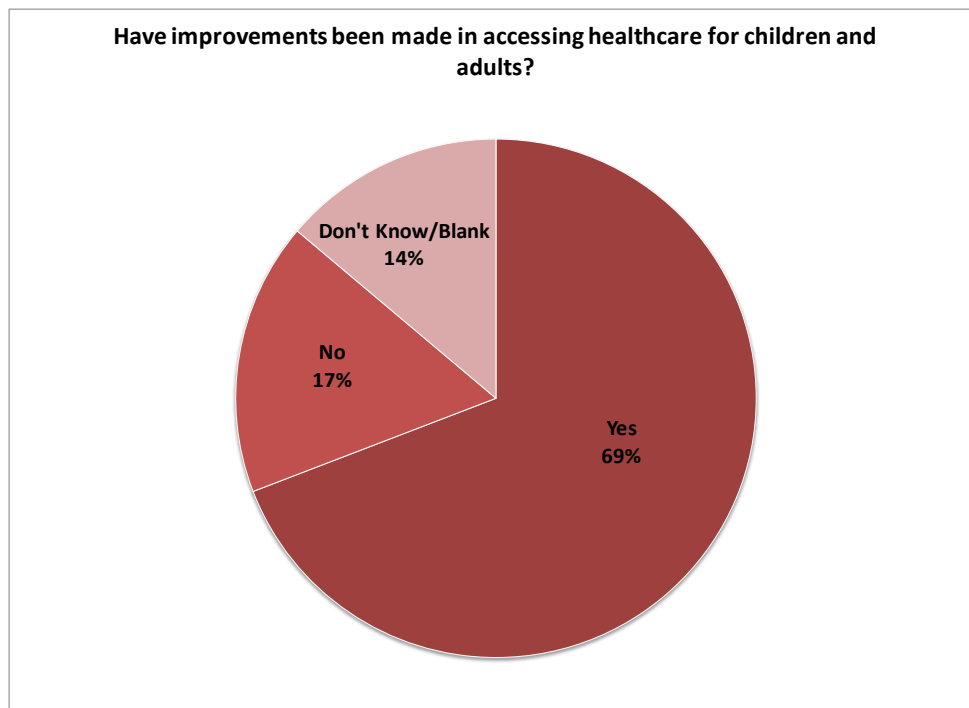
Diabetes mellitus is one of the top ten leading causes of death in Charles County as well as a significant contributor to morbidity. Slightly over half of the respondents were knowledgeable about diabetes health education efforts and rated the improvement seen within the county. Among those who rated the improvements, respondents felt that “some improvement” had been made or that improvements were currently “in progress.” This is true cumulatively and for all groups individually.

<i>Diabetes</i>	Number	Percentage
No Improvement	7	7%
Some Improvement	19	20%
In Progress	17	18%
Goal Met	2	2%
Don’t Know	43	46%
Blank	6	7%

Question 2: Has there been improvement in accessing healthcare for children and adults?

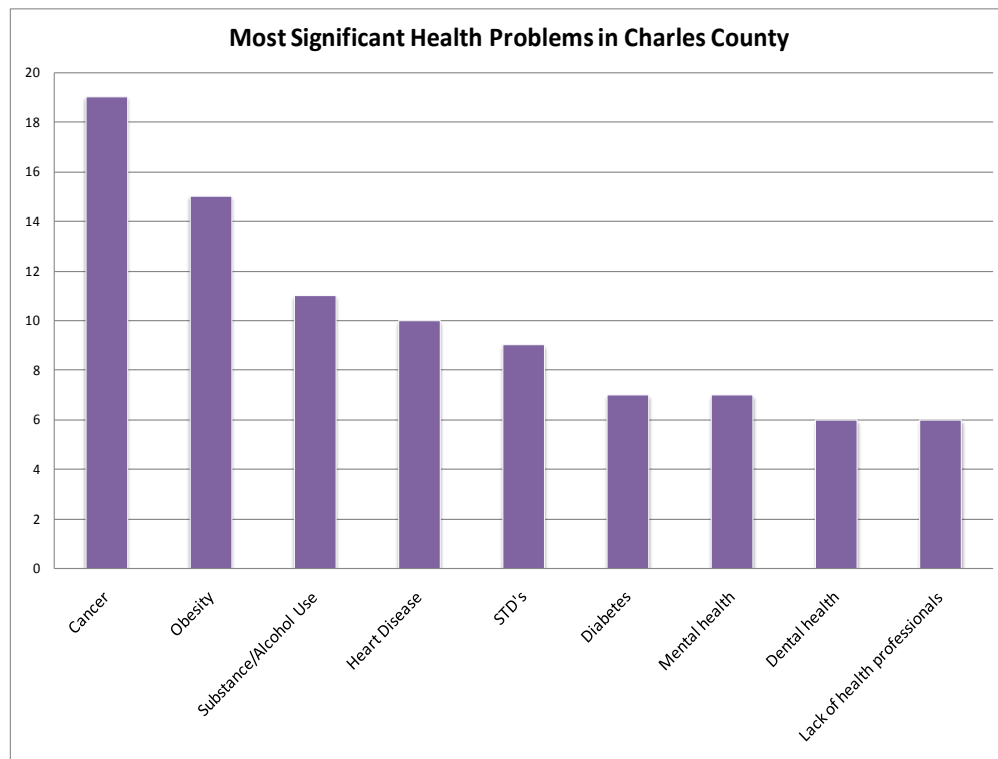
Two thirds of the respondents felt that improvements have been made to increase access to healthcare for adults and children (69%). The same trends in response were seen for all groups individually and for the group cumulatively. The most commonly listed improvement was

medical assistance programs. Another commonly listed improvement was more accessibility to health care and dental services.



Question 4/9: What do you think are significant health problems in Charles County today?

The commonly listed health problem listed by the cumulative group was cancer (20%). It was closely followed by obesity and substance abuse. Cancer was the most common answer for the group cumulatively, for the stakeholders, and for health department employees. Sexually transmitted diseases were the most common answer for clients, followed by Cancer.



Conclusions:

The minority population is increasing rapidly in Charles County. But with increases in the minority populations, increases in minority health disparities have not been observed. For many chronic and communicable diseases, rates appear to be similar for both the White and African American population. The biggest health disparities have been seen for heart disease, breast and cervical cancer, and diabetes. For some conditions, reverse disparities have occurred, such as lung cancer and all cause cancer mortality and stroke mortality.

It should be noted that comparisons on a county level could only be done with the White and African American populations. Because they are the two largest racial groups within the county, data with large sample sizes are available for comparative purposes. Data for other races and Hispanic ethnicity often have small sample sizes which yield unreliable results.

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<u>Subject:</u> Financial Assistance Program	<u>Effective Date:</u> May 1, 2007
	<u>Revision Date:</u> November, 3 2009
	Approved by _____

RESPONSIBILITY: Customer Service Representative

Procedure:

Eligibility – patient eligibility will be based on 200% of the federal poverty guidelines and all of the following information listed below.

All emergent and urgent inpatient and outpatient accounts are eligible for financial assistance. An application must be filled out by the patient or guarantor.

- This application includes: (see attachment A – Financial Aid Application)
- Income from all sources, listing gross income from the last two pay stubs, If only 1 paycheck stub due to new employment then they must supply there wage history statement.
- Liquid assets from saving accounts, checking accounts, CD's, stocks, bonds, money markets, real estate, etc. (1 person \$7500, 2 persons \$15,000)
- Assets including home, cars, boats and other vehicles
- Monthly expenses and number of dependents
- Copy of most recent federal income tax forms (See attachment B – Financial Aid Checklist)

All third party resources and programs including public assistance, Medicaid, must be exhausted before financial assistance can be granted.

Deductible and co-insurance amounts are eligible for financial aid benefits if financial circumstances warrant.

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	Approved by _____

Program Administration – the financial aid program will be administered according to the following guidelines.

- The application along with the required documents will be reviewed and verified by patient accounts personnel
- After reviewing income and required documents, patient accounts personnel will forward documentation to the Supervisor of Patient Accounts to determine if the patient/guarantor will qualify for financial aid based on the income and assets guidelines worksheets (See Attachment C)
- If the patient/guarantor qualifies for 100% charity he/she will be notified and the account written off per procedure
- If the patient/guarantor qualifies for a reduction in liability he/she will be notified and a payment arrangement made for the non write off amount.

Falsification of application or refusal to cooperate will result in the denial of financial aid benefits.

Civista Medical Center reserves the right to change benefit, determination if financial circumstances have changed.

Patient/guarantor must re-apply every 6 months

MISSION

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

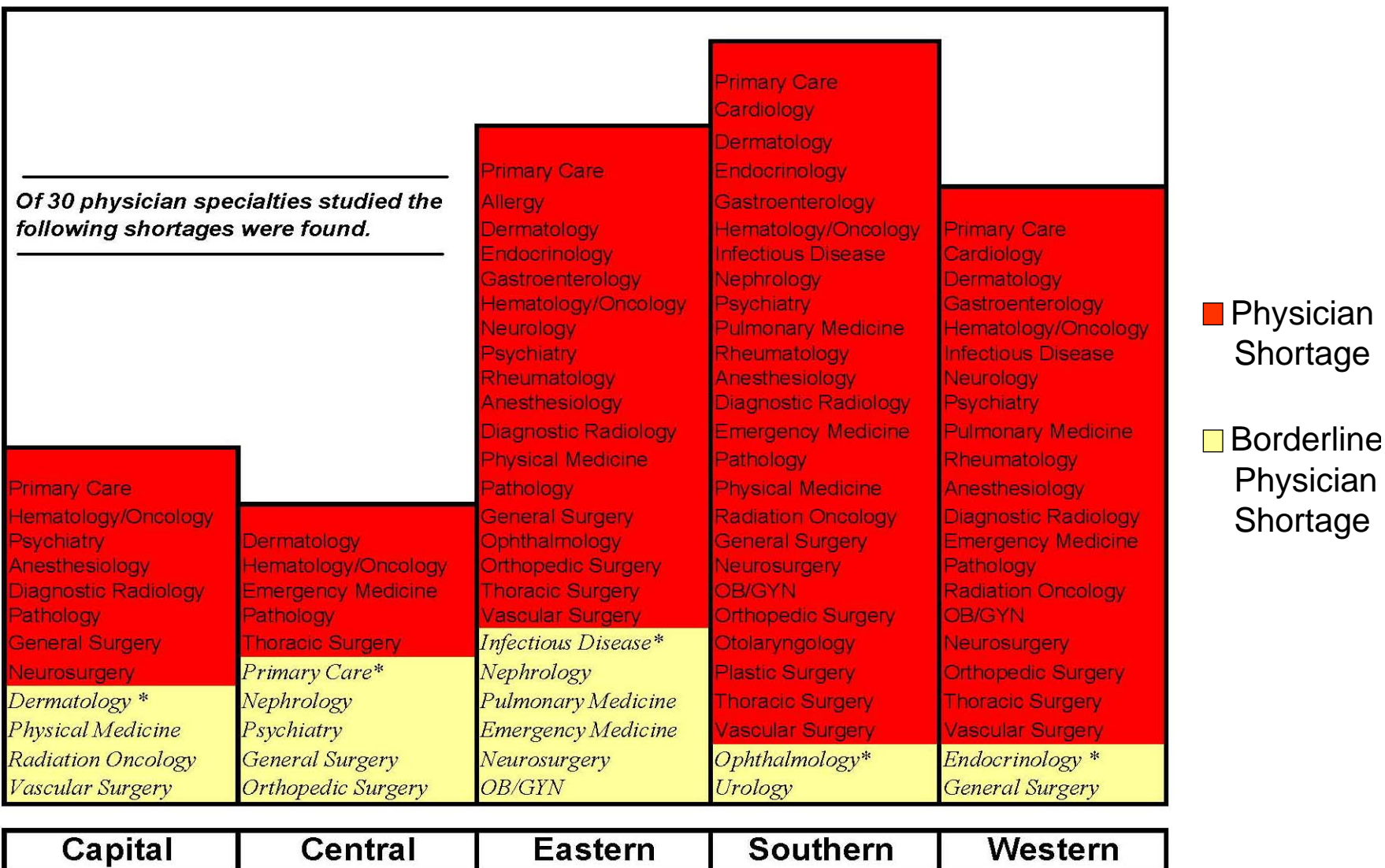
VISION

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

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



Maryland Physician Shortages by Region 2007



**Specialties listed in italics represent specialties where there are borderline supplies of physicians.*

12/15/2009

Civista Health, Inc

Selected Categories - Detail

For period from 7/1/2008 through 6/30/2009

<u>Category / Title / Department</u>	Monetary Inputs			Outputs
	Expenses	Offsets	Benefit	Persons
Community Building Activities (F)				
Workforce Development (F8)				
Charles County Commissioners				
Administration/Corporate Services (9600)	81	0	81	1
CSM Advisory Board				
Information Technology (9360)	2,030	0	2,030	1
Healthcare Roundtable				
Marketing & Planning (9660)	60	0	60	1
Maryland Hospital Association - Nurse Retention				
Administration/Corporate Services (9600)	492	0	492	Unknown
Physician Recruitment Search costs				
Medical Staff Development (9680)	362,235	0	362,235	Unknown
Physician Shortage Task Force				
Administration/Corporate Services (9600)	1,558	0	1,558	Unknown
University of Maryland Outreach Program				
Administration/Corporate Services (9600)	85	0	85	Unknown
*** Workforce Development	366,541	0	366,541	3
**** Community Building Activities	366,541	0	366,541	3
Number of Activities 7 Grand Totals	366,541	0	366,541	3

Narrative Reporting

#1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

195 licensed beds and 11,900 for inpatient admissions for FY2009.

#2 Describe the community your organization serves. The narrative should address the following topics:

Population in Prince George's County: 825,000

INCOME: The median income of households in Prince George's County was \$71,242. Eighty-eight percent of the households received earnings and 20 percent received retirement income other than Social Security. Eighteen percent of the households received Social Security. The average income from Social Security was \$13,158. These income sources are not mutually exclusive; that is, some households received income from more than one source.

POVERTY AND PARTICIPATION IN GOVERNMENT PROGRAMS: In 2006-2008, 8 percent of people were in poverty. Nine percent of related children under 18 were below the poverty level, compared with 7 percent of people 65 years old and over. Five percent of all families and 11 percent of families with a female householder and no husband present had incomes below the poverty level.

Census.gov

Life expectancy

Mortality rates

Percentage of hospital's patients who are uninsured or Medicaid recipients

Gross Patient Revenue:	FY 2009	FY 2008
Medicaid	5%	4%
Self-Pay Patients	5%	6%

Source: Audited Financial Statements

#3 Identification of Community Needs:

Describe the process your hospital used for identifying the health needs in your community, including when it was most recently done.

- a. DCH uses a variety of different sources in which to identify and respond to the health needs of our community. Census data, county and state demographic data, hospital demand and capacity analysis, competitive intelligence along with physician trending and service line analytic software all facilitate planning and development as well as divestiture of underutilized programs.
- b. No, did not use local health department
- c.

#4 List the major needs identified through the process explained in question

The most pressing need identified through our analysis was the need for expansion of our hospital's capacity and throughput, particularly in the ER. The ER represents the entry point for over 90% of our patients and is a critical link to our community. Due to capacity constraints and the inevitable inefficiencies that follow we embarked on an aggressive construction and technology acquisition program to improve "door-to-doctor" time in the ER.

We expanded the space by 17 bays (a 50% increase) and added an imaging unit within the ER to speed scan time. In addition we constructed a 90-bed patient tower with all private rooms and are in the process of converting all semi-private rooms with the intent on being an all private room facility by the summer of 2010. The private rooms will have profound implications on care preventing infection while providing a more relaxing environment to heal, but will also afford us the ability to more quickly admit patients and thus improve throughput and care processes.

Other areas of focus that were identified are the expansion of our Joslin Diabetes outreach due to our high risk population. Wound care services as they relate to a high incidence of diabetes in the community and breast imaging and women's services, as there remains a massive unmet need in relation to these programs. Finally, primary care recruitment and retention remains essential to ensuring the community has access to high quality preventative care.

#5

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

Due to the scale of the effort the entire hospital participated in the determination of what projects would be undertaken and when. Of particular note would be physicians both employed and independent, service directors, the executive team and the board of directors. Substantial input was also sought for design and care implications from front line care givers including nurses and physicians who would work in the redesigned environments.

#6

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

The programs in our Community Health Services are focused on the areas identified: diabetes, women's health as well as cardiac health.

#7

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

A large portion of our efforts have been in workforce enhancements, through Maryland Hospital Association, the local higher education schools and our own hiring ability, we have seen an increase in qualified healthcare workers.

#8

Provide a written description of gaps in the availability of specialists providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Doctors Community Hospital (DCH) is facing increasing challenges relating to specialist on-call coverage for the Emergency Department, with the potential to compromise patient access to needed care. As procedures increasingly shift out of the hospital facility the need for admitting privileges becomes less important for specialists. It is within these agreements that on-call requirements normally reside and many specialists are questioning the necessity of participation. Additionally concerns regarding quality of life, increased liability exposure and a growing indigent population all serve to

further discourage call participation by specialists. Through a variety of measures DCH has been able to secure on-call coverage for the hospital to date, but until the more systemic issues of malpractice costs and uninsured patients are addressed it is unlikely that this problem will improve. DCH remains committed to providing access to the highest level of care and will continue to seek all alternatives to reduced specialist coverage.

9 Did not use Physician Subsidies

Notification Procedures regarding Charity care:

There are signs posted in the Emergency Department, and all Admissions areas of the hospital. Each patient is given a brochure with the following information at time of admission and a copy is sent with any bills:

There is a Spanish version of the brochure available as well.

Financial Assistance

Financial Assistance is available for patients who receive urgent or emergency services and do not have health insurance including Medicaid. Free care is provided for patients whose gross family income is at or below 150 percent of the Federal Poverty Guidelines. A 25-percent discount will be applied to qualified patients whose gross family income is 151 percent to 200 percent of the Federal Poverty Guidelines.

Financial Assistance applications may be obtained at the Emergency Registration or Outpatient Registration Departments or by calling the Business Office at 301-552-8186.

Upon request, an application will be mailed to the patient. To qualify, the applicant must also provide proof of family income and expenses.

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients with Maryland Medical Assistance applications who have received Inpatient or Emergency Outpatient care. Patients who have received Inpatient care and do not have insurance may contact one of the phone numbers listed below:

Annually we have an announcement posted in the local newspapers as well.

Appendix 2

DOCTORS COMMUNITY HOSPITAL
HOSPITAL POLICY/PROCEDURE

SUBJECT: CREDIT AND CHARITY

POLICY NUMBER: 1.5

DATE: November 2008

Administration

Prepared by/Department

SUPERSEDES POLICY

DATED: September 2000

Philip B. Down, President

Approved by/Title

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

Medical Executive Committee

POLICY

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

PROCEDURE

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

Appendix 3

Description of the Hospital Mission Vision & Values

The main purpose of our hospital is to provide quality healthcare to our surrounding community, we have dedicated ourselves to doing just that. We have pledged to always do that to the best of our ability by providing a quality healthcare team, with quality tools, equipment and education.

Our Values are vested in the word SERVICE.

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

Appendix 4

HOSPITAL MISSION, VISION AND VALUES

The Mission of Doctors Community Hospital is

"Dedicated to Caring for Your Health."

Our Vision is to

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

Our Values are vested in the word SERVICE.

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

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

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

Beds: 37

Submission Date: December 15, 2009

Executive Summary

During reporting year 2008-2009, Fort Washington Medical Center (FWMC) provided benefits to the community that included charity care, teaching-preceptor opportunities, health screenings, community health education, community sponsorship opportunities, disaster preparedness and hospital strategic planning activities.

These contributions amounted to \$991,509 in community benefits for FY 2009. The benefits were in four areas: (a) increased participation in nursing and allied health preceptor ship programs; (b) charity care reporting (c) increased health screenings in part with community organizations and (d) increased community awareness.

Licensed Bed Designation

Fort Washington Medical Center (FWMC) is licensed for 42 beds. The hospital utilizes 33 acute-care beds; with four beds designated for intensive care use. During this reporting year, Fort Washington Medical Center saw close to 43,000 patients in its Emergency Room; admitted 3,076 as inpatients, and because of a lack of beds, transferred out approximately 2,700 patients to other hospitals during this period. Many of the transfers were by ambulance that was subsidized by the Hospital.

Fort Washington, Oxon Hill and Temple Hills Demographic Information

Fort Washington Medical Center serves primarily the areas of Fort Washington, Maryland, where it is directly located; and the cities of Oxon Hill and Temple Hills, Maryland. These three areas constitute almost 70% of the entire patient base for the hospital.

All three cities are suburban in nature and are within a short distance of the Washington, D.C./Maryland line and are based in Prince George's County. Many residents cross into the District on a daily basis en route to work at District and Federal government sites, and to private sector locations.

Of the three cities, Fort Washington is furthest south and is 14 square miles. It has a population of almost 24,000 people and has approximately 8,000 households. The racial make-up includes 67% African-American; 18% White; 10% Asian (mostly Filipino) and the remainder other races, including Native-American Indian, Pacific Islander, Hispanic and Latino.

According to the 2000 Census, the median age is between 39 years; the median household income is \$81,000; and the median household income for a family is \$88,000. About 2.8% of families and 3.7% of the population are below the poverty line, including 5% of those under 18 and 4.5% of those 65 or over.

Oxon Hill is 9 square miles. It surrounds parts of the Fort Washington, and extends along the 210 North corridors and along Southern Avenue which separates it from Washington, D.C. Its population is 35,000; with 13,700 households and 9,069 families. The racial make-up includes 86.68% African-American; 7.64% White; 2.78% Asian; and the remainder consisting of Native American, Pacific Islander, Hispanic/Latino and other.

The median income per household is \$46,500; and the median income per family is \$52,227. About 6.7% of families and 8.8% of the population are below the poverty line including 12.3% of those under age 18 and 8.2% of that age that are 65 and over.

Temple Hills is 1.4 square miles, and is west of Oxon Hill and southeast of Washington, DC. It has a population of almost 8,000 people; 3,156 households and 1,937 families. African-Americans comprise 85% of the population; 9.32% are White; and the remainder consist of Native American, Asian, Latino/Hispanic, Pacific Islander and other.

The median income per household is \$44,868, and the median income for a family is \$49,318. Almost 10% of families and 10.4% of the population are below the poverty line including 16.4 of those under age 18 and 2.9% of those 65 or over.

Identification of Community Needs

Fort Washington underwent a rigorous planning process that began in 2004 with its first strategic plan. As part of that initiative, focus groups were held, and a survey of 500 residents were undertaken in an effort to understand the needs of the community. In 2006, the Medical Center undertook a feasibility study to determine the community support for the development of a hospital expansion program. During this initiative, Board leaders, physicians and community leaders provided input into the assessment that ultimately resulted in the hospital moving forward to create an expansion program.

FWMC has continued to work on the initial strategic goals it established previously. These goals include the following:

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

A review of the top 10 DRGs at Fort Washington Medical Center revealed that five of those conditions can be significantly impacted by lifestyle. Lifestyle is considered those factors that can positively impact health, including (a) nutrition (b) stress management (c) behavior modification (d) education and (e.) exercise. Listed below are 5 of the top 10 conditions presented at FWMC during this period.

- a. COPD
- b. Malignant Hypertension
- c. Hypertension (Unspecified)
- d. Congestive Heart Failure
- e. Chest Pain*

An internal committee which consists of representatives from the FWMC Emergency Room, the Education/Performance Improvement Department, hospital administration and Corporate Development discuss the best ways of addressing health conditions impacting the community as seen by the Hospital. The Committee provides guidance on outreach efforts that the Hospital undertakes to support the community benefit program.

In addition to the Committee, the Hospital works with strategic partners. These partners include the Prince George's Health Department (PGHD), the American Heart Association, American Lung Association, YMCA-Potomac Overlook, the American Red Cross, and Harmony Hall (Maryland Parks and Planning).

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

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

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

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

It is believed that at least 90% of the emergency room cases are linked to diabetes. According to the Health Department, the program at FWMC has been highly successful. Participants themselves rate the program highly, noting the expertise of the PGHD instructors, the design of the class and the easy access to the class.

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

The Hospital continues to work with its strategic partners, including the American Lung Association (ALA). During this reporting year, Fort Washington co-sponsored a "Breathe Well, Live Well" workshop targeted to adult asthma sufferers.

For the fourth consecutive year, Fort Washington Medical Center has worked with the American Red Cross (ARC), Greater Chesapeake and Potomac Region to raise awareness around the need to donate blood. FWMC's partner in the effort was the YMCA Potomac Overlook, which contributed space and manpower to provide further visibility to the drives, and to increase community access. The YMCA also works with FWMC to coordinate health fairs at its facility.

Preceptorship Program/Medical Training

Fort Washington Medical Center's teaching – preceptor program continues to be a major portion of community benefit. In reporting year 2008-2009, nursing and allied training preceptor opportunities have increased at FWMC. During this reporting period, there were 77 nursing, allied health and EMS students from Prince George's Community College and other teaching institutions in the state.

Under the direction of the FWMC's Performance Improvement Department, which adheres to the standard established by JACHO, students are required to meet certain hospital standards. The Department works with the nursing and allied health schools to insure that the standards are met and that there is appropriate reporting, as required from all participants.

Gaps In Service

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

Community Benefit Evaluation

During this reporting period, a formal evaluation of FWMC's program was not undertaken. Evaluation of parts of the program, i.e. the Diabetes Awareness Program, and preceptor-ship programs are built in and are done on a continual basis. Funding will be budgeted for 2010 to do an update of the FWMC strategic plan, which includes a formal community needs assessment and an evaluation of the program overall.

2009 FWMC Community Benefit Report

Appendix 1

Description of Fort Washington Medical Center's Charity Policy

Fort Washington's policy is to provide care to all individuals regardless of their ability to pay. Specific guidelines exist. Individuals must demonstrate that there is financial hardship. Fort Washington makes every effort to work with patients. Individuals are apprised of the program in a number of ways at the Hospital.

A summary of the charity care policy is posted throughout the facility, including in Admitting Department, the Emergency Room, waiting areas and in administrative areas. A designated financial counselor is available to talk with individuals in Admitting. Information on financial assistance is provided to patients during the intake process. Information pertaining to the policy is also provided to patients with discharge materials.

The availability of other services and government benefits, including Medicaid, is routinely discussed with patients and families. Fort Washington will assist persons that qualify for the programs.

Guidelines are also available in a brochure format that is available in the Hospital and online via Fort Washington's website.

Appendix 2
FWMC Financial Assistance Plan

TITLE: FINANCIAL ASSISTANCE PLAN

Policy No. RI 240
Page 1 of 6

PURPOSE:

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

POLICY:

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

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

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

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

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

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

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

PROCEDURE:

1. Patient's will be informed of the following upon admission through the Financial Assistance Brochure/Information Sheet:
 - a. Description of the Financial Assistance Policy;
 - b. Patient's rights and obligations with regard to hospital billing and collection under the law;
 - c. Contact information at the hospital that is available to assist the patient, the patient's family/significant other, or the patient's authorized representative in order to understand:
 - i. The patient's hospital bill;
 - ii. The patient's rights and obligations with regard to the hospital bill;
 - iii. How to apply for free and reduced cost care in the billing office;
 - iv. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

- d. Contact information for the Maryland Medical Assistance Program;
 - e. Physician charges are not included in the hospital bill and are billed separately.
2. The patient's initial bill will include reference on whom to contact for Financial Assistance Information.
 3. The Financial Assistance Brochure/Information sheet will be made available upon request to patients.
 4. An evaluation for Financial Assistance can be commenced in a number of ways:
 - a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - c. A physician or other clinician refers a patient for financial assistance evaluation for potential admission.
 5. The Insurance Verification Representative/Financial Counselor (located in the Admitting office), Admitting and Patient Accounts personnel will be responsible for taking Financial Assistance applications.
 6. When a patient requests Financial Assistance, the staff member who receives the request will:
 - a. AFTERHOURS/WEEKEND: Give the patient a Financial Assistance Program and Practices brochure and application (attached) and refer the patient to contact the Insurance Verification Representative/Financial Counselor. Patients may drop off applications with anyone in the Admitting area.
 - b. DURING THE WORKWEEK NORMAL BUSINESS HOURS: Refer the patient to the Insurance Verification Representative/Financial Counselor.
 7. The applicant must bring the following to any personnel in Admitting or Patient Accounts.
 - a. A completed Maryland State Uniform Financial Assistance Application (attached).
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return, and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of US citizenship or permanent residence status.
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.

8. The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations (See Attached Poverty Level Guidelines Table).
9. A Letter of Conditional Approval for probable eligibility (see attached) will be sent to the patient within three days of receipt of a completed application.
10. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. If the patient's application for Financial Assistance is determined to be complete and appropriate:
 - a. the Insurance Verification Representative/Financial Counselor will forward all documents and recommended patient's level of eligibility to the Director, Patient Accounts;
 - b. the Director of Patient Accounts has the authority to approve/reject charity amounts less than \$5000; and
 - c. the Chief Financial Officer has the authority to approve/reject charity amounts estimated to exceed \$5000.
11. Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review.
12. The following must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medicare Prescription Drug Program or Qualified Medicare Beneficiary (QMB) coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.
 - c. The patient must be a United States of America citizen or permanent resident (Must have resided in the U.S.A. for a minimum of one year).
 - d. All insurance benefits have been exhausted.
13. A Letter of Final Determination (see attached) will be sent to the patient within 30 days to inform him/her eligibility for:
 - a. Financial Assistance (Full or partial)
 - b. Payment Plan
14. FWMC has the option to designate certain elective procedures for which no Financial Assistance options will be given.

15. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Fort Washington Medical Center. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
16. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the Chief Financial Officer.
17. The Director of Patient Accounts will advise ineligible patients of other alternatives available to them including Medical Assistance or bank loans.

GLOSSARY

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

TRAINING:

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

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

DOCUMENTATION:

Registrars will document that they provided the newly admitted patient with the Financial Assistance Brochure/Information Sheet in the information system by placing a check in the HIPAA box. This check indicates that HIPAA, Patient's Rights Brochure and the Financial Assistance Brochure was given to the patient.

ANNUAL EVALUATION:

FWMC Trends of Annual Percent of Financial Benefit
Update Poverty Table

Review of literature for national, state and local legislative review to maintain current compliance.

APPROVAL PROCESS/COMMITTEE FLOW:

Finance Committee
Patient Safety/Performance Improvement Committee (for information)
President and CEO

REFERENCE (S):

January 2009 Federal Register (2009 Poverty Level Guidelines)
Maryland legislation §19-214.1
Maryland State Uniform Financial Assistance Application located at
[http://198.173.115.122/data_collection_tools/documents/uniformfinancialassistance.doc]

FWMC Patient Rights and Responsibilities brochure
HB 1069 HSCRC Financial Assistance and Debt Collection Policy (Effective 6/1/2009)

ATTACHMENT(S):

Financial Assistance Program and Practices brochure
Letter of Conditional Approval
Letter of Determination
Financial Assistance Notice for lobby
2009 Poverty Level Guidelines (January 2009 Federal Register)
Maryland State Uniform Financial Assistance Application

DATE REVIEWED:	SIGNATURE:	DATE REVIEWED:	SIGNATURE:
APPROVED:		DATE ISSUED:	DATE REVISED:
Verna S. Meacham, President/CEO		11/1998	12/21/07, 6/2009

Financial Assistance Application



Fort Washington FY 09

Information About You

Name _____
First Middle Last

Social Security Number _____ - ____ - ____
US Citizen: Yes No

Marital Status: Single Married Separated
Permanent Resident: Yes No

Home Address _____ Phone _____

City State Zip code Country _____

Employer Name _____ Phone _____

Work Address _____

City State Zip code

Household members:

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

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Financial Assistance Application

FWMC

Fort Washington FY 09

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

I. Family Income

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

Total _____

II. Liquid Assets

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

Total _____

III. Other Assets

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

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

Total _____

IV. Monthly Expenses

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

Total _____

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Please return this form to a Financial Counselor located in the Admitting Office.

If you have any questions, please call: 301-203-2271 or 2154.

2009 POVERTY GUIDELINES

ALL STATES EXCEPT ALASKA AND HAWAII AND D.C.

Income Guidelines as Published in the Federal Register on January 2009

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF WRITE OFF									
	100%	90%	80%	70%	60%	50%	40%	20%	10%	
1	16,244.00	19,494.00	21,604.00	21,930.00	24,367.00	28,428.00	30,052.00	32,490.00	40,612.50	
2	21,855.00	26,226.00	29,067.15	29,504.25	32,827.50	38,246.25	40,431.75	43,710.00	54,637.50	
3	27,465.00	32,958.00	36,528.45	37,077.75	41,197.50	48,063.75	50,810.25	54,930.00	68,662.50	
4	33,075.00	36,690.00	43,989.75	44,651.25	49,612.50	57,881.25	61,188.75	66,150.00	82,687.50	
5	38,685.00	46,422.00	51,451.05	52,224.75	58,027.50	67,698.75	71,567.25	77,370.00	96,712.50	
6	44,295.00	53,154.00	58,912.35	59,798.25	66,442.50	77,516.25	81,945.75	88,590.00	110,737.50	
7	49,905.00	59,886.00	66,373.65	67,371.75	74,857.50	87,333.75	92,324.25	99,540.00	124,762.50	
8	55,515.00	66,618.00	73,834.95	74,945.25	83,272.50	97,151.25	102,702.75	111,030.00	138,787.50	

FOR FAMILY UNIT OF MORE THAN 8 MEMBERS, ADD \$3,740 FOR EACH ADDITIONAL MEMBER.



LETTER OF CONDITIONAL APPROVAL FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

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

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

In order to make a final determination, please provide us with the following information:

- ☐ A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return, and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
- ☐ A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
- ☐ A Medical Assistance Notice of Determination (if applicable).
- ☐ Proof of US citizenship or permanent residence status.
- ☐ Proof of disability income (if applicable).
- ☐ Reasonable proof of other declared expenses.
- ☐ No other information is necessary at this time.
- ☐

You will be notified within thirty days of our final determination. We thank you for your patience. If you have any questions or if we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts



Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Fort Washington FY 09

FINAL LETTER OF DETERMINATION FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

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

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

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

Sincerely,

Betty Edwards
Director, Patient Accounts

Appendix 3

Description of FWMC's Mission, Vision Statement

Fort Washington Medical Center updated its mission and vision statements in 2005 as part of the initial strategic plan. As a result of sessions with internal and external stakeholders, the Hospital identified the core elements of its mission, which is to work with all aspects of the community; to identify health issues and wellness strategies to create a healthier community; to strive for and maintain quality; and to provide compassion, care and concern to patients, families and community members.

It is the goal of Fort Washington to be the community hospital that patients and community members turn to first for the provision of health services and health education.

Appendix 4

FWMC Mission and Vision Statements

Mission Statement

The mission of the Fort Washington Medical Center is to advance the health and wellness of individuals in the communities we serve by delivering the highest quality, most compassionate and responsive health care services.

Vision Statement

The vision of Fort Washington Medical Center is to be the health care system of choice in our community.

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1. **Licensed Bed designation:** 380
Inpatient admissions: 30,446

2. **Community description (IRS Schedule H, Part V, question 4)**

- a. **Geographic:** Located in the Rosedale section of Eastern Baltimore County, Maryland, Franklin Square Hospital Center's primary service area includes sixteen zip codes from eastern Baltimore City thru eastern Baltimore County and extending up to southern Harford County, adjacent to the Chesapeake Bay.
- b. **Significant Demographic characteristics relevant to the needs the hospital seeks to meet:**

This area has a large base population of approximately 533,000, and is projected to grow by 3.4% in the next five years, to about 551,000. The service area has become a much more diverse community over the past few decades. The area, particularly eastern Baltimore City and eastern Baltimore County, can be described as blue-collar, high-school educated, and economically depressed, with a diverse population consisting of Caucasians (71.9%), African-Americans (20.5%), Asian/Pacific Islanders (2.5%), Hispanics/Latinos (2.9%), and Others (2.2%). Thirty-seven percent of the population is either very young or senior with 24% children under eighteen years old and 13% over 65 years old.

Poverty is a significant problem in Eastern Baltimore County. Statistics show that 48% of the residents have a high school or lower level of education. Statistics show that the median household income in the Essex Middle River area of \$50,244 is much lower than the county average of \$63,038. The number of individuals who are uninsured or under insured in the hospital's catchment area is estimated to be 38% and growing. This is a direct result of the decline in manufacturing industries in the region, which are being reduced or declaring bankruptcy, e.g. General Motors Oldsmobile assembly plant and Bethlehem Steel Corporation, both of whom were previously major employers in the area. Currently, the largest employer in the area is the Hospital. The increasing number of families and individuals with either no health insurance or severely curbed health insurance represents a serious concern for the healthcare community and government agencies.

3. **Identification of health needs (IRS Schedule H, Part V, question 2)**

a. **Process:**

Franklin Square led, and financially supported, the Southeast Area Network of providers in conducting a community needs assessment of the health and well-being in the southeastern portion of Baltimore County. The purpose of this project was threefold: (1) assess current health and well-being in the southeast area; (2) identify discrepancies in service needs and outcomes among area residents; and (3) devise a strategic plan for correcting these discrepancies. In April 2008, Franklin Square published the resulting action plan for developing coordinated and collaborative efforts and investing in economic and social resources in ways that improve the health and well-being for all of southeast Baltimore County's residents now and in the future. Assessment of resources which are currently available to meet the action plan were identified in FY09 by a

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collaboration of professional networks, county agencies and community organizations. Prioritizing and planning action items are FY10 goals for the Network.

b. Health department consultation:

The Baltimore County Health Department was integrally involved in the initial assessment (participation on Steering, Child and Adult Committees), and continues to be a major participant in the evolving action plan.

4. Major needs identified (see #3)

- a. Cardiac Disease
- b. Domestic Violence
- c. Cancer
- d. Access to care

5. Parties involved in determining which needs would be addressed:

- a. Hospital Board Community Awareness Committee
- b. Community Service Line Director
- c. Community Outreach Manager
- d. Community RN Education Specialists

6. Major Community Benefits initiatives which address needs addressed in #4

- a. Cardiac Disease:

Community Blood Pressure Screening

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

For over 16 years, Franklin Square has partnered with various community sites to offer free blood pressure (BP) screenings. The goals of the screenings are to increase the participants' awareness of their individual BP level, the effects of uncontrolled hypertension, and available resources. White Marsh Mall, Eastpoint Mall, Target (Bel Air), and Rosedale American Turner Hall provide space with tables and chairs for Registered Nurses to take participants' BP and advise them of appropriate follow-up activity. Participants are also screened at various health fairs and wellness activities.

- b. Domestic Violence:

Child Abuse Prevention Services

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

After reviewing cases of children who were injured and treated in the Emergency Department (ED), it appeared that many were not receiving complete evaluations and

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cases of child abuse were possibly being missed. Additionally, in a two-year period from 1998-2000, five children who were born at Franklin Square returned severely injured from Abusive Head Trauma (AHT).

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

In 2002, a three-pronged prevention program began. The primary focus for the prevention of AHT includes educating all newborn parents about the dangers of shaking infants and giving them strategies to cope with a crying infant. Each parent of a newborn receives a brochure and signs a statement acknowledging the dangers of shaking infants. They are encouraged to watch a video on coping with a crying infant. The other two programs include parent education classes and daycare provider education classes that focus on discipline techniques without the use of violence. These programs are done in collaboration with local non-profit organizations (The Family Tree and Child Care Links). In January 2009, a new initiative to address Infant Safe Sleeping was begun. This program was patterned after the Shaken Baby Syndrome program using education and social contracts at time of discharge.

c. Cancer:

Tobacco Use Prevention

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

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

d. Access to care:

Healthcare for the Homeless – Baltimore County

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

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

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homelessness are at an increased risk for cardiovascular problems, leg ulcers, upper respiratory infections and exposure-related illnesses.

7. Efforts taken to evaluate or assess the effectiveness of major CB initiatives

Name of initiative: Community Blood Pressure Screening

Year of evaluation: 2008

Outcome measures: In FY 2009, over 2,000 people were screened at more than 70 events. At each event, an average of half of the participants are identified as hypertensive; a few are advised to take urgent action. For those who do take action, stroke, heart attack and renal failure may be prevented. In addition to avoiding the toll of human suffering, thousands of dollars in emergency and rehabilitative care may be saved. In addition, blood pressure, hypertension and stroke education was offered to over 12,000 people

Result of evaluation – Plan to continue screenings with referrals and educational services.

Name of initiative: Child Abuse Prevention Services

Year of evaluation: 2008

Outcome measures: The child abuse programs have served thousands of children and parents since its inception in 2000. The CPT has evaluated 2600 children; 35% of the cases were physical abuse evaluations, 32% of the cases sexual abuse, and 30% neglect. Of the cases reported to the Department of Social Services (DSS), 84% of them are accepted for investigation. As a comparison, DSS screens out 40% of countywide referrals. As a measure of the improved evaluative process in the ED, appropriate evaluations of infants with fractures are being done more than twice as often as it was prior to the formation of the CPT.

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

We evaluate the AHT prevention program by monitoring the community for children who have become victims in collaboration with the local children’s hospitals and DSS and the overall community rate appears to have fallen to 1 case/year (was 3-5/year prior). A more rigorous case-control study funded by the Centers for Disease Control evaluating the program is ongoing. Additionally, we have monitored the return rate of signed commitment statements. The rate has increased annually from 70% to 95%, showing a statistically significant difference. Our results were recently presented at the North American Conference on Shaken Baby Syndrome in 2008. Return rates remain consistently in the ninety percentile. Sleep Safety affidavit return rates reached 80% within four months of program start, compared to the four years required for the Shaken Baby Program.

Result of evaluation – Plans to continue CPT efforts and increase commitment statement signatures. The Infant Sleep Safety initiative was modeled after the Shaken Baby Syndrome program due to its success rate. Although statistics are not yet available, it has

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been anecdotally noted that deaths related to Shaken Baby Syndrome and co-sleeping presenting in the Emergency Room have decreased significantly in 2009.

Name of initiative: Tobacco Use Prevention

Year of evaluation: 2008

Outcome measures: : Tobacco education programs, sponsored by Franklin Square, directly influenced over 2,700 participants in various stages of use in area businesses, shelters, support centers, churches, senior centers, schools and community organizations. Primary prevention efforts (health fairs, presentations to prevent tobacco usage) include Tobacco Truth Tours that brings small groups of youth into the hospital to view the direct effects of tobacco use (lab, x-ray, and patients). One hundred percent of these “Tourists” said they learned new information about tobacco effects. Secondary prevention included interventions at health fairs, events attended by smokers and cessation programs tailored to be population-sensitive.

Franklin Square utilizes visuals and handouts from American Cancer Society (ACS) and American Lung Association of Maryland (ALAM) with our Wellness Wheel that addresses tobacco questions to increase knowledge deficits in youth and adults.

Presentations are targeted to the specific age, culture and needs of the participants with audiovisuals from ACS, ALAM and some independent companies.

The adult cessation program, Stop Smoking Today, is a five session series that combines deep relaxation with guided imagery and traditional behavioral modification. These classes reached adult participants of diverse backgrounds and medical issues including pregnancy at local sites (two homeless shelters - Nehemiah House and Eastside Family Shelter, and Chesapeake High School) with a last class quit rate of 42% for 2008-9 year. Because of the high quality and comprehensive program approach, the American Lung Association of Maryland, the American Cancer Society and the Baltimore County Department of Health recognize Franklin Square as an expert and leader for tobacco issues in the area.

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

Result of evaluation – Plans to continue tobacco education, prevention and cessation programs.

Name of initiative: Healthcare for the Homeless – Baltimore County

Year of evaluation: initial - 2006, last annual point in time survey – 2009

Outcome measures: Over 700 people have benefited from over 3,500 primary care visits at Healthcare for the Homeless – Baltimore County (HCHBC) since its opening in November 2007. Fifty-five percent of those served are temporarily housed in the East Side Family Shelter located in the same building as the clinic. Approximately 18% of HCHBC clients are children. Although 25% of HCHBC clients have adequate case management services from other sources and 25% have no need for these services, the remaining 50% of HCHBC clients are in need of frequently complex case management assistance. This partnership establishes a medical home for vulnerable county residents

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and provides the preventive health care services people need before their health issues escalate into an emergency.

Result of evaluation – Due to need for resources (space, specialty care, medications) beyond those supplied by the HRSA grant, additional funding is being sought. Through our partnership with Baltimore County, a case manager is available to assist with the multifaceted needs for these services.

8. Description in the gaps of availability of specialist providers including outpatient specialty care to serve the uninsured cared for by the hospital.

In response to the recognized need for services to the county's homeless population, Franklin Square collaborated with HCH and BCHD under a HRSA grant to offer a new point of access for primary care. Needs for specialty care are addressed on an individual basis. Many of these needs, as well as similar needs of the larger under/uninsured population are addressed by our charity care policy.

Both Pediatric and OB/GYN outpatient practices are operated at a loss due to the community need for these services.

We posed this issue to our physician leadership and case management staff. They consistently identified several areas of concern:

- Timely placement of patients in need of inpatient psychiatry services
- Limited availability of outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse treatment
- Medication assistance

9. Physician subsidy detail

Included the Hospital's 2009 Community Benefit Report are subsidies for losses from physician services stemming from serving patients that are uninsured or underinsured, including the Medicaid population that are truly community benefits.

The amount in Primary Care Physician, Hospitalist, and Breast Surgery subsidies provides community services and ensures adequate primary care coverage for our community. The amount in Emergency/Trauma ensures that the Hospital maintains adequate surgical call coverage for the emergency department. The Anesthesia subsidy ensures adequate on-call anesthesia coverage. These subsidies make up for the shortfall in payments in relation to the cost of providing 24/7 coverage.

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Appendix 1: how the hospital informs patients about their eligibility Charity Care policy (IRS Schedule H, Part V, question 3)

i. Posting in facilities

Franklin Square's Charity Care Policy, including a description of the applicable communities it serves, is posted in each major patient registration area and in any other areas required by applicable regulations, and will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients.

ii. Provision of copy during intake process

iii. Provision of copy during discharge process

iv. Inclusion with bills

v. Discussion with patients and assistance with application

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

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Appendix 2: Charity Care Policy

See corporate Appendix 2.

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines.

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

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

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

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

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

- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

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

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

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

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

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

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

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

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Appendix 3: Description of Hospital mission, vision and value statements

Franklin Square Hospital Center's mission is to provide the highest quality healthcare and education to our communities. This commitment is acknowledged by the Medicare Quality Improvement Award and by Magnet designation.

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Appendix 4: Hospital mission, vision and value statement

MedStar Health and each entity (hospital and diversified business) share a common vision and set of values. MedStar Health's common vision is to be the trusted leader, caring for people and advancing health. MedStar Health's common set of values are services, patient first, integrity, respect, innovation and teamwork. Each entity has a unique mission, or purpose for which it exists. MedStar Health's mission is to serve our patients, those who care for them and our communities. Franklin Square Hospital Center's mission is to provide the highest quality healthcare and education to our communities. This commitment is acknowledged by the Medicare Quality Improvement Award and by Magnet designation.

Mission

To serve our Patients, those who care for them, and our communities.

Vision

The Trusted Leader in Caring for People and Advancing Health.

Values

- Service: We strive to anticipate and meet the needs of our patients, physicians and co-workers.
- Patient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- Integrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- Respect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- Innovation: We embrace change and work to improve all we do in a fiscally responsible manner.
- Teamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.

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MedStar Health

Vision

*The Trusted Leader
in Caring for People
and Advancing Health.*

Mission

*To Serve Our Patients, Those
Who Care For Them, and
Our Communities.*

Values

Service
We strive to anticipate and meet the needs of our patients, physicians and co-workers.

Patient first
We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.

Integrity
We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.

Respect
We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.

Innovation
We embrace change and work to improve all we do in a fiscally responsible manner.

Teamwork
System effectiveness is built on the collective strength and cultural diversity of everyone, working with open communication and mutual respect.

Frederick Memorial Healthcare System

2009 Community Benefits Report

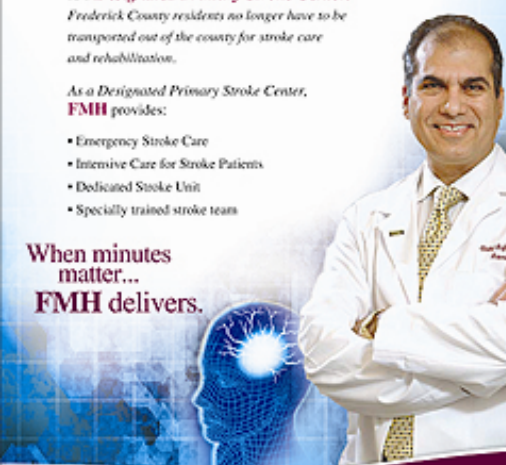
The FMH Stroke Center of Excellence

FMH has been granted a 5-year certification as a **Designated Primary Stroke Center**. Frederick County residents no longer have to be transported out of the county for stroke care and rehabilitation.

As a Designated Primary Stroke Center, FMH provides:

- Emergency Stroke Care
- Intensive Care for Stroke Patients
- Dedicated Stroke Unit
- Specially trained stroke team

When minutes matter... FMH delivers.



Dr. Shahid Rafiq

Future OPERATING ROOM STAFF


Ready to Join Them?

Take a hands-on, fully-interactive tour of Frederick Memorial Hospital's state-of-the-art surgical facilities.


NOVEMBER 1, 2008
9:00 A.M. - 3:00 P.M.

See two operating suites set up and ready for surgery - the way our doctors and nurses see them every day! Watch a video of an actual gallbladder removal surgery in Room One, and then try out the laparoscopic surgical instruments in a simulated abdominal cavity. Next it's on to Room Two, set up with all of the hardware for a spinal surgery. Pick up and examine models of the spine and the actual tools used to perform back surgery.

FMH
Frederick Memorial Healthcare System
To R.S.V.P. call 240-366-3553



Our Perioperative Nurses are certified by




FMH 4th Annual BREAST CANCER SYMPOSIUM

Sponsored by the Frederick Memorial Healthcare System's Regional Cancer Therapy Center

A Focus on Wellness and Risk Reduction

October 28, 2008
Ceresville Mansion
from 5:30 - 8:30 pm.

SCHEDULE OF EVENTS

5:30 - 5:50	Registration
5:50 - 5:55	Introduction Doree Johnson Leonard, MD Medical Director, Coordinated Breast Services
5:55 - 6:15	"The Environment and Human Health: Focus of Prevention" Allison Davis, PhD, RN Environmental Sciences, University of Maryland
6:15 - 6:30	Break
6:30 - 7:15	Keynote Conference on topics related to Wellness/Prevention Gregory Baruch, MD Medical Oncology
7:15	Break
7:15 - 7:30	Break
7:30 - 7:45	Break
7:45 - 8:00	Break
8:00 - 8:15	Break
8:15 - 8:30	Break

Enhancing Patient Care Through Technology

Our Passion is Patient Safety

At Frederick Memorial Hospital patient safety is a top priority. In the FHM's Rush-Pace, we're using a new computerized documentation system that puts our patients' clinical information right at our fingertips, helping us provide safe, timely, focused care.

Katharine Murray, MSN, RN
Director, Women's & Children's Services




The Rush-Pace Electronic Medical Record system helps our doctors and nurses gain immediate access to your clinical information at the bedside, improving patient safety.

FMH

HÁGALO POR USTED POR SU FAMILIA POR SU FUTURO ¡GRATIS!

EXÁMEN PARA LA DETECCIÓN DEL CÁNCER DE LA PRÓSTATA

Servicios ofrecidos gratuitamente a los **hombres** de nuestra comunidad. Los exámenes se llevarán a cabo en el FMH Wellness Center ubicado en el FSK Mall (El centro comercial sobre la Ruta 85).

Sábado, 16 De Septiembre, De 9:00 am - 12:00 pm.

Exámenes físicos y pruebas de sangre que detectan el antígeno específico prostático, o PSA por sus siglas en inglés.

Es necesario hacer cita. Por favor llame al **240-379-6010** para hacer la cita.

FMH
Frederick Memorial Healthcare System

Patrocinado por el Centro Regional para el Cáncer del FMH, el FMH Wellness Center, el Departamento de Salud del Condado de Frederick, y la Sociedad Norteamericana para el Cáncer

Frederick Memorial Healthcare System 2009 Community Benefits Report



Staffing the Medical Tent at the
Great Frederick Running Festival



Oncology Services and Tx:Team at Health
Fare in the Francis Scott Key Mall

The Year in Review

The 2009 fiscal year was difficult for the healthcare industry as the worldwide economic downturn impacted patient volumes nationwide. The collapse of the stock market in October of 2008 triggered a series of unfortunate events that are impacting the industrial and financial sectors of the economy even today. Grim economic forecasts throughout the fiscal year combined with diminished profits reported by big business, a tightening job market and a dramatic decline in new home construction shook consumer confidence. Consumers canceled or deferred elective health maintenance and diagnostic testing procedures. Inpatient and outpatient volumes declined in direct proportion to the economic crisis.

The FMH management team wasted no time in making some difficult decisions to streamline operations, cut down on waste and unnecessary spending, and to correct budget forecasts to reflect the economic realities facing the Healthcare System. Employee teams were convened to address process improvement issues, department reorganizations, and the challenges associated with materials and supplies. Team work, commitment to quality, safety and service, and dedication to the organization's mission and vision have allowed FMH to not only weather the difficult economic environment, but to keep plans on track to expand existing services and create new opportunities to provide care to the community we serve.

Even in challenging times, Frederick Memorial Healthcare System has managed to make remarkable progress in improving employee, physician and patient satisfaction scores. With the creation of a new Service Excellence Department, accountability for superb performance in all phases of patient care and customer service has been taken to the next level. "Superb Quality. Superb Service. All the Time." has transitioned from Vision Statement to the expectation in the way we treat our patients, interact with the public, and collaborate with one another.

Major Accomplishments in Fiscal Year 2009

Interventional Cardiology : C-PORT II Protocol



In March of 2009, FMH received approval from the Maryland Health Care Commission to participate in the npPCI (Elective Angioplasty) Research Waiver Program. This unanimous decision was preceded by a complex and lengthy application process which fully demonstrated FMH's ability to participate in this important research protocol and provide elective angioplasty to the Frederick community.

One of the key pieces of our approval has been the success of the hospital's primary (emergency) angioplasty (pPCI) program for patients experiencing acute heart attacks in the community. FMH's median Door to Balloon time, among the best in the State of Maryland, is currently less than 60 minutes, well under the American College of Cardiology standard of 90 minutes. The success of the pPCI program has been due to incredible teamwork and dedication of many groups including: FMH medical and interventional cardiologists, the Emergency Room physicians/staff, the cardiac cath lab team and the ICU intensivists and nursing staff.

Stroke Center of Excellence

In May of 2009 the Maryland Institute of Emergency Medical Service Systems (MIMES) granted the FMH Stroke Program a 5-year Center of Excellence designation. This is the highest designation level awarded by the State, and is an achievement of which we are extremely proud.

The BirthPlace Goes LIVE with Electronic Documentation

Centricity Perinatal

The Neonatal Intensive Care Unit was the final portion of the *BirthPlace* to come online with Centricity Perinatal electronic documentation system. Now staff members in the Family Center, Labor & Delivery and the NICU are all using this technology.

With Centricity Perinatal, a state-of-the-art electronic documentation system, the staff is able to not only enter routine documentation, but also their patients' intake and output with summaries for both 12 hour totals and 24 hour totals. Labs are available to the staff with a click of the mouse. These lab results come directly from Meditech and can still be seen in Patient Care Inquiry (PCI) by other staff members who do not routinely use Centricity Perinatal.

FMH Pharmacy Goes LIVE with Galactica Rx

A Pharmacy medication order scanning application called GalacticaRx was moved into production in January. By using GalacticaRx, nursing units scan medication orders into the system which then get transmitted to a work list used by the Pharmacist who enters the order into MEDITECH. The Pharmacist is able to use the system to view the orders electronically, thereby eliminating paper and the use of fax machines to receive orders.

ED Fast Track Opens

In February, construction was completed on the new ED Fast Track area. The new 8-bay Fast Track space expanded the capacity of the FMH Emergency Department by providing care to sub-acute patients in a more expeditious manner, and in an environment that is significantly less stressful than the ED.

FMH Receives Center of Excellence Status from United Healthcare

United Healthcare awarded Frederick Memorial Hospital Center of Excellence (COE) status for 2 clinical programs, the **FMH Interventional Cardiology Program** and **FMH Joint Works Program** (for Hip and Knee surgery). The COE program recognizes facilities and their medical staff for commitment to high quality, cost efficient health care.

A rigorous application including data from 2007 to present was compiled and evaluated by a United corporate medical team that reviews requests from facilities nationwide looking for best practices and comparison to national benchmarks. They verify information submitted through comparison to data available from CMS and other outside accrediting and reporting agencies. Of particular note, the Joint Works received the highest ranking possible, a 3-star designation for quality and a higher than average ranking for cost efficiency. The cardiac rating will be re-reviewed every 6-months, the joint program rating is good for 2-years.

FMH Awarded United Health Premium Cardiac Specialty Center Designation

FMH was awarded the UnitedHealth Premium[®] Cardiac Specialty Center designation in recognition of providing quality cardiac care.

UnitedHealthcare developed the UnitedHealth Premium Specialty Center designation program to give its members information about access to cardiac hospitals meeting rigorous quality criteria. The designation is based on detailed information about specialized training, practice capabilities and proficiencies that we submit to UnitedHealthcare and is designed to help members make informed decisions should they need cardiac care.

To receive this designation, FMH met extensive quality and outcomes criteria based on nationally recognized medical standards and expert advice. The criteria incorporate measurements of breadth and depth of care, staff experience, emergency care, quality and outcomes reporting.

Bedside Medication Verification System Goes Housewide

FMH completed the transition to electronic bedside medication verification in May of 2009. All in house units are using the system to ensure that the right patient, gets the right medication, in the right dose at the right time.



Bedside Verification allows caregivers to utilize bar code scanning technology prior to administering medications, to confirm patient identity and medication information against data readily available via MEDITECH's on-line Medication Administration Record. Immediate access to a patient's current results and medication administration information greatly reduces preventable medication errors. The use of bar code scanning increases accuracy and efficiency of caregivers completing medication administration records, providing physicians faster and easier access to critical information to manage patient care.

Computerized Physician Order Entry

FMH began using Computerized Physician Order Entry (CPOE) in June of this year. Implementing CPOE has improved patient safety by virtually eliminating legibility and transcription errors and has dramatically reduced callbacks to physicians for order clarification. CPOE has also increased efficiency, by reducing the turnaround time for processing orders and receiving test and lab results.

Surgical Patient Tracking Board

A patient tracking board designed to help families follow their loved ones' progress -- without compromising patient confidentiality- was mounted on the wall in the surgical waiting area. The screen uses a randomly-assigned number to identify each surgical patient. Family members who have that number can simply look to the monitor to see where their loved one is at any point in time. Each location is highlighted by a change in color as the patient moves through Pre-Op, OR, PACU and Admit or Discharge.

FMH Regional Cancer Therapy Center Receives 3-Year Accreditation

The FMH Cancer Program was surveyed by the Commission on Cancer (COC) - the only national accreditation for cancer programs in hospitals, free standing treatment facilities, and healthcare network cancer programs in the United States. The FMH Cancer Program was awarded a "Three Year Accreditation with 6 Commendations." This places the FMH program in the top 40% of COC approved programs.

Statistical and Service Profile

Licensed Bed Capacity: Frederick Memorial Hospital is a **274** licensed bed, acute care facility that has been caring for the citizens of Frederick, Washington and Carroll Counties for over 107 years. In FY 2009, **20,444** patients were admitted to the hospital for in-patient care. From the 2-ward hospital with an “Accident Room,” that opened as Frederick City Hospital in 1902, Frederick Memorial Healthcare System has grown into a state-of-the-art healthcare provider offering the following service lines, departments, programs and satellite facilities:

Service Lines

Women’s & Children’s Services



FMH NICU

- The FMH Auxiliary Prenatal Center
- The Family Center
- The BirthPlace
- The Billy Miller Neonatal Intensive Care Unit
- The Department of Pediatrics

Oncology Services



FMH CyberKnife Team

- Oncology Care Consultants
- The FMH Radiation Oncology Center
 - Intensity Modulated Radiation Therapy
- The Center for Chest Disease
- The Center for Breast Care
- Outpatient Intravenous Therapy Center
- Clinical Trials
- The FMH CyberKnife Center
- Inpatient cancer care

Vascular Services



Cardiac Cath Lab

- Vascular Surgical Services
- Stroke Center of Excellence
- Cardiac Catheterization Laboratories
- Interventional Cardiology Program
- Peripheral Artery Disease Screening & Treatment
 - Primary and Elective PCI

Imaging Services



CT Scan

- Digital Mammography
- Stereotactic Breast Biopsy
- Ultrasound sonography
- Contrast radiography
- MRI
- CT Scan
- PET/CT Scan

Other Departments and Services:



- Emergency Services
- Surgical Services
- Comprehensive Rehabilitation Services
- Cardiac Rehabilitation
- Pulmonary Rehab
- Medical Fitness Program
- Advanced Wound & Skin Care
- The FMH Wellness Program
- Center for Advanced Sleep Studies & EEG
- Home Health Services
- Home Medical Equipment
- Social Services
- Care Management
- Behavioral Health Services

FMH SATELLITE FACILITIES



FMH Urbana

FMH Urbana

3430 Worthington Blvd.
Frederick, MD 21704

- Imaging
- Laboratory
- Physician Specialty Practices



FMH Rose Hill

FMH Rose Hill

1562 Opossumtown Pike
Frederick, MD 21701

- Imaging Services
 - Digital Mammo, Sterotactic Breast Biopsy, Ultrasound, MRI, PET/CT, CT Scan, Vascular Lab
- Comprehensive Rehabilitation
- Laboratory



Mt. Airy Health Services

Mt. Airy Health Service

1502 South Main Street
Mt. Airy, MD 21771

- Imaging Services
 - Digital Mammo,
 - Ultrasound,
 - CT Scan, Vascular Lab
- Comprehensive Rehabilitation
- Laboratory



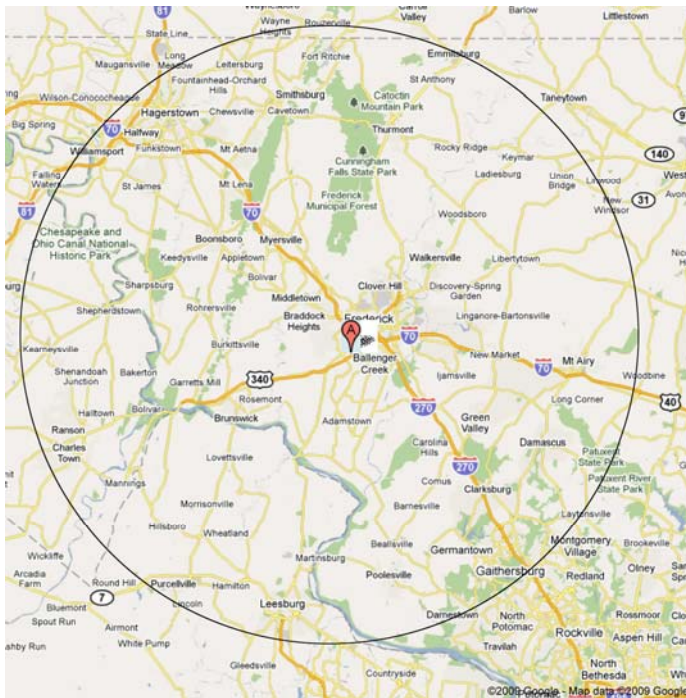
Crestwood II

FMH Crestwood

7196 Crestwood Blvd
Frederick, MD 21703

- Imaging Services
 - Digital Mammo,
 - Ultrasound,
 - CT Scan, Vascular Lab
- Comprehensive Rehabilitation
- Laboratory
- Women's Health Services
 - COMING SPRING 2010

Service Area Geographic Profile



Frederick Memorial Healthcare System's patients are primarily from Frederick County, Maryland, that has an estimated population of 233,000 citizens. Referrals for primary care coming from outside the county include:

Washington County

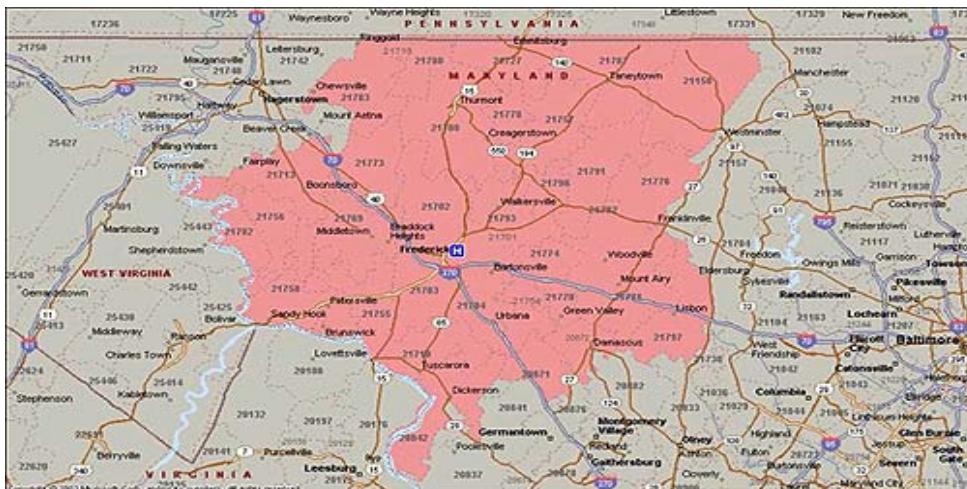
Carroll County

Regional areas from which patients come for specialty services such as cancer care, CyberKnife Radiosurgery, Interventional Cardiology procedures and Neonatal Intensive Care, include:

Southern Pennsylvania

Eastern West Virginia

Northern Virginia

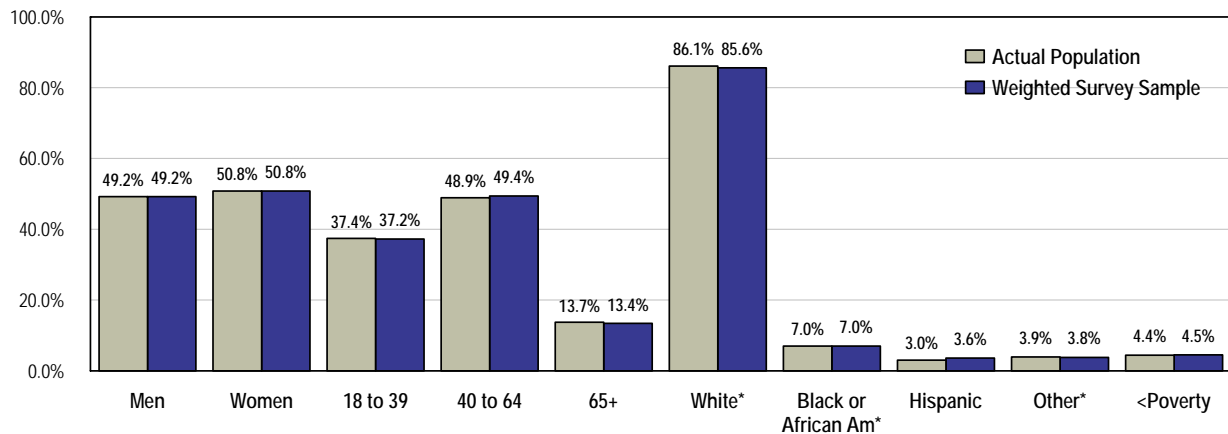


Frederick Memorial Healthcare System is located in the south central portion of Frederick County, Maryland.
Population: 233,000.

State	Number of Inpatients
Maryland	19,233
West Virginia	574
Pennsylvania	266
Virginia	98
Other	273
Total	20,444

Population & Sample Characteristics

(Frederick County, 2007)



Source:

- Census 2000, Summary File 3 (SF 3). U.S. Census Bureau.
- 2007 PRC Community Health Survey, Professional Research Consultants.
- Hispanic can be of any race.
- *White, Black, and Other sample percentages do not include Hispanic respondents who did not offer a race response.

Statistical Profile of Service Area

Income Profile of Primary Service Area

According to the 2006 American Community Survey, Frederick County had a median household income of \$74,029. This is \$8,885 more than the median income of Maryland, \$65,144. Since 1979, when County residents made only \$560 more than the average State resident, Frederick County has continued to increase the gap between the median income of the Maryland and the County. Within the past 27 years, Frederick County residents have increased their median household income by 114%. The greatest increase in household income was between 1989 and 1999, when residents went from making \$41,382 to \$60,276 in 10 years; a 46% increase. Even within the last 7 years residents have seen a 23% or \$13,753 increase in income.

Since 1999, the majority of households make \$50,000 - \$74,999 a year. In 1999, the income ranges of households were more evenly distributed than in 2006, taking on a bell shaped curve appearance. Incomes spiked at \$50,000 – 74,999 and on both sides of this spike the percentage of households slowly dropped. In 2006, the household income still spiked at the \$50,000 – 74,999 range; however the 2 sides of this spike were not evenly distributed. The income ranges rise at a slow rate until spiking and then remain at constantly higher percentage levels. In essence, the division of poor and rich households in Frederick County has become more extreme within the past 7 years.

Households Income Characteristics for Frederick County						
1999			2006		Change 1999 - 2006	
Total Households	70,115	100.0%	79,983	100.0%	9,868	14.1%
Income Range						
\$0 – 9,999	2,754	3.9%	2,034	2.5%	-720	-26.1%
\$10,000 - 14,999	2,260	3.2%	1,580	2.0%	-680	-30.1%
\$15,000 - 24,999	5,519	7.9%	4,100	5.1%	-1,419	-25.7%
\$25,000 - 34,999	6,554	9.3%	5,731	7.2%	-823	-14.4%
\$35,000 - 49,999	11,063	15.8%	10,021	12.5%	-1,042	-9.4%
\$50,000 - 74,999	16,815	24.1%	17,246	21.6%	431	2.6%
\$75,000 – 99,000	11,846	16.9%	14,550	18.2%	2,704	22.8%
\$100,000 - 149,000	9,495	13.5%	15,496	19.4%	6,001	63.2%
\$150,000 +	3,809	5.4%	9,225	11.5%	5,416	142%
Median Household Income	\$60,276		\$74,029	\$13,753		22.8%

Poverty Levels

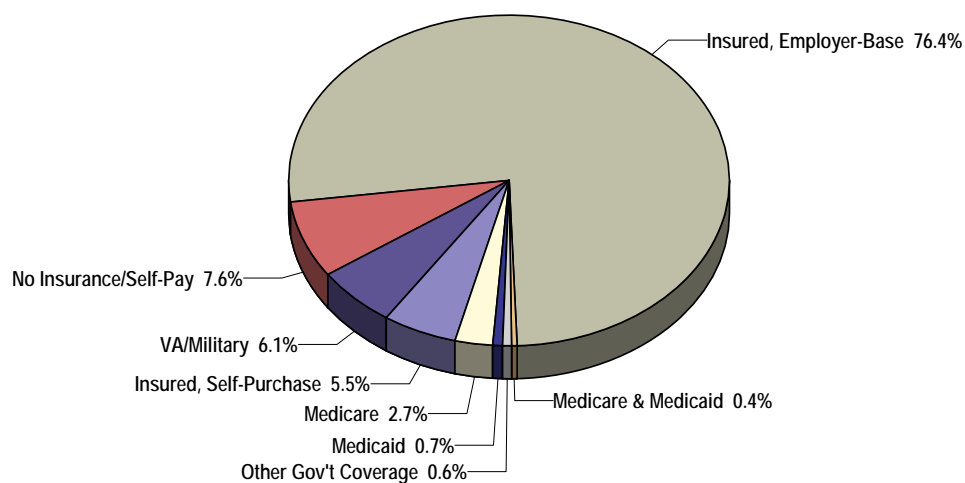
Since income levels have consistently risen in Frederick County, it stands to reason that the percentage of people below the poverty levels would drop. In 2006 fewer people and families were below the poverty level than in 1989 and 1999. Since 1989, the poverty level has consistently dropped going from 4.8% of all people to 3.9% in 2006 – the latest year for which statistics are available.

The greatest decrease in poverty levels occurred in the female householder category. In 1989 17.3% of these households were below poverty level, in 2006 this has decreased to only 7.7%. Female householders with children still have the highest percentage of poverty levels but the decrease has been very significant within the past 17 years. Within the subcategories of female headed households there was also extreme decreases. Households with children under 5 years old decreased from 36.6% in 1989 to 11.5% in 2006. Households with children under 18 years old decreased from 25.1% in 1989 to 9.0% in 2006.

Poverty Status for Frederick County Residents			
	1989	1999	2006
All individuals	4.8%	4.5%	3.9%
Persons 18 years and over	4.5%	4.2%	4.2%
Persons 65 years and over	9.2%	6.0%	5.4%
Related children under 18 years	5.6%	4.9%	2.8%
Related children under 5 to 17 years	5.3%	4.6%	1.6%
Related children under 5 years	6.2%	6.1%	6.1%
Unrelated Individuals over 15 years and older	13.9%	13.8%	15.9%
All families	3.5%	2.9%	1.6%
Families with related children under 18 years	4.8%	4.1%	2.4%
Families with related children under 5 years	5.4%	5.6%	2.4%
All female Householders with children	17.3%	13.8%	7.7%
Households with related children under 18 years	25.1%	19.2%	9.0%
Households with related children under 5 years	36.6%	32.8%	11.5%

Healthcare Insurance Coverage

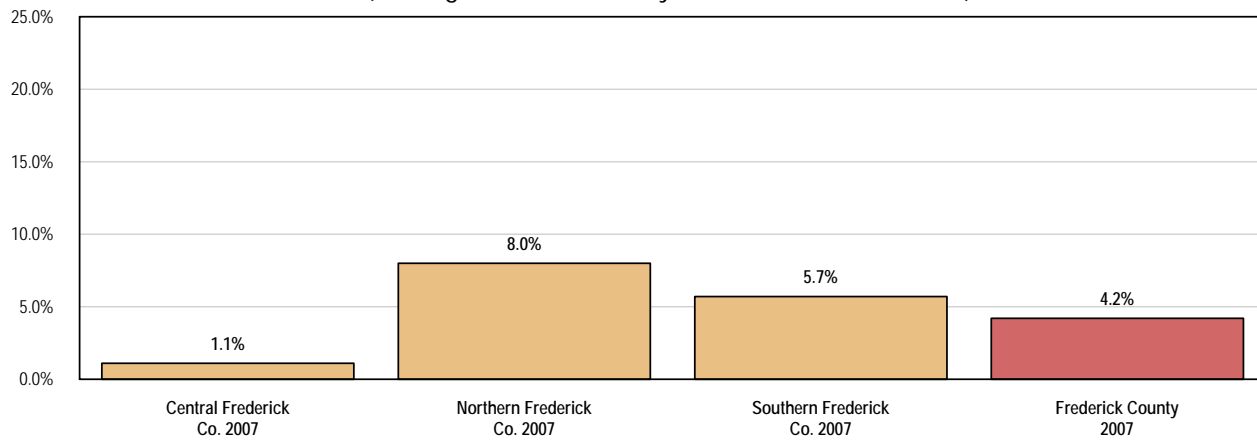
(Among Adults Age 18 to 64; Frederick County, 2007)



Source: • 2007 PRC Community Health Survey, Professional Research Consultants. [Item 185]
 Note: • Reflects respondents age 18 to 64.

Lack Healthcare Insurance Coverage for Child

(Among Frederick County Parents of Children <18)



Source: • 2007 PRC Community Health Survey, Professional Research Consultants. [Item 195]

Note: • Reflects respondents with children under 18.

Community Health Assessment

In 2007, the Frederick County Health Department contracted Professional Research Consultants, Inc., to perform a telephone survey of 1,000 Frederick County, Maryland adults aged 18 and older. This was the first time that a community wide Health Assessment was performed for the Frederick community. The survey instrument used for this study was based largely upon the Centers for Disease Control and prevention (CDC) Behavioral Risk Factor Surveillance System, as well as other public health surveys.

As part of this community health assessment, there were five health related community focus groups. These focus groups included meetings with Physicians, Social Services Providers, Political and Community leaders, and Allied Health Professionals.

The data collected by the Community Health Assessment has serve as a tool for reaching three basic county-wide goals:

1. To improve residents' health status, increase their life spans, and elevate their overall quality of life.
FMH ACTION: The FMH Wellness Center created a number of screenings, programs and educational events to increase the community's knowledge about specific disease conditions that were identified in the Community Health Assessment as areas of concern for our community: Cancer, Heart Disease, Nutrition and Weight Management. Armed with the knowledge needed to make the necessary lifestyle and behavioral changes to remain healthy has enhanced our community's health status in many positive ways.
2. To reduce the health disparities among residents. The demographic information gathered during the survey process has allowed the Health Department and the Frederick Memorial Healthcare System to identify population segments that are most at-risk for various diseases and injuries.
FMH ACTION: The FMH Regional Cancer Therapy Center hosted prostate cancer screening events, and Vascular Services performed screenings for Peripheral Artery Disease in areas of the county where access to such services is challenging. The African American and Hispanic populations are both high-risk demographics in Frederick County for both of these disease conditions.
3. To increase accessibility to preventive services for all community residents.
FMH ACTION: An area identified by the Community Health Assessment as requiring immediate action relative to access issues was in the Prenatal care arena. Many women in Frederick County were receiving no prenatal care. Their babies being delivered at FMH were requiring admission to the Neonatal Care Intensive Care unit in percentages far above the expected admission rate when compared with actual patient admissions. The FMH Auxiliary Prenatal Center was established to provide these underinsured or uninsured women with the prenatal care necessary to ensure a healthy birth weight baby that was full-term gestational age. It worked!

Areas of opportunity identified by the survey's data – and the **ACTIONS** taken by the Frederick Memorial Healthcare System to improve community health include:

- Availability to Care/Inconvenient Office Hours
 - **FMH ACTION:** FMH Immediate Care Centers increased hours of operation.
- Health Disparities/Low income and Minorities
 - **FMH ACTION:** FMH and the Health Department targeted underserved areas and populations to receive educational programs and screening events for specific disease conditions.
- Heart Disease & Stroke
 - **FMH ACTION:** FMH established the Stroke Center of Excellence, and expanded cardiovascular services to include and Interventional Cardiology Program and Peripheral Artery Disease (PAD) surgical service.
- Cancer (Prostate/Lung/Breast)
 - **FMH ACTION:** The FMH Regional Cancer Therapy Center expanded its screening programs relative to Prostate Cancer and targeted those areas and populations in Frederick County that were underserved and experiencing access issues. The Center for Chest Disease was established to address issues relative to lung cancer diagnosis and treatment. The Center for Breast Care – now treating patients – was in the development stages in FY 2009.
- Respiratory Disease (Asthma)
 - **FMH ACTION:** The Pulmonary Rehab Department created a Community Outreach Program to increase awareness of the fact that asthma is a significant health problem in our community. Two certified asthma educators (AE-C) have been assigned to educate the community about this chronic disease.
- Prenatal Care – access to care, incidence of low-birth weight babies
 - **FMH ACTION:** The FMH Auxiliary Prenatal was established and is providing care to the underinsured and uninsured in Frederick County.
- Modifiable Health Risks: (Overweight & Obesity, Tobacco Use)
 - **FMH ACTION:** The FMH Wellness Center has created a number of programs, classes and events designed to educate and address specific behaviors relative

FMH Wellness Center



The FMH Wellness Center is a division of the Frederick Memorial Healthcare System which promotes healthier lifestyles and enhanced levels of wellness by providing health education classes, health screenings and individual services. Because early detection and education are the keys to a highly informed and educated community, the hospital vigorously supports the Wellness Center in a variety of client centered wellness activities. During the fiscal 2008– 2009 year the FMH Wellness Center touched over **73,000** members of our community.

Corporate Partners and Community Wellness Services

The health and wellness of the residents of Frederick County and the surrounding areas is the most important contribution of The Frederick Memorial Healthcare System Wellness Center. Each year we search for new partnerships and programs that focus on guiding our friends and families towards healthier lifestyles. During our 2008 – 2009 fiscal year, these organizations and businesses joined us in a collaborative effort to secure a greater level of health for members of our community.

- Accounting Software Services
- Airline Owners and Pilots Association
- American Red Cross
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Radiology Services
- ARC of Frederick County
- Arthritis and Osteoporosis Center Of Maryland
- Avemco
- BP Solar
- Big Brothers and Sisters of America
- Boy Scouts of America

- Breast Cancer Awareness of Cumberland County
- Carroll Lutheran Village
- Citigroup
- City Of Frederick
- Country Meadows Retirement Community
- Corporate Occupational Health Services
- Drees Homes
- Earth Data
- Elder Expo
- Erickson Retirement Communities
- Families Plus
- Fannie May
- FMH Select
- Frances Scott Key Mall
- Frederick County Board of Realtors
- Frederick County Board of Education
- Frederick Community College
- Frederick County Commission On Women
- Frederick County Department Of Aging
- Frederick County Department of Social Services
- Frederick County Health Department
- Frederick County Head Start
- Frederick County Hospice
- Frederick County Parent Teacher Association
- Frederick County Public School System
- Frederick News Post
- Girl Scouts Of America
- Goodwill Industries
- Greater Frederick Fair
- Green Valley Jazzercise Fitness Center
- Hagerstown Community College
- Heartfields Assisted Living
- Key 103
- Kiwanis Club
- LIFE and Discovery Inc.
- MedImmune
- Middletown Mom's Club
- Middletown United Methodist Church
- Mount Moriah Baptist Church
- Morgan-Kellar Inc.
- National Cancer Institute at Frederick
- Patriot Technologies
- Preit, Inc.
- Rotary of Fredeick
- SAIC of Fort Detrick

- Somerford Assisted Living
- Susan G. Komen Foundation
- TAMCO
- Transit Services of Frederick County
- TX Team
- United Healthcare
- UP County Family Services
- Urbana Fire Department
- US Department of Energy
- US Department of Health and Human Services
- Volunteer Frederick

Services/Programs

Either through joint efforts with our collaborative partners or independently, the following services were designed and implemented by the Frederick Memorial Healthcare System Wellness Center.

- **12** blood pressure screenings attended by **250** participants
- **6** wellness lectures serving **223** members of the Frederick County Community.
- **3** mall wellness events specifically designed to address the general health issues of all ages for more than **1,500** community members
- **2** activities sponsored by the Frederick County Commission for Women and FMH Medical Fitness which provided information and screenings to more than **200** members of the community
- General health and wellness information event boxes, distributed to **4** elementary school events and Fort Detrick that reached over **1,750** individuals
- Physician Information and Referral Service for greater than **1,360** individuals and families.
- Wellness information sessions **3800** attendees at various businesses and community organizations.
- General health and wellness information distributed during **123** business events serving **16,375** members of the community.

Employee Wellness Program

The Wellness Center in partnership with the FMH Human Resources Department, continued the Employee Wellness Program. This program, designed to address the specific health needs of members of the hospital family provided **130** events for over **1,880** members of the hospital staff and volunteers.

Cancer Prevention Services

The FMH Wellness Center received two grants from The Cigarette Restitution Fund to provide tobacco education and cessation programs to the Frederick County community. Grant monies allowed **25** people to participate in smoking cessation classes, and helped to provide **35** smokers with one-on-one appointments with a Nurse Practitioner or Behaviorist. Classes were held at the Wellness Center, as well as several businesses in the community, including the YMCA and Metropolitan Steel.

Additionally, **750** education materials were provided to the Centro Hispano and HOPE VI/Housing authority, and **1,000** education materials were provided to the FMH Immediate Care and CorpOHS departments. A new initiative during the fiscal year was to offer education and cessation resources to the FMH inpatient out outpatient psychiatric programs. A total of **120** patients received the information. Also, an inpatient to outpatient referral process was initiated at FMH, which identified smokers who were interested in cessation resources. These individuals were provided one-on-one telephonic support. Smoking Cessation Programs also assisted over **1,900** members of the community in their journey to stop smoking.

Other community education efforts included:

- **3** major tobacco events: Kick Butts Day, World No Tobacco Day and the Great American Smokeout
- Smoking cessation promotion at **19** health fairs; **2,610** attendees
- **8** minority health events; **320** attendees

Additional efforts within the Healthcare System included:

- **2,159** participants in Maternal Child Health programs received cessation materials and incentives
- **1,750** brochures and incentives were provided to the FMH Stroke Program
- **21** persons with the FMH Walking Works program received education on smoking hazards, as well as cessation resources
- **30** brochures and incentives were given to the FMH Pediatric Asthma Program
- **34** FMH employees were education on stress and it's relation to smoking
- **7** Diabetes Program participants were educated on smoking hazards.

In total smoking cessation events reached over **11,099** community members

Diabetes Services

Diabetes Healthcare Services offered through the Wellness Division supported the management of inpatient diabetic patients by staffing the hospital with one Nurse Practitioner and two Registered Nurses. Staff were certified by the American Diabetes Association as Diabetic Educators. These nurses evaluated and managed over **5,400** patients. In addition to patient education and disease management services offered to more than **6,400** members of Frederick County, the FMH Outpatient Diabetes Services provided monthly support groups for adults and school aged children and general community education which served more than **640** individuals.

This year the FMH Wellness Center piloted a new service by providing evaluation insulin management to outpatient diabetics. The outpatient Diabetic Nurse Practitioner gave care to more than **100** patients through this new service.

In partnership with several area businesses and community organizations, over **530** participants were screened for diabetes at the annual community screenings.

Family Focus Program Services

The Wellness Center's Family Focus Program provides education and support to the core of our community – the family. The program works in conjunction with the **FMH BirthPlace** to provide expectant parents a preview tour of the birth facility. The Family Focus Program also helps parents prepare for the birth of their child by providing quality Childbirth and Parenting Education to thousands of parents every year. Siblings-to-be participate in the ever-popular “Small Wonder” program to help them welcome a new baby brother or sister. Family Focus has served over 8,783 community members.

Just like the family – this program continues to grow and thrive each year to benefit our community!

Safety and Injury Prevention Programs

FMH continues to support Safe Kids Frederick County, a local coalition affiliated with Safe Kids Worldwide – the only grassroots, long-term effort dedicated solely to preventing unintentional injury – the number one killer of children age 0-14 years. FMH Wellness Center and Frederick County Health Department are the co-lead agencies. The co-lead agencies conduct **10 annual meetings** with representatives from the member agencies to discuss, plan, and develop a coordinated program of public awareness, education, legislative action and enforcement to help to prevent these unintentional injuries in Frederick County children. Access to low cost safety products is also offered to Frederick County families.

We have created unique partnerships with the following organizations and businesses to provide quality safety services to members of our community:

- American Red Cross
- Carroll County Health Dept.
- Child Care Choices
- Families Plus!
- Family Partnership
- Fitzgerald Auto Mall
- Frederick County Autism Society of America
- Frederick County Dept. of Emergency Planning
- Frederick County Dept. of Fire & Rescue Services
- Frederick County Head Start
- Frederick County Health Department
- Frederick County Highway Safety Task Force
- Frederick County Parks & Recreation
- Frederick County Public Schools
- Frederick County Sheriff's Department
- Frederick County Volunteer Fire & Rescue Association
- Frederick Memorial Hospital – Pediatrics Dept. & Neonatal ICU
- Frederick Peddlers
- Frederick Police Department
- Ft. Detrick First Steps Program
- Healthy Families Frederick
- Heartly House
- Kiwanis Club-Suburban Frederick
- Marriott International
- Maryland Poison Center
- Maryland State Police
- MIEMSS
- Parent Power (Mental Health Association)
- Priority Partners
- State Farm Insurance
- US Fire Administration
- Volunteer Frederick!
- YMCA of Frederick County

In FY'09 the following services were provided:

- **660** telephone consultations educating parents and caretakers on child safety issues
- **119** car seats rented/distributed to low income families or individuals having out of town guests with small children
- **539** individual car safety seat checks
- **59** parents/caregivers attended car seat training classes

- **1863** community members attended **17** Events/Safety Fairs. Five (**5**) of these events were held for ESL residents
- **102** bicycle & multi-sport helmets distributed & fitted properly
- **86** children participated in 2 bicycle rodeos
- **38** carbon monoxide detectors distributed to families without one in a home that is heated with a fossil fuel
- **11** smoke alarms distributed to families without one in their home
- **26** case managers at Frederick County Dept. of Social Services taught crash dynamics and child passenger safety awareness
- **14** cadets at Frederick Police Academy taught child passenger safety awareness
- **32** law enforcement officers, firefighters, EMTs and health educators child passenger safety technicians updated prior to their re-certification
- **37** law enforcement officers, firefighters, EMTs and health educators trained as child passenger safety technicians
- **2** firefighter child passenger safety technicians mentored through the initial part of their instructor candidacy process. They will complete their process in FY'10
- **36** NICU nurses from around the state of Maryland taught child passenger safety for premature infants and angle tolerance testing protocols prior to discharge
- **72** children of FMH employees taught what to do "Till Help Arrives" and how to respond to someone who is choking at Bring Your Child to Work Day
- **368** community residents instructed in CPR/First Aid

The Injury Prevention Coordinator at FMH Wellness Center participates with the following county/state committees as an injury prevention expert.

- Frederick County Interagency Early Childhood Committee
- Frederick County Highway Safety Task Force
- Maryland Child Passenger Safety Advisory Board
- Maryland Occupant Protection Committee
- Safe Kids Maryland

FMH Stroke Center of Excellence

On May 12, 2009 the Maryland Institute of Emergency Medical Service Systems (MIMES) granted the FMH Stroke Program a 5-year Center of Excellence designation. This is the highest designation level awarded by the state. Frederick County residents no longer have to be transported to neighboring facilities to receive acute stroke care. A program with the highest level of preparedness and State recognition is right here at Frederick Memorial Hospital.

FMH Stroke Program partners with Frederick County Emergency Medical Systems to provide annual **Stroke training**. This training ensures the first-responders are aware of Stroke signs and symptoms and also the most current treatments. The cooperation between these two entities enables the patient to have the best care possible at every stage of treatment.

The Stroke Program offers **free Stroke workshops** to people of Frederick County. The Stroke workshops increase awareness and provide details on stroke care and prevention. Attendees are given information on risk factors and steps they can take right away to change their own risk for stroke. At the conclusion of the workshop, attendees are able to name and identify stroke signs and symptoms and know what to do in case they or someone they know is having a stroke.

In a partnership with the Frederick County Diabetes Coalition, the Stroke Program has screened hundreds of area residents for Stroke and risk factors associated with Stroke. The Stroke program also teaches stroke prevention to the Power to Prevent classes offered by the Frederick County Health Department.

The Director of the FMH Stroke Center of Excellence has hosted and been invited to a number of groups and organizations to present information and educational materials about stroke and stroke prevention:

• WallMart	40
• Glade Valley Nursing Home	20
• Homewood Retirement Comm	30
• WallMart	35
• Home Depot	20
• FMH	15
• Women's Civic Club	40
• Maranatha Church of God	150
• Frederick Towne Mall	100
• Fred Cty Publi Schools	70
• FMH	20
• Frederick Kiwanis Club	20
• Christ Reform Church	20
• FMH Employee Health	20

• FMH Home Hlth Services	25
• Adventist Rehab Hospital	10
• Middletown Amvets	110
• FCC Nursing Students	50
• Md. Stroke Alliance Conf.	25

Pulmonary Rehabilitation Community Outreach Program

Asthma Awareness/Smoking Cessation

Tobacco continues to be the leading cause of preventable disease and death in the United States. Smoking harms nearly every organ of the body and generally diminishes the health of smokers. Quitting smoking has immediate as well as long term affects. People who stop smoking greatly reduce the risk of dying prematurely and lower their risk of heart disease, stroke, lung disease and other health conditions. Frederick Memorial Hospital's Community Outreach Program promotes a healthier community by offering both intermediate and intensive smoking cessation counseling as a service to the community. Smoking cessation facilitators provide information, resources and tools to treat tobacco use and dependence.

Asthma is a chronic lung disease with varying levels of severity and is characterized by exacerbations. With access to quality healthcare and appropriate medications, combined with an understanding of how to avoid specific environmental triggers, asthma is a controllable disease. The keys to control are knowledge, skill and behavior. The goal of Frederick Memorial Hospital's Community Outreach Program is to increase awareness of the fact that asthma is a significant health problem. FMH has two certified asthma educators (AE-C) dedicated to educating the community about this chronic disease that strikes so many throughout the state of Maryland, allowing for better disease management.

Programs

First Annual Asthma Awareness Day



Frederick Memorial Hospital hosted the 1st Annual Asthma Awareness Day on May 27, 2009. The community was invited to come to the hospital to learn about the advances being made in self-management of asthma and symptomatic control of the disease. Speakers from the Environmental Protection Agency and Maryland Department of Health and Mental Hygiene joined us in efforts to educate our community about the importance of self-management of asthma. Free

portable pulmonary function test and pulse oximetry checks were offered. The Asthma Awareness Day Event reached approximately **60** individuals from the community in search for information on asthma.

Freedom From Smoking Facilitator Training Program

On June 10th and 11th staff attended the American Lung Association's Freedom From Smoking Facilitator Training Program. This was a workshop that provided an understanding of how to work with adults in a group setting along with opportunities to learn about nicotine addiction, facts about tobacco control and the content of the FFS Clinic sessions.

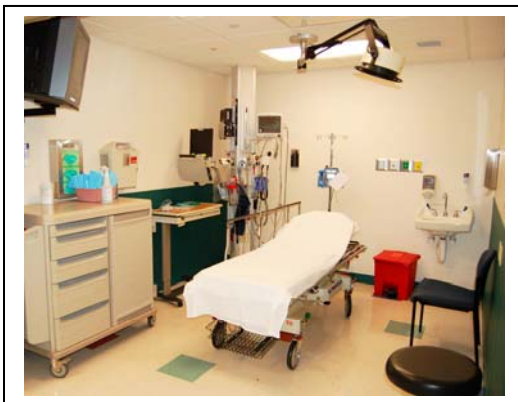
The FMH Emergency Department



The FMH Emergency Department continues to be one of the busiest emergency departments in the State of Maryland. In fiscal year 2009, over 74,000 patient visits were recorded. The Frederick Memorial Healthcare System has been providing emergency care to the citizens of Frederick County ever since a one bed “Accident Room” was set-aside in 1905 on the first floor of the old Frederick City Hospital. Since that day, the doors have remained open 24 hours a day, 7 days a week, 365 days a year for nearly 107 years.

Fast Track

To meet the growing needs of our community, a new 7 bed Fast Track was opened in March 2008. This clinical area is staffed by a Physician Assistant, R.N. and ED Technician. Hours of operation are 1100 – 2300 seven days per week. On any given day, approximately 40 – 50 patients are treated and released from the Fast Track area with a length of stay averaging 95 minutes.



The Shields Emergency Department is one of the largest emergency departments in the region. With over 24,000 square feet, the ED houses:

- 50 beds and treatments rooms
- 14 general-purpose rooms
- 5 Crisis rooms
- 1 SAFE Room
- 15 Acute care beds
 - CT scanner dedicated to ED patients only
 - X-ray suite dedicated to ED patients only

The FMH Emergency Department has forged strong working relationships with the Frederick County School System, the Frederick County Court System, and community law enforcement agencies. Many of the community benefit programs offered by the Emergency Department are the result of collaborative efforts between these agencies and organizations and Frederick Memorial Hospital's ED staff.

Community Benefit Programs

The Emergency Department in conjunction with the above mentioned organizations have developed the following programs:

1. SAFE Program
2. The Take a Moment Program

1. SAFE Program

The SAFE program provides services to victims of acute sexual assault and abuse of all ages. Since the beginning of the program in October 1997, over 383 victims have been served by the program. There are 9 nurses who currently provide 24 hour on call services and response when a victim presents to the ED. The Maryland Board Of Nursing has certified these individuals after completing extensive training as Forensic Nurse Examiners (FNE's). Currently the staff is comprised of: Katherine Lecomte R.N., Safe Coordinator, Kim Day, R.N., Rebecca Marrone, R.N., Michelle Seavolt, R.N., Helen Dickison, R.N., Kara Linthicum, R.N., Lorena Mauney, R.N. (who is certified as a spanish translator), Brooke Bae, R.N., and Julie Shank, R.N.

In addition to providing medical forensic evidentiary examinations to victims, they also do suspect examinations, and education for law enforcement officers, Heartly House staff and community groups. Most recent community education about our SAFE team and the services we offer, included classes to our Hispanic community Even Start Programs.

Programs:

- In response to a recent Sexual Assault in a Frederick County high school, our SAFE program coordinator and other members of the team have worked with the Frederick County elementary and middle school staff on the curriculum for safety. They have presented the services that FMH offers to the crisis and health educators in the schools.
- The SAFE Team has presented four classes to the students at Mt. St. Mary's University (Navigating Your Independence) (10- 20 participants per class)
- SAFE Team staff are all members of the Frederick County Domestic Violence Fatality Review Board, and the Frederick County Domestic Violence Coordinating Council, and they were an intricate part of the White Ribbon Campaign. (100 participants at opening)
- At the request of the Youthful Offenders Program, now utilized in Frederick County, SAFE presents a class on the Cycle of Domestic Violence and Safe dating. Our SAFE team had partnered with a local church to set up Wednesday afternoon "cookie time" with the middle and high school students to facilitate relationships and assess needs of at risk students.

At the request of the Frederick County Sheriff, and the Brunswick and Frederick City Police Academies, the SAFE program is presented to help orient new recruits about the vulnerabilities of rape victims, and to educate seasoned officers about the proper use of forensic evidentiary kits. In providing this important and specialized training, the program reaches and impacts a dramatically underserved population who would otherwise have no access to critical – and time-sensitive – healthcare; and to the judicial system.

Program Presentations

• Frederick County Sheriff's Office Academy Training	15 Officers
• Frederick County Sheriff's Office Crime Team Training	10 Officers
• Frederick City Police Academy	15 Officers
• Frederick County School Resource	6 Officers
• Heartly House Advocate Training	6 Advocates

The FMH SAFE program has impacted the lives of many women who have been the victims of sexual assault. The SAFE Program extends beyond the boundaries of Frederick County, and has helped the residents of our neighboring counties.

2. The "Take a Moment" Program

The Take a Moment program was developed at the request of the Frederick County Court System, and the Frederick County and Frederick City law enforcement agencies who identified the need to present a "drunk driving" awareness program. This program is now shown at special times. Take a Moment targets offenders convicted of driving while intoxicated, and is designed to show the consequences of driving under the influence of drugs or alcohol. The target audience is new military personnel who live and work in the area, and students of local high schools.

The program is a two-part presentation:

- A program focusing upon "Choices and Their Consequences" is presented to participants, and they are shown pictures from fatality scenes that graphically depict the results of poor choices.
- Participants engage in "role play" scenarios wherein one is a patient and the other a healthcare worker having to deal with an intoxicated patient. The patient is placed in restraints, and the unpleasant procedure known as a gastric lavage (having your stomach pumped) is demonstrated.

Program Presentations

The Victim Impact Panel presents the "Take A Moment" program every other to offenders of driving under the influence, who are ordered by the court to attend this program.

Take A Moment was provided to new personnel stationed at local military facilities:

- Fort Detrick 200 personnel
- Private High School 300 students
- Mt St Mary's University 30 students

Frederick County Court System's rate of recidivism statistic is used as the gauge by which the program's efficacy is measured. The rate of recidivism has declined since the implementation of this program in Frederick County. Mothers Against Drunk Driving (MADD) supports the Take a Moment Program. Their evaluations provide feedback to the FMH Emergency Department staff and the State Police instructors.

Perioperative Services Open House



FMH's Perioperative Services hosted their second annual Open House on Saturday, November 1, 2008. Hundreds of attendees got a look at FMH's surgical suites from the pre-operative area, into two operating rooms and back out into the post-anesthesia care unit (PACU). The open house was a very hands-on event, with visitors getting the chance to don gowns, caps, gloves and booties and pick up just about anything they wanted to inspect -- including trying their hands at laparoscopic 'surgery' (removing gummie snakes and reptiles from a simulated abdomen).

Preventive Cardiology and Rehabilitation Medical Fitness Program

The FMH Medical Fitness program is a medically supervised fitness program that helps special populations promote health, improve physical fitness and enhance the quality of their life through exercise, education and service. The Medical Fitness program is recommended for people with health concerns such as high blood pressure, heart disease, diabetes, lung disease, circulatory problems and weight issues.



Evidence clearly supports that regular exercise improves quality of life. Many people who live day to day with the challenges associated with a number of conditions and diseases miss out on the healthy benefits of routine exercise because of the fears associated with cardiovascular workouts. The staff at Medical Fitness consists of registered nurses and degreed exercise physiologists trained and certified in BLS and Advanced Cardiac Life Support. The staff prepares an individualized exercise program for each participant and monitors the exercise routine. Included in this program is regular blood pressure readings, glucose measurement (as needed), exercise prescription, from our staff (as needed) and regular feedback

and communication with physicians. Sign language and foreign language interpreters are also used when needed. The Medical Fitness program was provided **free of charge to 10 patients** in FY 09. These patients must attend the fitness programs regularly.

The gratis participants in the program remain in excellent health. Their energy levels, range of motion, cardiovascular condition and overall health is exponentially better than if they had not had access to a medically supervised exercise program.

Training & Organizational Development Department

The Training and Organization Development Department supports FMH mission, vision, and strategic goals by helping to develop the skills and competencies of FMH staff. Competent and skilled staff contribute to customers choosing FMH as their health care provider of choice.

FMH has signed student affiliation agreements with colleges whose programs include: nursing, imaging, and rehabilitation. These collaborative efforts allow students the opportunity to complete a clinical rotation at FMH. Schools throughout Maryland, as far as the Eastern Shore, have signed affiliation agreements with FMH.

Given the shortage of both nursing and allied health professionals, many schools have looked to increase enrollment in these programs. Any increase in enrollment has meant the need for additional clinical placements. During FY09 FMH continued its partnership with the new nuclear medicine course at Frederick Community College, helping in an advisory role and clinical rotation site. This course was started based upon the severe shortage of nuclear med technicians throughout the state of Maryland. FMH is proud to provide clinical placements for these students.

Community Benefit Services



Clinical placements at FMH provide a real-world environment in which the students may observe, learn, and practice their skills under the direct supervision of a licensed practitioner. Structuring a positive student clinical has led to many students applying for open positions at FMH. In addition, FMH provides direct financial support to Frederick Community college enabling it to offer associate degree programs in nursing, respiratory therapy, and nuclear medicine.

Outcomes Assessment

Every program is evaluated via regular contact with school faculty, the completion of a student evaluation, as well as feedback from the hospital department staff. Modifications to the clinical rotations have been made when warranted.

Presentation Schedule

Students are placed at FMH year round, with the busiest periods being in the spring and fall. On average, during a spring or fall semester, about 130 nursing students from a variety of colleges could be completing a clinical rotation at FMH. Imaging and rehabilitation students number from 1 to 5 in any given semester.

Support of Frederick Community College (FCC)



Students on FCC Campus

Monetary support paid to FCC to help fund their allied health and nursing program = \$100,000.00. In addition, FMH pledged \$40,000.00 to FCC through the Maryland Hospital Association's "Partners in nursing program".

Finally, FMH also provides space and phone at no charge for a training lab valued at \$1032.48 monthly and the phone service we provide is valued at \$60.40 per month = \$13,114.56. The total support of FCC comes to \$153,114.56.

Support of business and educational partnerships through the Frederick County Chamber of Commerce (FCBRE).

FMH is a founding member of the **Frederick County Business Roundtable for Education**. This group supports, amongst other initiatives, educational internships for high school students, career fairs highlighting the math and science jobs available within Frederick County, and continuing educational programs for public school teachers.

FMH provides committee members who dedicate their time and ideas to this effort, along with an annual monetary pledge of \$10,000.00.

The FMH Auxiliary Prenatal Center

The FMH Auxiliary Prenatal Center – made possible in part by a \$500,000 pledge by the FMH Auxiliary – provides prenatal care for women with no insurance - or with Medicaid programs who are unable to obtain care from other providers. Many of the women in the Prenatal Center's programs are high-risk pregnancy patients, and many of the women present with medical conditions of which they are unaware, that may pose significant risk to full-term fetal development. The staff of the FMH Auxiliary Prenatal Center – 2 nurse midwives, a medical assistant, a department assistant, and an interpreter – under the direction of Dr. Edwin Chen, Medical Director for the Prenatal Center, and Dr. Wayne Kramer, perinatology consultant with the practice of Mid Maryland Perinatology Associates, are able to diagnose and treat these underlying conditions before they adversely affect the course of the pregnancy.



Access to the FMH Auxiliary Prenatal Center is mainly through referrals from the Frederick County Health Department (FCHD), and the Frederick County Mission of Mercy. Women who suspect that they may be pregnant are given a pregnancy test through either organization. If the pregnancy test was provided by the FCHD, and the results indicate that they are pregnant, they are

enrolled in the FCHD's Healthy Start Program. If the pregnancy test was administered by the Mission of Mercy, and the results are positive, the women are given the option of staying with the Mission of Mercy program – or enrolling in the FMH Auxiliary Prenatal Center's prenatal care program. (If the Mission of Mercy determines that there are factors present that may indicate a compromised pregnancy, the patients are not given an option, but are sent directly to the FMH Prenatal Center.) The vast majority of patients who are given the option of continuing with the Mission of Mercy, or having their prenatal care provided by the FMH Prenatal Center opt for the later choice. Before the FMH Prenatal Center opened, there was a backlog of 80 patients waiting to be seen at the Mission of Mercy. The opening of the Prenatal Center has completely eliminated that backlog of patients. There is no waiting time at all at the Mission of Mercy.

The Frederick County Health Department's Healthy Start Program, and programs through the Mission of Mercy provide education, and assistance in locating community resources, signing up for medical assistance programs, and enrolling in the FMH Auxiliary Prenatal Center program. Those women, who are not eligible for Medical Assistance, are sent to Frederick Memorial Hospital where a financial counselor will work with them to determine a payment scale that best suits their situation and circumstance. If it is determined that there is no reasonable expectation of payment, the patient is nevertheless given access to the FMH Auxiliary Prenatal Center's services as a recipient of uncompensated, charity care.

In FY 2009, the FMH Auxiliary Prenatal Center logged 3,160 patient visits. All patients were residents of Frederick County.

Patient demographics are as follows:

5% African-American, 30% Caucasian, 60% Hispanic, 5% Asian, and 5% “other,” i.e. French.

The services of the Prenatal Center’s on staff Spanish Interpreter were required in 46% of the visits. 83% of the patients seeking care are Frederick City residents, and the remainder live within Frederick County.

The most important statistic is that an estimated 95% of the patients being cared for at the FMH Auxiliary Prenatal Center had no health care at all before entering the FMH program.

FMH has delivered 247 healthy babies from Prenatal Center patient mothers in FY 2009. Only 12 (4.8%) newborns required a short stay in the hospital’s Billy Miller Neonatal Intensive Care Unit.

Community Contributions

FMH receives numerous requests for financial support from a wide variety of worthy community organizations. The FMH Department of Marketing and Communications serves as the Healthcare System’s clearing house for vetting the many requests. While the hospital helps whenever and wherever it can in providing in-kind contributions of time and talent; cash contributions are used to support those organizations or community initiatives that espouse a cause that is most in keeping with that of the Healthcare System’s mission to contribute to the health and well being of area residents.

Heartly House is a nationally recognized organization dedicated to combating domestic violence, and providing shelter, legal assistance and transitional housing to victims. FMH works closely with Heartly House, as advocates from that organization often accompany women to the FMH Safe Program describe above, and observe the process of forensic examinations. We assisted Heartly House with their lifesaving work by helping them publicize their services and by print materials for their fundraising events.

While some of the assistance FMH provided was in the form of purchasing advertising space in local publications, some in-kind contributions in time and talents proved to be even more valuable to the organization.

Total Heartly House contributions = \$2,500

Other community events to which the Healthcare System contributed:

• Asian Lunar New Year Diversity Event	\$1,000
• Community Foundation Golf Tournament	\$ 750
• Mental Hlth Ass. Of Frederick - Catoctin Affair	\$2,000
• Mental Hlth Ass. Of Frederick – Guide to Services	\$2,500
• Leadership Montgomery	\$ 300
• Mission of Mercy	\$ 500
• Frederick Marathon	\$5,000
• Indian Association of Frederick	\$ 250

The Department of Marketing and Communications has contracted with Nassau Broadcasting and Clear Channel radio to broadcast a health awareness program called “FMH Medical Minute.” The 60-second spots air on 4 radio stations: WWEG – 106.9, WAFY 103.1, WFRE – 99.9, and WFMD 930 am. The spots are not advertisements for services or programs. They are educational in nature, and inform the public about topics such as:

- Signs and symptoms of heart attack
- Weight management and nutrition
- Sleep apnea
- Hospice care
- Stroke prevention

Investment in FY 09 = \$15,000.00

Mission Driven Health Services

The mission of Frederick Memorial Healthcare System is to contribute to the health and well-being of area residents by providing quality healthcare in a caring, cost efficient and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

In order to fulfill our mission, The Healthcare System has entered into a number of exclusive contracts and/or subsidy arrangements with hospital based physicians/physician groups. These arrangements provided for timely patient care in a cost effective manner, and allow for efficient allocation of physician time and resources.

The following specialty practice physicians are subsidized to be on-call, 24/7 at FMH:

- Hospitalists
FMH Hospitalists are specialists trained in the care of hospitalized patients. They provide care to the patients of those physicians with whom they have established a relationship, and assume the medical management of the patient throughout the duration of their hospital stay. The hospitalists also provide care to those patients who do not have a primary care physician and/or are uninsured.

- Intensivists**
 The FMH Intensivist program was initiated as an adjunct service for the expansion of the FMH Heart Service line. With the advent of the Interventional Cardiology Program, it was necessary to have 24/7 specialty care in the Intensive Care unit. Intensivists are physicians who have special training in critical care medicine. The specialty requires additional fellowship training for physicians who complete their primary residency training in internal medicine, anesthesiology, or surgery. Research has demonstrated that ICU care provided by intensivists produces better outcomes and more cost effective care.
- Obstetricians**
 FMH's recent designation as a Neonatal Intensive Care center has increased the number of high-risk pregnancies choosing to delivery in our BirthPlace. An increase in our demographic profile of those individuals less likely to have adequate – or any – prenatal care has also increased the probability that immediate/emergent obstetrical care be available. Our obstetric on-call schedule permits for that need 24/7.
- Emergency Physicians**
 FMH's Emergency Department is the third busiest ED in Maryland, registering over 65,000 annual patient visits. Because of the nature of our growing community, and the severity of the emergencies encountered, it is increasing necessary to provide around-the-clock physician specialty care. A variety of specialty and sub-specialty physicians are on call to provide the emergent care 24/7.
- Anesthesiologists**
 In addition to the on-site, 24/7, OB anesthesiology coverage, FMH has a “first-call” anesthesiologist available to cover emergency cases should the in house anesthesiologist be occupied with another patient. The availability of an on-call anesthesiologist has decreased the time interval between diagnoses and surgical intervention, resulting in significantly better patient outcomes.
- Interventional Cardiologist**
 FMH contracted a group of Interventional Cardiologist to provide 24-hour service for emergency angioplasty services. The Interventionalists are available 7-days a week and are serve as the Code Heart Team leaders when responding to an emergency situation.

Total Net Community Benefits by Category:

Community Health Services	\$1,403,054
Health Professions Education	\$113,096
Mission Driven Health Services	\$9,521,644
Financial Contributions	\$60,250
Charity Care	\$5,877,400
Total Community Benefit	\$16,945,444

APPENDIX 1

Charity Care Policy Information to Patients

Frederick Memorial Healthcare System posts its charity care policy and financial assistance contact information in admission areas, the FMH Emergency Department, and in all of our satellite facilities in areas where eligible patients are likely to present.

FMH provides a summary of the Charity Care Policy and financial assistance contact information to all patients at the time of admission to the hospital.

FMH admissions personnel discuss the availability of various government benefits such as Medicaid or state programs with patients and/or their family members, and they assist patients with qualification for the programs.

For Patients **Financial Assistance**

The Frederick Memorial Hospital Financial Assistance Program

Frederick Memorial Hospital is committed to being the most trusted health care provider in our community. That involves a commitment to provide accessible services to individuals who do not have the resources to pay for necessary care.

Frederick Memorial Hospital has a financial assistance program that offers free or discounted services to patients who qualify. Applications and information are available through the financial counselors, cashiers and in patient registration areas. Your hospital bill will not include fees charged by non-hospital-employed physicians. These fees will appear on separate bills, sent to your home, from the physicians who perform the services.

For more information, visit one of our patient registration areas, or call Financial Counseling at 240-566-3311.

Para Nuestros Pacientes **Ayuda Financiera**

El Programa de Ayuda Financiera del Hospital Memorial de Frederick

El Hospital Memorial de Frederick se compromete a ser el mejor proveedor de cuidados de salud en nuestra comunidad. Esto significa el cumplir con nuestro compromiso a proveer servicios accesibles a aquellas personas que no tienen los recursos para pagar por el cuidado necesario.

El Hospital Memorial de Frederick tiene un programa de ayuda financiera que ofrece a los pacientes que califican cuidado gratis o a un descuento. La aplicación y la información acerca de este programa se pueden obtener a través de nuestros Consejeros Financieros, las Cajeras, y en las áreas de inscripción del hospital. Recuerde que el cobro del hospital no incluirá cobros de los doctores que lo atendieron en el hospital. Éstos enviarán por separados sus cobros.

Para obtener más información favor visitar una de nuestras áreas de inscripción, o llame a la oficina de los Consejeros Financieros marcando el 240-566-3311.

Appendix 2

Charity Care Policy

Payment Services for FMH Patients

Frederick Memorial Hospital (FMH) is dedicated to providing patients with the highest quality of care and service. To assist our patients, and to comply with Maryland state law, FMH offers the following information.

Hospital Financial Assistance

FMH provides emergency or urgent care to all patients regardless of their ability to pay. Under the FMH financial assistance policy, you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.

FMH financial assistance eligibility is based on gross family income and family size of the patient and/or responsible person. Annual income criteria used will be 200% of the most current poverty guidelines published yearly in the Federal Register. Assets and liabilities will also be considered. Financial assistance is given in increments of 25%, 50%, 75% and 100%.

If you wish to get more information about or apply for FMH Financial Assistance, please call 240-566-4214 or download the uniform financial assistance application at http://www.hscrc.state.md.us/consumers_uniform.cfm. Financial Assistance applications are also available at all FMH registration areas.

Patient Rights

Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill. If you believe you have been wrongly referred to a collection agency, you have the right to contact the FMH business office at 240-566-3330.

You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments and it pays the full cost of health coverage for low-income individuals who meet certain criteria. In some cases, you may have to apply and be denied for this coverage prior to being eligible for FMH financial assistance.

For more information regarding the application process for Maryland Medical Assistance, please call your local Department of Social Services by phone 1-800-332-6347; TTY:1-800-925-4434; or internet www.dhr.state.md.us. We can also help you at FMH by calling 240-566-3862.

Patient Obligations

For those patients with the ability to pay, it is their obligation to pay the hospital in a timely manner. FMH makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. It is the patient's responsibility to provide correct insurance information.

If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office at 240-566-3330.

If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. It is the obligation of the patient to assure the hospital obtains accurate and complete information. If your financial position changes, you have an obligation to contact the FMH business office to provide updated information.

Physician Services

Physicians who care for patients at FMH during an inpatient stay bill separately and their charges are not included on your hospital billing statement.

Appendix 3

Description of Mission/Vision/Value Statements

While the composition of the individual FMH Mission, Vision and Value statements is not extraordinary – the orchestration of the three to create a harmonious whole – is exceptional.

FMH Mission Statement

The Mission Statement is quite ambitious, and describes in a single sentence the purpose to which the employees and staff have dedicated their professional lives. In addition to purpose, our Mission Statement characterizes the parameters within which our operations are delivered, and details the programs through which services are rendered. But more than that, the FMH Mission Statement anchors the Frederick Community by solidifying a commitment to care that has never faltered. There is a stability to the words that suggests competency, compassion and confidence. They are comforting words to the citizens of our community, and remain steadfast and true regardless of world condition or personal circumstance.

FMH Statement of Values

Our Value Statement reflects those qualities of comportment and service delivery in which we believe as an organization. These attributes dovetail with our Mission Statement in that they describe the philosophy that directs our business operations and governs our provision of care. Each statement is powerful as a stand-alone expression of purpose and belief; but together they provide the foundation upon which the Frederick Memorial Healthcare System has been built.

FMH Vision

As powerful as our Mission and Values Statements are, it is our Vision Statement that most directly governs day-to-day operations, provision of care, and the personal comportment of employees and staff. **Superb Quality. Superb Service. All the Time.**

These seven words are the ideals to which we aspire every single day. They guide our business practices, our interactions with our customers and visitors, the care delivered to every patient, and the degree of respect with which we treat one another.

Appendix 4 Mission/Vision/Value Statements

VISION

SUPERB QUALITY. SUPERB SERVICE.

All the time.

MISSION

The mission of Frederick Memorial Healthcare System is to contribute to the health and well-being of area residents by providing quality healthcare in a caring, cost efficient, safe and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

VALUES

We believe in.

Quality • Responsibility • Stewardship • Respect & Dignity
Empowerment • Honesty & Integrity • Collaboration & Teamwork

Garrett County Memorial Hospital
Community Benefits Report
Fiscal Year 2009
Evaluation Framework

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

Garrett County Memorial Hospital is licensed to operate 36 beds. The number of inpatient admissions for fiscal year 2009 was 2,602.

2. Description of the community Garrett County Memorial Hospital serves:

Garrett County Memorial Hospital (GCMH) opened its doors as a 30-bed acute care facility in May of 1950. Through the years, the buildings, equipment, staff and services have increased in size and complexity, but the Hospital's goal has remained constant: to provide quality health care services to the residents and visitors of Garrett County.

GCMH has a 54-year track record of providing innovative, community-based and community-involved health care. The Hospital has a strong team of family practice physicians and renders high-quality primary care services in the emergency department. Garrett County is designated by the State and Federal Government as both a "Medically Underserved Area" and a "Health Professional Shortage Area."

In addition to serving the people of Garrett County, GCMH is available to communities of nearby West Virginia and Pennsylvania. GCMH is the only source of acute care in this rural, mountainous area of Western Maryland. There are only three U. S. designated highways that traverse the county. These winding, two lane roads make travel difficult, especially during the winter months. With average annual snowfalls of 86 inches, and some years with over 200 inches, travel via automobile and ambulance is often treacherous and air transport to tertiary care facilities may not be possible for a number of days. The nearest referral hospitals are sixty miles to the east or west.

The population of Garrett County in 2008 was 29,698 with a median household income of \$43,496. Fifteen-percent of the residents in Garrett County live in poverty. Twenty-seven percent of the hospital's patients are uninsured or Medicaid recipients.

3. Identification of Community Needs:

In 2008, staff from Garrett County Memorial Hospital and the Garrett County Health Department worked together with the Garrett County Health Planning Council to define strategies for communities and agencies to collaborate and improve the health of Garrett County residents.

The members selected to use a model adapted from the National Association of County and City Health Officials and the Centers for Disease Control and Prevention called Mobilizing for Action through Planning and Partnerships (MAPP). MAPP is a community-wide strategic planning tool

for improving community health. Through the MAPP process, communities make every effort to achieve optimal health by assessing their strengths, resources, and needs in order to develop and implement a strategic plan for public health improvement.

4. Major Needs Identified:

Based on the findings from the MAPP process, four action-goals were identified:

- Strengthen and support those components of our public health system that are fragile because of funding, workforce capacity, demographic shifts, etc.
- Empower, educate, and motivate Garrett County residents to lead a healthy lifestyle and prevent harmful behaviors such as substance abuse and domestic violence.
- Achieve and maintain optimal health and independence for vulnerable populations.
- Ensure healthy living and working conditions for Garrett County residents by protecting and increasing our natural and built resources as our population grows.

5. Description of the decision making process to determine which needs in the community need to be addressed through community benefits activities:

The Wellness Department of Garrett County Memorial Hospital has evaluated the action-goals from the MAPP process and continues to develop positive interventions to improve the health of our community. The management of the hospital is informed of these initiatives on a routine basis and community benefit activities are determined.

6. Community Benefit program initiatives that address the needs listed in #4:

An example of the hospital's community benefit initiatives reflecting evidence-based needs is the Community Blood Screening Program, which is offered once a year, to benefit those individuals who are uninsured or underinsured. The program offers a comprehensive series of blood tests to the participant at a substantially lower cost than a laboratory's rates.

In addition to the Community Blood Screening Program, GCMH continues to bring screening services to the work place. First United National Bank & Trust, Garrett College, Mettiki Coal and Garrett County Board of Education are some of the companies that have contracted with the Wellness department of Garrett County Memorial Hospital to provide blood screening services for all of its employees.

Other Community Benefit programs that address the needs of the county would be the various programs offered through the hospital's Family Center Maternity Suite. Included is the Parent Help Line, where parents can call the staff of the Family Center Maternity Suite to ask questions concerning the care of their newborn. This service is available twenty-four hours a day, free of charge regardless of where the child was born.

This is the purpose of all community benefit activities, to empower, educate, and motivate Garrett County residents to lead a healthy lifestyle. We want to improve our community's health one person at a time.

7. Provide a description of the efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives:

Both the Accounting and Wellness departments are responsible for monitoring how the hospital's activities fulfill the goals identified in the plan through regular progress reporting. At this time, programs are enhanced, revised, discontinued or repeated based on levels of interest, participation and outcomes. The community is kept informed of activities provided by the hospital through press releases and promotional efforts.

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

Garrett County Memorial Hospital's (GCMH) size and rural location limits the number physicians who provide specialty services. In addition, the expected physician shortage over the next five to ten years in Maryland's rural areas creates another challenge to the hospital. It has been noted that fifty-percent of the county's current physician group will be eligible for retirement within the next ten years. Rural Maryland counties are at disadvantage when it comes to recruiting physicians, because they lack the resources to offer incentives for setting up a practice.

Garrett County has been designated a federal medically underserved area and has a "low income" designation as a Health Professional Shortage area for primary care. Approximately eighteen-percent of the population has no form of health care coverage. In the past, most underserved residents of the area came to the hospital's Emergency Department for treatment of minor illnesses since we provide care regardless of ability to pay. With the opening of a Federally Qualified Health Center in Garrett County in 2006, these same individuals can now obtain quality health care services regardless of their ability to pay.


Since GCMH does not employ physicians for certain specialty areas, some patients requiring Neurology, Pulmonary, and Cardiology services, as well as major trauma patients, are stabilized and transferred to an appropriate facility for treatment. Even though there are gaps in the availability of specialty providers, GCMH will always strive to offer high-quality healthcare services to all patients.

Garrett County Memorial Hospital
Community Benefits Report
Fiscal Year 2009

Appendix 1: Describe your hospital's Charity Care policy and how the hospital informs patients about their eligibility for assistance.

Garrett County Memorial Hospital's "Caring Program" offers financial assistance to underprivileged, underemployed, and/or underinsured patients for healthcare services they may not be able to pay for due to circumstances beyond their control. The qualifying criteria are wide-ranging so the hospital can apply maximum flexibility to offer financial assistance to program applicants.

Garrett County Memorial Hospital informs patients about the Caring Program through various methods. Signs are posted in the reception areas of the Patient Financial Services Department and Admissions Department. Information is printed in the Patient Handbook and on the hospital's website. Ads are placed in the local newspaper, at least on an annual basis, informing the community of the hospital's caring Program. Automated monthly statement messages are generated to advise individuals about the Caring Program and encourage them to apply for financial assistance.

	Department: Patient Financial Services	Policy Title: Caring Program (Financial Assistance)	
	Original Date: 09/01/01	Policy Number: 8520.000	Page Number: 1 of 7
	Effective Date: 09/01/01	Reviewed/Revised Dates: 06/03/03; 04/01/06; 03/14/08; 01/20/09;03/06/09	
Approval Signature & Title:	Approval Signature & Title:	Approval Signature & Title:	
Katherine Rhoden, Director Patient Financial Services Date: 03/06/09	TracyD. Lipscomb, CFO, VP Finance Date:		

Policy Statement:

The "Caring Program" enables Garrett County Memorial Hospital (GCMH) to offer financial assistance for healthcare services rendered to underprivileged, underemployed, and/or underinsured patients who have difficulty providing themselves with life's necessities, i.e., food, clothing, shelter, and healthcare. In an effort to assist those in need and to further the hospital's charitable mission, GCMH has established a financial assistance program to allow the write-off of unpaid account balances upon determination of the "Caring Program" eligibility. Individuals with a demonstrated inability to pay rather than unwillingness to pay are eligible to apply for the financial assistance program at GCMH.

Objective:

The qualifying criteria are minimal and broad so GCMH can exercise maximum flexibility to offer financial assistance to program applicants. GCMH retains the right to use its discretionary judgement in making final decisions regarding eligibility to the "Caring Program." Eligibility to the "Caring Program" represents "free" healthcare and as such, is included as part of the hospital's charitable mission.

Guidelines:

- A. GCMH will grant financial assistance for eligible applicants for medically necessary services that are urgent, emergent, or acute in nature. Services included in the program are emergency room visits, inpatient admissions, and outpatient laboratory, radiology and cardiopulmonary services. Elective surgical procedures may also be eligible for financial assistance for eligible applicants through the "Caring Program" and will require individual consideration by management.

- B. Screening for Medicaid eligibility is required.
 - a. If Medicaid eligibility is likely, the patient must apply for Medicaid within 60 days of the service date or the date the patient assumes financial responsibility for the services rendered.
 - b. If Medicaid eligibility is not likely, i.e., no extraordinarily high medical bills, no children in the household, no disability, etc., a formal denial from Medicaid is not required; however, all Patient Financial Services Representatives have the authority to request the Medicaid application whenever there is a chance of Medicaid eligibility.
 - c. Patients who qualify for Maryland or West Virginia Medicaid's Primary Adult Care (PAC) Program do not need to apply for Medicaid or provide proof of income as their financial need has already been proven to the State.
 - d. Parents of children with Medical Assistance do not need to apply for Medicaid as the State has already determined they are not eligible.
 - e. Any patient who is not eligible for Medicaid may apply for financial assistance through "The Caring Program."
 - f. Any patient who is eligible for Medicaid but has a "spend-down" requirement to meet before Medical Assistance begins to cover charges may apply for "The Caring Program."
 - g. Incomplete applications and/or failure to apply and follow through with the Medicaid application will result in a denial from the "Caring Program."
- C. The "Caring Program" application must be completed and returned via the U.S. Postal Service, delivered in person, or completed over the telephone within 60 days of date the patient becomes financially responsible for services rendered.
 - a. All applications require the signature of the individual who is financially responsible for the unpaid bills as well as proof of financial information used to determine program eligibility. If the applicant cannot read/write, PFS will read the policy to the applicant and assist with the form completion, requiring only a witnessed signature of an "X."
 - b. Any additional information requested by a Patient Financial Services Representative must be returned to the Patient Financial Services (PFS) Department within 30 days of the request. If the information is not returned within that time, the patient is ineligible for assistance through the "Caring Program" for those service dates that related to the application.

- D. In order for an individual to qualify, he/she must have exhausted all other sources of payment, including assets easily liquidated, i.e., bank accounts, money market accounts, Certificate(s) of Deposit, savings bonds, etc. Calculation of the applicant's income excludes net assets of \$10,000 or less.
- E. The following definitions of family size and income will assist in the "Caring Program" eligibility determination:
1. Family: A family is a group of two or more persons related by birth, marriage, or adoption, living in the same residence, sharing income and expenses. When a household includes more than one family, GCMH will use each separate family's income for eligibility determination.
 2. Individual: An individual is a person who is emancipated, married, or 18 years of age or older (excluding inmates of an institution) who is not living with relatives. An individual may be the only person living in a housing unit, or may be living in a housing unit with unrelated persons.
 3. Income: Before taxes from all sources, as follows:
 - a. Wages and salaries
 - b. Interest or dividends
 - c. Cash value of stocks, bonds, mutual funds, etc.
 - d. Net self-employment income based on a tax return as calculated by GCMH. Non-cash deductions (depreciation), income tax preparation fees, expenses for use of part of a home, entertainment, and any other non-essential expense will be subtracted from the reported business expense deductions in determining financial need and program eligibility.
 - e. Regular payments from Social Security, railroad retirement, unemployment compensation, veterans' payments, etc
 - f. Strike benefits from union funds
 - g. Workers' compensation payments for lost wages
 - h. Public assistance including Aid to Families with Dependent Children
 - i. Supplemental Security Income
 - j. Non-Federally funded General Assistance or General Relief money payments
 - k. Alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household

- l. Private pensions or government employee pensions (including military retirement pay)
- m. Regular insurance or annuity payments
- n. Net rental income, net royalties, and periodic receipts from estates or trusts
- o. Net gambling or lottery winnings
- p. Capital gains
- q. Assets withdrawn from a financial institution one year or less before program application
- r. Proceeds from the sale of property, a house, or a car
- s. Tax refunds
- t. Gifts of cash, loans, lump-sum inheritances
- u. One-time insurance payments or compensation for injury

F. Eligibility for 100% financial assistance at GCMH is available to applicants whose income is at or below 150% of the current Federal Poverty Guidelines when the applicant has less than \$10,000.00 in net assets. Any Individual treated at GCMH, regardless of permanent State residence, may apply for financial assistance through "The Caring Program." Partial assistance is available with incomes up to 200% (after the \$10,000 net asset exclusion) of the Federal Poverty Guidelines, as follows:

- 1. Eligibility for 95% financial assistance is available for incomes at 151%-155% of the Federal Poverty Guidelines.
- 2. Eligibility for 85% financial assistance is available for incomes at 156%-160% of the Federal Poverty Guidelines.
- 3. Eligibility for 75% financial assistance is available for incomes at 161%-165% of the Federal Poverty Guidelines
- 4. Eligibility for 65% financial assistance is available for incomes at 166%-170% of the Federal Poverty Guidelines.
- 5. Eligibility for 55% financial assistance is available for incomes at 171%-175% of the Federal Poverty Guidelines.
- 6. Eligibility for 45% financial assistance is available for incomes at 176%-180% of the Federal Poverty Guidelines.
- 7. Eligibility for 35% financial assistance is available for incomes at 181%-185% of the Federal Poverty Guidelines.
- 8. Eligibility for 25% financial assistance is available for incomes at 186%-190% of the Federal Poverty Guidelines.

9. Eligibility for 15% financial assistance is available for incomes at 191%-195% of the Federal Poverty Guidelines.
 10. Eligibility for 5% financial assistance is available for incomes at 196%-200% of the Federal Poverty Guidelines.
- G. If ineligibility results from the financial guidelines stated above or the applicant is eligible for partial assistance only and the applicant indicates an inability to pay the outstanding balance, the applicant will be asked to complete a financial statement to determine if his/her available monthly income is consumed by the daily necessities of life. Individual consideration of eligibility for applicants in this situation will apply to assure members of our community who cannot pay for their hospital care are included in our financial assistance program.
1. Mutually agreed upon interest-free monthly payments (based on available income after expenses) will be discussed and offered to those who are otherwise ineligible for the "Caring Program" and have expressed a need for an extended repayment period.
- H. Individuals with a need for financial assistance who are unable to apply or do not have an individual to apply on their behalf are not overlooked for financial assistance through the "Caring Program." The following indicates the available methods for GCMH to obtain information needed for eligibility determination in these situations:
1. Telephone contact, including TTY communication and verbal information about the individual's financial situation
 2. Discussion of the situation with the individual's state Medicaid office to obtain a preliminary determination of Medicaid eligibility
 3. Research the applicant's other GCMH accounts
 4. Work with the next of kin or other person able to speak about the individual's financial condition
 5. Have personal knowledge of the individual's living situation
 6. Observe applicant's appearance
- I. Documentation requirements include the application for financial assistance, proof of income and/or any unusual expenses, financial statement, release of information, etc.
- J. GCMH has posted signs publicizing the Program at all registration areas and in the reception area of the Patient Financial Services (PFS) Department. Information about the program is printed in the "Patient Handbook" and on the hospital's web site. Monthly self-pay statements include a pre-printed notification of the financial assistance program and instructions for applying to the "Caring Program." Automated monthly statement messages also encourage applications for financial assistance. Whenever a patient/guarantor inquires about the availability of a financial assistance program at GCMH, staff members should refer the inquiry to the PFS Department; offer to supply

the telephone number of the PFS department, and/or direct patients to the PFS department. All PFS personnel review the financial assistance policy annually, at a minimum, discuss policy changes at departmental meetings, and have access to the current financial assistance policy during all work hours.

- K. GCMH will post, at least on an annual basis, an ad in the local newspaper informing residents of the availability of its financial assistance program, or upon approval of updates to the program guidelines. Printed copies of the application forms are available at the time of registration or at any registration location. Copies of the financial assistance policy and applications are also available in the Patient Financial Services Department upon request and may be picked up in person or mailed to your home.
- L. Self-pay accounts will be screened for financial assistance regardless of the dollar amount of the account; however, self-pay balances resulting from insurance company payment to the individual or from the individual's failure to respond to an insurance or GCMH query will not be considered eligible for the program.
- M. Financial assistance is not available for any account already referred to a collection agency or attorney for formal collection action. All third party collection agencies receive a copy of the financial assistance policy on an annual basis, or when changed, which ever occurs first.
- N. Financial assistance through the "Caring Program" will continue for a period of one year after the eligibility approval date, unless income significantly changes, when based on fixed incomes such as social security or retirement, or the tax return of a self-employed individual. Eligibility based on the guarantor's past three months of income will qualify for a six-month eligibility to the Caring Program unless the income of the applicant changes significantly.
 - 1. After the designated period of eligibility, a new application for financial assistance must be completed/signed by the guarantor. Fixed income verification is required annually and applies for one calendar year (January through December) for eligibility determination if the applicant completes the renewal application at the appropriate time.
 - 2. Upon application approval, GCMH will write-off eligible account balances. GCMH may reverse the determination of eligibility if any of the information supplied on the application was incorrect.
 - 3. If an individual's financial status deteriorates and he/she cannot pay the agreed upon monthly payment amount, GCMH will again review (upon request) the individual's eligibility to the program.
 - 4. Once GCMH has determined that an account is eligible for financial assistance or is not collectible, that financial classification is final.
 - 5. GCMH will post payments received from any source (after the eligible account balance is written-off) to the appropriate hospital account and will adjust the amount of the financial assistance write-off accordingly. GCMH will not refund

self-pay payments received before or after the approval of the financial assistance application.

- O. Individuals who have incurred hospital expenses for care and/or treatment ordered through the Garrett County Health Department (GCHD) as part of the Garrett County Cancer Control Program shall be eligible for financial assistance for balances remaining after payment from GCHD. GCHD is responsible for notifying GCMH of all claims that fall into this category.
- P. Upon receipt or notification of an individual's or a guarantor's notice of bankruptcy filing, all accounts with an outstanding self-pay balance for that individual or guarantor will become eligible for 100% financial assistance through the Caring Program.
- Q. Self-pay accounts for individuals who are deceased and have no assets or estate shall be eligible for 100% financial assistance through the Caring Program.

Garrett County Memorial Hospital
Community Benefits Report
Fiscal Year 2009

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

Garrett County Memorial Hospital's (GCMH) mission is to provide safe, high-quality healthcare services to the community. This is accomplished by using a continuous process of responding to the health and wellness needs of our region. GCMH is able to recruit and retain talented and caring employees. GCMH also believes in the process of never-ending improvements in order to provide a high level of care and resources to the community.

Our mission and vision statement is displayed throughout the hospital in every department and public area.

**GARRETT COUNTY
MEMORIAL HOSPITAL
MISSION STATEMENT**

OUR MISSION

**To promote the health of our regional community and provide
safe, high-quality care and health services for our patients.**

**GARRETT COUNTY MEMORIAL HOSPITAL
VISION STATEMENT**

Garrett County Memorial Hospital:

- 1. Will be viewed as the provider of choice in the region and be recognized for our progressive personal service encompassing the full continuum of care.***
- 2. Will be known for our excellence across the region.***
- 3. Will continue as a community partner and resource, striving to proactively respond to the health and wellness needs of our region.***
- 4. Will provide a high level of community service and stewardship for the resources with which we have been entrusted.***
- 5. Will recruit and retain the most talented and caring employees through continuous efforts to be the employer of choice in the region through employee friendly programs and policies.***
- 6. Will collaborate and partner with other providers, as needed, to achieve our strategic direction.***
- 7. Will be characterized by cohesive leadership, efficiency, sound management, financial strength and a positive work environment.***
- 8. Will maintain a collaborative partnership between the Board of Governors, Medical Staff and Administration.***

9. *Will strive to exceed the expectations of those we serve.*
10. *Will be dedicated to the process of never-ending improvement.*
11. *Will be more obvious in our expression and fulfillment of our charitable mission and community benefit.*
12. *Will be dedicated to providing the best technological tools possible to assist our caregivers in providing the highest level of medical care achievable within our rural location.*



FY 2009 Community Benefit Report Supplemental Narrative

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

	FY 2009 <u>Licensed Beds</u>
Medical-Surgical Acute	145
Gynecologic (GYN)	27
Definitive Observation/Stepdown	34
Medical Surgical Intensive Care	24
Medical Cardiac Critical Care	<u>12</u>
Total Medical-Surgical Acute Care	242
<u>Other</u>	
Obstetric (OB)	60
Pediatric	<u>8</u>
Licensed Bed Capacity	310
Newborn Nursery	60
Neonatal Intensive Care	30
Skilled Nursing Facility	25
	FY 2009 Inpatient <u>Admissions</u>
Med-Surg Acute/OB/Pediatric	25,817
Skilled Nursing Facility	649

2. Describe the community your organization serves.

- a) See attached Powerpoint file titled "Supplemental Question 2-GBMC".

Supplemental Question#2

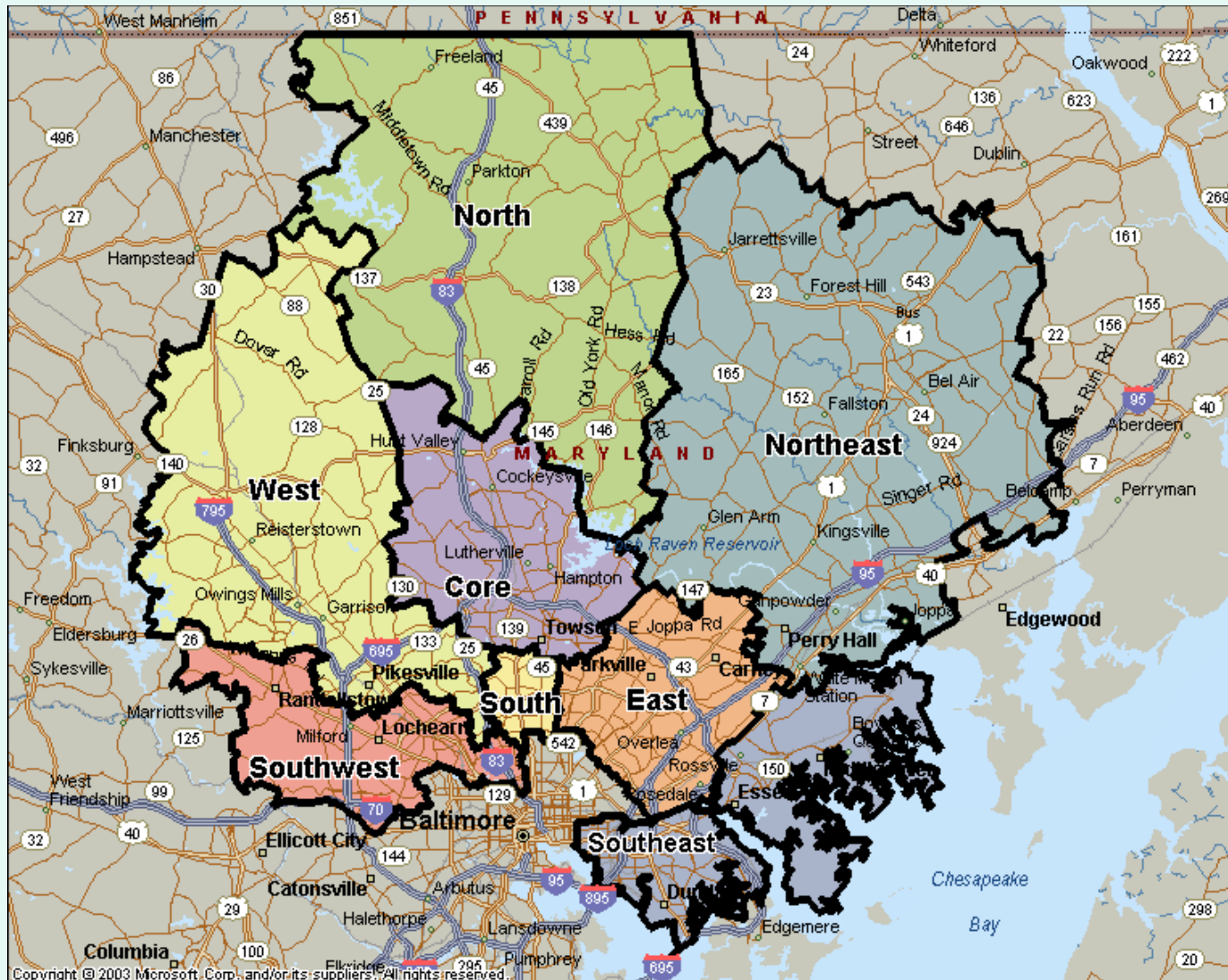
Information Regarding the Community Served
by Greater Baltimore Medical Center

GBMC's & It's Community

- **Greater Baltimore Medical Center, Inc. (“GBMC”) is a private, not-for-profit, 310-bed, regional medical center.**
- **Located in Towson, Maryland, a suburban Baltimore County community two miles north of Baltimore City.**
- **GBMC's primary service area includes all of Baltimore County, the northern portion of Baltimore City, and portions of Carroll and Harford Counties.**
- **In 2008, Baltimore County had an estimated population of 785,618.**
- **The population in GBMC's service area has traditionally been affluent.**
 - Baltimore County ranked 2nd among MD counties for the highest income per capita in 2007.
 - The 2007 per capita income in Baltimore County was 34% high than the nation.
 - But,in 2007 Baltimore County had:
 - 8% of the population in poverty
 - 9% of related children under 18 were below the poverty level
 - 8% of people 65+ years old were below the poverty line
 - 5% of all families lived in poverty
 - 14 % of families with a female householder and no husband present had incomes below the poverty level
- **In FY 2009GBMC's service area patients were 1.47% self-pay and 5.26% Medicaid.**
- **GBMC's patients in FY 2009, were 1.9% self-pay and 5.1% Medicaid.**

GBMC Eight Market Zones

GBMC FY 09



MD Healthcare Commission

TABLE 1: Health Insurance Coverage of the Nonelderly, 2006-2007

			Percent Distribution by Coverage Type ^b			
		Nonelderly (in Thousands*)	Employment- based	Direct- purchase	Medicaid & Other Public	Uninsured
Total Nonelderly^a		4,940	69	5	11	15
Age						
	Children—Total	1,460	65	4	20	10
	Adults—Total	3,480	71	5	7	17
	Adults 19-24	500	54	10	7	29
	Adults 25-29	350	58	3	8	31
	Adults 30-34	330	74	4	5	17
	Adults 35-44	820	73	4	6	17
	Adults 45-54	850	77	4	7	12
	Adults 55-64	630	78	4	10	8
Gender						
	Female	2,500	70	5	11	14
	Male	2,430	68	4	11	17
Annual Family Income^c						
	Up to \$30,851	860	27	5	31	37
	\$30,852-\$60,208	1,060	64	6	12	18
	\$60,209-\$104,546	1,370	77	5	7	12
	\$104,547+	1,650	87	4	3	6

NOTE:

This survey focuses on Maryland's nonelderly (under age 65) population because nearly all of the elderly are covered by Medicare.

MD Healthcare Commission

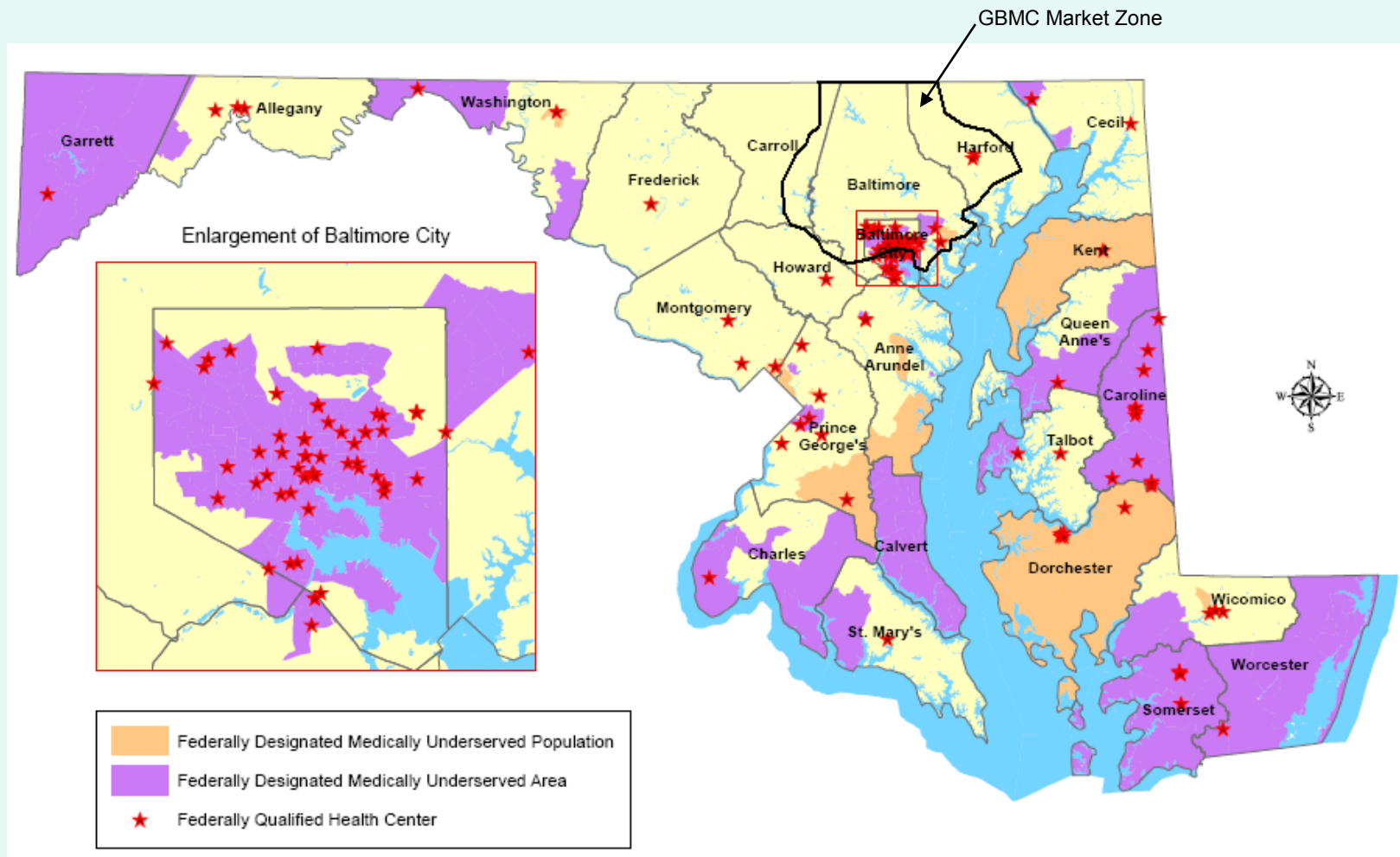
TABLE 1: Health Insurance Coverage of the Nonelderly, 2006-2007

		Percent Distribution by Coverage Type ^b			
	Nonelderly (in Thousands*)	Employment- based	Direct- purchase	Medicaid & Other Public	Uninsured
Total Nonelderly^a	4,940	69	5	11	15
Family Poverty Level^d					
Poor (≤100%)	430	17	4	43	37
Near Poor (101% to 200%)	520	38	4	24	34
Low Moderate (201% to 300%)	700	59	5	13	23
Mid Moderate (301% to 400%)	720	69	6	8	17
High Moderate (401% to 600%)	1,110	83	5	5	8
High (601%+)	1,450	90	3	2	4
Family Work Status^e					
3+ Full-time Adult Workers	240	71	1	4	23
2 Full-time Adult Workers	1,480	82	3	4	10
1 Full-time Adult Worker	2,440	72	5	9	15
Only Part-time Adult Worker(s)	140	41	12	23	24
Only Part-year Adult Worker(s)	330	43	8	26	23
No Adult Workers	310	21	5	44	30
Highest Educational Level of Adults in Family					
No High School Diploma	290	28	3	23	46
High School Graduate Only	1,060	50	4	20	25
Assoc. Degree/Some College	1,250	69	6	11	13
BA/BS Degree	1,180	79	5	6	10
Graduate Degree	1,160	86	4	4	6
Race/Ethnicity^f					
White, Non-Hispanic	2,740	78	5	8	9
Black, Non-Hispanic	1,490	60	4	18	18
Hispanic (Any Race)	400	41	3	10	46
Asian/Other, Non-Hispanic	300	74	4	7	16

NOTE:

This survey focuses on Maryland's nonelderly (under age 65) population because nearly all of the elderly are covered by Medicare.

Maryland Medically Underserved



GBMC

FY08 / 09 Revenue

Sub-Total Self Pay / Medicaid

<u>Primary Insurance Group</u>	<u>FY08 Total Gross Rev</u>	<u>% Total</u>	<u>FY09 Total Gross Rev</u>	<u>% Total</u>
Self Pay	7,295,615		7,744,250	
Medicaid	4,702,969		6,711,416	
Medicaid Pending	1,503,843		1,874,609	
MCO	9,646,704		12,147,287	
Sub Total:	23,149,132	6.3%	28,477,562	7.0%
Other	346,825,971	93.7%	375,810,436	93.0%
Total:	369,975,103	100.0%	404,287,998	100.0%

3. Identification of community needs:

- a) Describe the process used by your hospital for the health needs in your community, including the date when most recently compiled.

During fiscal year 2006 the Greater Baltimore Medical Center (GBMC) Community Needs Advisory Committee compiled a GAP assessment designed to evaluate and understand the unmet healthcare needs of the GBMC community, and how GBMC, given its service orientation, might be best served to assist in meeting the identified unmet needs.

Because Baltimore County has not prepared a formal community needs assessment, GBMC borrowed statistical and medical incidence data from the 2004 Carroll County community needs assessment, as well as various other national data.

- b) In seeking information regarding community health needs, did you consult the local health department?

During preparation of the GAP assessment, GBMC contacted the Baltimore County department of health regarding the use of a county-wide needs assessment and was informed that the county did not compile such an assessment. However, GBMC, in order to update the fiscal year 2006 GAP assessment, recently met with the Baltimore County Department of Health and Department of Aging. While a formal community needs assessment is still not prepared for the county, statistical incidence information on select disease categories can be provided by the County Health Department. The purpose of the meeting is to establish a cooperative relationship with the County Health Department and seek information to ensure that GBMC's community initiatives are focused on areas of unmet community need.

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

- a) Obesity/Weight-Management – focuses on growing incidence of inactive lifestyles and diet management, which when not managed properly lead to significant increases in diabetes, obesity and other health related issues.
- b) Obstetrics/Gynecology – centers primarily on the sexual behavior of adolescents and associated teenage pregnancy rates.
- c) Geriatrics – addresses the increasing percentage of the population aged 65 years and older, including the increased percentage living at or below federal poverty guidelines. This particular population is challenged

regarding access to primary care services due to transportation as well as health related issues. By not properly accessing care at a primary, or preventive stage, this population often presents to healthcare providers with advanced disease conditions.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?
 - GBMC maintains a inter-disciplinary Community Needs Advisory Committee, with representation from Outreach Services, Compliance, Finance, Legal and other clinic based areas, which meets monthly to evaluate, debate and approve community based initiatives. In addition, the Committee reports directly to the President & Chief Executive Officer and also maintains two Board members as members of the Committee.
6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?
 - a) Geriatric Nurse Practitioner – GBMC hired a nurse practitioner whose sole responsibility is to provide education and primary care services (physical history, medication management assistance, blood pressure screenings and seasonal vaccinations) at Towson area low-income senior living facilities. This was a service that had at one-time been provided by Baltimore County, but was discontinued a number of years ago.
 - b) American Diabetes Association (ADA) Partnership – Over the last three years GBMC has contributed \$50,000 to the ADA Youth II diabetes initiative. The program is designed to enroll qualifying participants in targeted geographic regions of Baltimore County and Baltimore City. Once enrolled, the participants are provided information and access to resources designed to improve daily routines, specifically diet and exercise.
7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major community benefit program initiatives.
 - The recent major initiatives undertaken by GBMC and described in the answer to question #6 have not yet been evaluated. Specifically, it was recognized that each of these programs would take a period of time to build volume and start to incur measurable and quantifiable results. Nonetheless, an element of each initiative is the tracking of encounter data, and in the case of the Geriatric Nurse Practitioner the type of services provided, to evaluate the effectiveness of each program to determine if continued funding is desirable.

8. Provide a written description of gaps in availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
 - As noted in previous years, GBMC continues to experience difficulty in providing anesthesia, obstetrical, and orthopedic services to Medicaid and uninsured patient populations.
9. If you list physician subsidies in your data, please provide detail.
 - GBMC owns and operates a physician practice that is committing to ensuring all patients have appropriate access to OB/GYN care. Accordingly, the practice operates with an annual loss due primarily to its provision of care to medically underserved patients. The annual operating loss is claimed as a community benefit.

Appendix 1**FY 2009 Community Benefit Report Filing**
Description of Financial Assistance Policy

GBMC has taken significant measures to ensure that its Financial Assistance Policy is both visible and accessible to patients by enacting the following measures:

1. Availability of Applications & Brochures

- Via website
- All hospital patient registration areas; including admitting, emergency department, laboratory stations, clinics and radiology services
- GBMC owned physician offices
- Billing Office
- Included in each billing statement to patient

In addition, to the availability of applications and brochures, signs describing the existence of a Financial Assistance Policy and opportunity for financial assistance are also prominently displayed throughout the hospital.

2. Direct Assistance

Utilizing the admitting and insurance verification process, prior to discharge, the Patient Financial Services department attempts to assist many patients with financial evaluations in order to determine the availability for financial assistance and/or qualifying insurance coverage. In addition, during the account resolution process, staff is also trained to evaluate a patient's unique circumstances and attempt to direct patients to financial assistance when appropriate.

GBMC will also assist patients in enrolling for State Medical Assistance coverage.

3. Education

To ensure that employees are qualified to direct patients in accessing financial assistance, new employees and volunteers are specifically educated during new-hire orientation programs on how to obtain financial assistance applications and brochures.

Appendix 2

Greater Baltimore Medical Center **Patient Financial Assistance Services** **Financial Assistance Policy**

I. PURPOSE

To establish guidelines assuring consistency in the implementation of the Financial Assistance Program.

II. POLICY

GBMC recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap, military status, or other discriminatory factors.

The Financial Assistance procedures are designed to assist uninsured individuals or individuals who qualify for less than full coverage under federal, state or local programs, or individuals whose patient balances after insurance exceed their ability to pay.

While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the Financial Assistance Program.

A. Eligible/Ineligible Services

1. Services considered medically necessary are covered under the program
2. Services considered elective (i.e. cosmetic) are not covered under the program unless directly to related or part of a medically necessary procedure
3. Applicants meeting eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration

B. Referral Sources

1. Financial Assistance referrals will generally originate in the Insurance Verification, Advocacy and Collection/Insurance departments accompanied with a **Financial Evaluation** (Attachment #1) and **Medical Assistance Eligibility Check List** (Attachment #1a)
2. Other referral sources include social services, physician offices, administration, etc.
3. GBMC recognizes the importance of communicating the availability of the

Financial Assistance Program to all patients

- a. The Financial Assistance Application and brochures explaining the program are located on the GBMC website
- b. Brochures and applications are available in all GBMC owned physician offices and in all hospital registration areas
- c. All new employees and volunteers are educated during their orientation programs with regard to the Financial Assistance Program and how to assist patients in obtaining applications and brochures

C. Financial Eligibility Criteria

- 1. Eligibility is based on gross household income
- 2. Gross household income is defined as wages and salaries from all sources before deductions
- 3. Other financial information such as liquid assets and liabilities are considered
- 4. Annual household income criteria is 300% of the current poverty guidelines published in the Federal Register
- 5. Applicants that exceed established household income levels may still be eligible when additional factors such as disposable net income are considered (See “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines”)

D. Household Income

- 1. Household Income to be considered
 - a. All wages and salaries
 - b. Social Security, veteran’s benefits, pension plans, unemployment and worker’s compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home
 - c. Generally, the availability of liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc. exceeding 2 months of living expenses will be considered (referred to in the policy as Liquid Assets)

- d. Based on individual circumstances, allowances can be made to have liquid assets exceed the two month test up to \$25,000

2. Proof of Household Income (Attachment #2)

- a. One or more of the following items may be requested from the applicant to verify income for each income producing member of the household. Monthly household income is prorated to determine annual household income level.
- b. Two recent pay stubs reflecting year-to-date earnings for each family member who is a guarantor or could be deemed responsible for the account.
- c. Most recent income tax return(s) with W2s
- d. Social Security Award Letter(s)
- e. Most recent unemployment insurance stub
- f. Two most recent checking and savings account statements
- g. Two most recent investment statements (money market, CD, stocks, etc.)
- h. Letter from federal, state or local agency verifying the amount of assistance awarded
- i. Applicants claiming zero household income must supply proof of how their living expenses are paid with a notarized letter of support. Cancelled checks and/or receipts may also be required if another individual is paying patient's bills
- j. Medical Assistance denial or spend-down determination letter
- k. Identified asset transfers within a 12 month period of application may be factored into determining eligibility.
- l. Other pertinent household income verification documentation as required

E. Expenses

- 1. Expenses to be considered (also see "Questionable Expenses" under "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

2. All reasonable living expenses (mortgage/rent, utilities and loan/credit card payments)
 - a. Either land-line telephone or cell phone bill will be considered (not both)
 - c. A monthly car payment of up to \$450 for one car is allowed
The maximum allowance per family (2 adults) is \$900
Any amount over the above allowance will be considered within the miscellaneous allowance
 - d. Payments for recreational items such as boats, motorcycles, etc. are not allowable expenses Exception: if motorcycle is only source of transportation
 - e. Expenses for Cable TV, Dish TV and/or Internet are considered within the miscellaneous allowance
 - f. Expenses for second homes are not allowable expenses (however, income from rental properties will be counted as Household Income)
 - g. \$150 food allowance will be given for patient; and \$75 food allowance for each additional family member
 - h. \$300 miscellaneous allowance will be given for ancillary living expenses (i.e.: gas for automobile, grooming items, automobile maintenance, tuition and tithing)
3. Medical expenses
 1. Up to \$100 in prescription expenses per person will be considered without receipts
 2. Prescription expenses that exceed \$100 per person cannot be considered unless patient provides receipts for the two prior months
 3. Medical expenses are considered upon proof from patient of active payment arrangements

III. PROCEDURES

A. Application Process

1. Patients may request Financial Assistance prior to treatment or after billing
 - a. A new application must be completed for each new course of treatment with the following exceptions:

Inpatient and outpatient Medicare patients are certified for one year (see “Medicare Patients”)

Inpatient and outpatient non-Medicare patients are certified for 6 months. However, if it is determined during the course of that period that the patient meets Medical Assistance eligibility criteria they are required to pursue Medicaid prior to receiving additional Financial Assistance

Mitigating circumstances impacting eligibility period are identified. (examples include favorable changes in the applicants income, winning a lottery, receiving notable inheritance, etc..) These determinations are made at the discretion of the Collection Manager and/or Director of Patient Financial Services.

3. At the time of application all open accounts are eligible for consideration with the potential exception of patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)
4. The signed/completed **Financial Evaluation** is referred to the Financial Assistance Department
 - a. Combined account balance(s) greater than \$2,500
 1. Completed **Financial Evaluation**
 2. Proof of household income
 3. Credit bureau report obtained and reviewed to verify information, develop additional sources for funds and utilized as a collection tool found
 - b. Combined account balance(s) less than \$2,500
 1. Completed **Financial Evaluation**
 2. Proof of household income
 3. Credit bureau report may be obtained and reviewed if household income and/or household expense discrepancies are found
 - c. Accounts are approved or denied based on household income criteria and applicant cooperation

B. Household Income Criteria for Financial Assistance Approval / Denial

1. Combined gross household income less than 300% of the poverty guidelines
 - a. Applicants are eligible for 100% Financial Assistance
 - b. However, applicants with liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc., not exceeding \$25,000, who meet the income eligibility requirements, will be considered for assistance at the discretion of the Director of Patient Financial Services and/or the Financial Assistance Committee. Inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for assistance.
 - c. Applicants with liquid assets (described above) exceeding \$25,000, may not qualify for assistance. However, at the discretion of the Chief Financial Officer, inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for full or partial assistance
2. Combined gross household income greater than 300% of the poverty guidelines and the patient is still unable to make acceptable payment arrangements (minimum - \$25 per month)
 - a. Applicants are reviewed on a case-by-case basis (see “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines”)

C. Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines

1. Applicants whose gross household income exceeds 300% of the poverty guidelines but state they are still unable to pay all or part of their account balance(s) may be further evaluated for Financial Assistance
2. In these cases, consideration is given to expenses, disposable net household income, total liquid assets and account balance(s)
3. Disposable net income is defined as gross household income less deductions and expenses (Program allows \$250 disposable income for one person and \$75 for each additional family member.) Disposable income (exceeding \$250 for one person and \$75 for each additional family member) will be used to determine patient’s ability to pay)
 - a. The applicant is required to supply proof of “questionable” expenses
 1. “Questionable” expenses are defined as any expense item that appears to be overstated/understated and/or not reasonable or

customary

- b. A credit bureau report is required to evaluate the application (regardless of account balance)
 - c. Patients whose disposable income is within the limits stated above and whose liquid assets do not exceed the standard (See Household Income); are eligible for 100% Financial Assistance
 - d. Patients who exceed the asset standard (See Household Income) are ineligible for Financial Assistance and need to make payment arrangements (See Resource Payment Arrangements)
 - e. Eligibility for patients who have excess disposable income is determined based on ability to satisfy outstanding balance(s) within timeframe defined (See Financial Assistance With Resource) All exceptions will be reviewed by the Director of Patient Financial Services
4. Applicants approved for 100% Financial Assistance (See “Processing Approved Applications”)

D. Financial Assistance With Resource

1. Resource amounts are determined based on the applicant’s ability to pay a portion of their account balance(s) without causing undue financial hardship \ using the following guidelines
2. Outstanding balance(s) owed to GBMC are divided by excess disposable income to determine the number of months needed to pay the outstanding balance(s) in full
3. Excess disposable income determines the amount of the monthly payment (See Resource Payment Arrangements for standards)
4. Outstanding balance(s) that cannot be satisfied within 24 months will be reduced by the difference between the total outstanding balance(s) and the total required patient payment amount (excess disposable income multiplied times 24 months)
5. All resource amounts are reviewed and approved by the Director and Collection Manager
6. Approval process
 - a. The completed **Financial Evaluation** (including resource recommendation), **Authorization Form** (Attachment #3) and documentation is forwarded to the Collection Manager

- b. The Collection Manager will ensure that all required authorization signatures are obtained
- 7. When authorization is obtained the patient is mailed a **Financial Assistance Reduction Letter** (Attachment #6) and a **Financial Assistance Promissory Note** (Attachment #6A) outlining the terms and conditions of the agreement
- 8. The **Financial Assistance Promissory Note** must be returned within 14 days. Failure to do so may result in the patient's ineligibility for Financial Assistance
 - a. Signed promissory notes are forwarded to the Collection Manager (see "Processing Approved Applications")

E. Resource Payment Arrangements

- 1. Resource payment arrangements will not exceed 24 months
 - a. Every effort is made to liquidate the resource amount within the earliest possible time frame
- 2. The minimum monthly payment amount is \$25
 - a. Patient is set up under a contract in Meditech with an alert on Patient Overview screen (alert is set to remind collector that partial write-off occurred in the event of patient default on resource payments)
 - b. Patients are automatically sent monthly statements through Meditech indicating their monthly payment amount, due date and account balance(s)
- 4. If a patient qualifies for Financial Assistance with a resource and has multiple account balances, all account balances are allowed leaving only one open account (if possible) for the resource amount
 - a. A weekly Meditech work list is reviewed to determine if patients are delinquent with their payments
 - b. Failure to pay as agreed will result in the patient being responsible for both the allowance amount and the unpaid resource balance
 - c. Forward the delinquent account to the Collection Manager
 - d. The Collection Manager/ or designee reverses the Financial Assistance allowance

- e. Patient is sent a final demand letter

F. Authorization For Financial Assistance

- \$1 - 2,499 - Coordinator
- \$2,500 - 5,000 - Collection Manager
- \$5,001 - 10,000 - Director of Patient Financial Services
- GT \$10,000 - EVP/CFO

G. Incomplete / Uncooperative

- 1. Failure to supply required information or to communicate reason for delay within 10 days may result in the applicant's ineligibility for Financial Assistance

H. Processing Approved Applications

- 1. Completed applications are forwarded to the Collection Manager with all appropriate supporting documentation
- 2. The Collection Manager will ensure that each applicant has met household income requirements, supplied appropriate supporting documentation and that proper authorization signatures are obtained
 - a. The Collection Manager or designee applies the Financial Assistance adjustment and files the **Financial Evaluation, Authorization Form** and related documentation
- 3. The patient is sent a Financial Assistance Award Letter (Attachment #4)

I. Processing Denied Applications

- 1. Applicants that are determined to be ineligible based on household income and/or asset criteria are sent a Financial Assistance Denial Letter Attachment #5)
- 2. Patients have the right to appeal denials. Final appeal decisions are at the sole discretion of the next level of required signature authority. (Example – Director of Patient Financial Services to review appeal for Collection Manager level denial)

J. Medicare Patients

1. Medicare patients are required to supply a copy of their Social Security Award Letter on a yearly basis
2. Medicare patients are certified for 1 year. However, if it is determined during the course of that year that the patient meets Medical Assistance eligibility criteria they will be required to pursue Medicaid prior to receiving additional Financial Assistance
3. The Financial Assistance Department will refer Medicare patients meeting Medicaid eligibility criteria to the Advocacy Department for processing

K. Medicaid Resources

1. Medicaid resources are automatically reviewed for Financial Assistance when a copy of the Department of Social Services (DSS) **0102 Form** (Attachment #7) is supplied to the Financial Assistance Department
2. DSS income calculations and Financial Assistance program allowances are used to calculate patient's disposable income (see "Gross Household Income Is Greater Than 300% Poverty Guidelines")

L. Recurring Accounts

1. Patients are certified 6 months for Non Medicare and 1 year for Medicare. Based on each unique situation, these periods may be extended at the discretion of the Director of Patient Financial Services.
2. If patients are admitted or start a new course of treatment, they are screened for Medicaid and/or reevaluated for Financial Assistance

M. Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

IV. ASSUMPTIVE FINANCIAL ASSISTANCE

Assumptive Financial Assistance is a program run in partnership with TransUnion credit reporting agency. Self-pay Emergency Department cases are referred to TransUnion, who utilizes a proprietary credit scoring system to determine likelihood of ability to pay based on estimated income and family size. The results from the TransUnion credit scoring are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection.

A. Eligible/Ineligible Services

1. Only bills for uninsured patients for services incurred in the Emergency Department are eligible for Assumptive Financial Assistance screening at this time
2. Patients seen in the Emergency Department as the result of a motor vehicle accident or for which any third party liability may exist will not be considered under the Assumptive Financial Assistance program
3. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the Assumptive Financial Assistance program until the Maryland Medicaid Psych program (MAPS) has been billed

V. PROCESSES UTILIZED BY TRANSUNION TO DETERMINE ELIGIBILITY STATUS

- A. TransUnion accesses credit data, via the Healthcare Revenue Cycle Platform (HRCP). TransUnion built and maintains a proprietary matching algorithm to select consumer credit files, including data like; name, address, SSN, Soundex and other criteria to match input inquiries to the correct credit file. This algorithm is used to match hundreds of millions of credit inquiry requests each year. It is constantly reviewed and maintained to provide accurate credit data to tens of thousands of customers. The minimum customer input requirement is name and \ address. TransUnion also accepts, SSN, previous address and date of birth input as part of its matching algorithm. HRCP then employs proprietary algorithms and expert business rules to match each hospital's own charitable, regulatory guidelines and policies to patient qualifications.
- B. HRCP employs a proprietary algorithm to estimate minimum family income and size. The algorithm uses information like debt to income ratios, current financial obligations that are being met, residual income for household members and cost of living calculations to estimate the minimum monthly income. HRCP also estimates family size based upon data such as, joint credit accounts, authorized users of credit cards, etc. The algorithm calculates FPL based upon these data. Customers may evaluate and configure certain parts of the algorithm like residual income to level the estimates for cost of living differences in geographic areas.
- C. Under the Fair Credit Reporting Act (FCRA) and other privacy regulations, TransUnion cannot disclose financial information regarding individual consumers to anyone without satisfying permissible purpose requirements.
- D. The HRCP proprietary algorithm used for estimating FPL (minimum estimated family income and size) uses both credit data and other calculations like residual income and cost of living. In the absence of credit data, other calculations are used and can be configured to consider certain geographic cost of living differences as

stated above. In such instances where credit data is absent, it is recommended to further qualify FPL if possible through documentation or patient interviews.

VI. ASSUMPTIVE FINANCIAL ASSISTANCE PROCEDURES

A. Identifying Patients For Assumptive Financial Assistance Write-offs

1. Up to three invoices per Emergency Room visit will be sent to each uninsured patient for hospital charges incurred. In addition, at least one phone call will be generated to the patient by the Patient Liability Staff.
2. Patient Financial Services may accelerate the screening process based on individual patient experience or accumulated historical data.
3. The invoices will be generated at the time of final billing of the patient's account and then 30 days from initial billing and then 60 days from initial billing
4. Within 10 days after the final invoice has generated, a file will be created to identify all accounts that have remained in a self pay status (excluding motor vehicle accidents, emergency petitions, and other third party liability)
5. The file will be sent to TransUnion for credit scoring **(see VI. on page 12 for Processes Used By TranUnion To Determine Eligibility Status)**
6. TransUnion will return the file with the credit scoring for each individual
 - a. **Meets Charity Guidelines** means the patient income is below 300% of the Federal Poverty Guidelines and the patient does not have the ability to pay. The patient qualifies for a write off of their Emergency Room bill under the Assumptive Financial Assistance write off code (CHAASSUMP) in Meditech.
 - b. **Collect Hospital Charges, Pursue Payment Arrangement or Question Household Income** means the patient appears to have the ability to pay and the Patient Liability staff will pursue a payment plan or offer Financial Assistance Screening through our non-assumptive program
 - c. **No Credit Found** means the patient demographic information did not match any information in the TransUnion data bank. The Patient Liability staff will pursue the patient and if additional or corrected demographic information is uncovered, they will have the patient rescreened through TransUnion.

- d. **Social Security Number not issued by Social Security Administration** or Social Security Number used in death benefits requires that we pursue patient. If the Patient Liability staff uncovers a data entry error with regard to Social Security Number they will have the patient rescreened through Trans Union.

B. Reversal Of Assumptive Financial Assistance Write-offs

1. If verifiable insurance is uncovered at anytime after the Assumptive Financial Assistance write-off, the write-off will be reversed and the patient's insurance billed

C. Assumptive Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

Review Cycle: Annual

Approved By: Eric Melchior,
Executive Vice-President and CFO
July 2009

Appendix 3/4



FY 2009 Community Benefit Report Filing
Mission, Vision & Values Statement

MISSION

Health. Healing. Hope.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

VISION

Medical Sophistication with Personalized Service.

The vision of GBMC is to be the preferred medical center in Maryland for the best physicians, nurses and staff by providing medical sophistication with personalized service, enhanced by clinical education and research with the guiding principle that *“the patient always comes first.”*

GREATER VALUES

The values of GBMC are our GREATER Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.

Good Samaritan Hospital Community Benefit Narrative FY 09

Good Samaritan Hospital, located in the northeast section of Baltimore City, has a rich history of providing health care and services to its community. Founded in 1968 through a gift from local merchant and philanthropist Thomas J. O'Neill, the hospital has **317 licensed beds** and provides comprehensive services which include intensive and cardiac care units and an expanding number of innovative medical and surgical capabilities. Inpatient **admissions total 18,038** in fiscal year 2009 (July 2008 to June 2009), including 657 admission to subacute TransitionalCare.

Good Samaritan has been long known as a specialty center for rehabilitation and orthopedics, and takes a comprehensive approach to caring for patients, which includes: educational seminars, support groups, pre-op classes, pre-habilitation therapy and post surgical programs. Good Samaritan has expanded its range of health care services to better serve those in our community by expanding its full service emergency department as well as gynecologic and pediatric services so that the entire family has access to care. To help meet the needs of the uninsured and underinsured the Center for Primary Care is committed to providing affordable and accessible primary care for the community as well as comprehensive medical care for HIV patients. In February 2008, The National Burn Reconstruction Center opened at Good Samaritan to offer comprehensive services prior to surgery through rehabilitation.

COMMUNITIES SERVED

Good Samaritan Hospital's primary service area includes the Northeast section of Baltimore City and is comprised of the following neighborhoods; Chinquapin Park/Belvedere, Greater Govans, Hamilton, Harford/Echodale, Lauraville, Loch Raven, and Northwood. The hospital also serves parts of Towson and Parkville located in Baltimore County. The base population of these areas is approximately 420,303 and has a diverse population consisting of Caucasians (41.7%), African Americans (51.4%), Hispanic/Latinos (2.0%), Asian/Pacific Islanders (3.0%), and Others (1.9%). The population served by the hospital is primarily adults. Approximately 77% of the community's residents are over 18 years old with 14% of the population over 65 years of age. The average annual income of this community is approximately \$45,000 – \$50,000 with 75% of the adult population having less than a four year college degree. According to new Census Bureau estimates, 22.2 % of residents in Baltimore City live in poverty. Average life expectancy for these areas is 74.4 years while the greater Baltimore City area is 70.9 years. The percentage of Medicaid and uninsured that Good Samaritan served are as follows: Medicaid 13.3% - uninsured 4.4%.

IDENTIFYING COMMUNITY NEEDS

The needs of the community are assessed on information provided by the Baltimore City and County Health Departments, and also information gathered from community partners such as local schools, the Northeast Development Alliance (NEDA), a community development corporation with the goal of fostering a healthy and vibrant environment for residents in the northern neighborhoods of Baltimore City and the Northeast Community

Organization (NECO), a partner in (NEDA). Meetings are held bi-monthly with NEDA and bi-annually with NECO.

Good Samaritan has had ongoing contact throughout the year with the Baltimore City Health Department in regard to needs in the community. The hospital also uses statistical data from the “Neighborhood Health Profiles” put out by the city health department in 2008.

Heart disease, cancer, stroke, and diabetes are among the leading causes of death in the local community. Based on information from the above resources, many of the hospital’s Community Benefit initiatives have been developed to target the aging population, the uninsured and elementary school children, with the focus on disease prevention programs (stroke, heart disease, diabetes, obesity), chronic disease management and programs to improve quality of life.

The Community Benefit initiatives are decided upon through our strategic and annual planning processes. The strategic planning process occurs on a three-year cycle and is led by a Board committee comprised of Board members, physicians and executive staff. The priorities are reviewed annually and incorporated into the annual operating plan. The annual planning process involves the Board, physician and administrative leadership.

COMMUNITY BENEFIT PROGRAM INITIATIVES

Charity Care

Charity care is an integral component of the benefit that Good Samaritan provides to the community. We treat all patients, regardless of their ability to pay, and provide care without charge, or at a discounted rate, to patients who meet certain criteria. The hospital’s financial aid policy is consistent with our mission and vision and takes into account each patient’s ability to contribute to the cost of his or her care. During fiscal year 2009, Good Samaritan provided more than \$4.2 million in charity care.

Chronic Disease Self-Management Program

This six-week (15 hour) program, taught by Good Samaritan community outreach nurses, is offered quarterly to people who suffer from chronic diseases. The program was developed at the Stanford Patient Education Research Center and is conducted in partnership with the Baltimore County Department of Aging. The goal of this program is to empower individuals to manage chronic illnesses such as heart disease, diabetes, hypertension and arthritis. Evaluations are given at the end of the six-weeks to each participant. Approximately 75% of participants have noted in the evaluation that they are “very likely or likely” to use the strategies to manage their chronic illness that were presented in the program. Follow up calls are made six months after completion of the program and approximately 80 % of participants state that they are using the information they acquired from the program to manage their chronic disease. They rate the program as being very successful.

Blood Pressure Screening Program

Good Samaritan's Community Outreach and Parish Nurse Program partner with many churches and community organizations such as senior centers and senior housing to offer free blood pressure screening on a monthly basis. Hypertension is a disease that usually has no symptoms and greatly increases the risk of heart attack and stroke. The goal is to raise awareness, educate, and identify people who have high blood pressure.

In FY 09, 1,500 people were screened for hypertension and approximately half had blood pressure readings over the normal range. Participants were advised to take urgent action if needed or were given educational literature on hypertension and stroke. For participants that did not have a primary care physician due to lack of insurance or other reasons, names and phone numbers of physicians were offered as well as Good Samaritan Hospital's Primary Care Center where the uninsured can gain access to health care.

Barber Shop Screenings

This past year the hospital extended the program to include 5 local barber shops with the goal of identifying hypertension in African American men. Screenings were conducted monthly in cooperation with the shop owners. Over a 10 month period 150 African American men were screened with approximately 20% having blood pressure readings above normal. Men with high readings were advised to contact their physician or were given an appropriate referral and were also given educational information.

Baltimore City Parochial School Vision and Hearing Screening Program

In response to a request from the Baltimore city parochial schools, Good Samaritan Hospital works with Loyola College and another local hospital to conduct vision and hearing screenings for grade school children. Good Samaritan and Loyola College's Speech and Hearing Department screen children in grades Pre-K through 8 at five local parochial schools on a yearly basis. Unidentified, untreated problems with vision and hearing in children can lead to loss of vision and hearing, learning difficulties and delayed sensory, motor, cognitive, and social-emotional development.

In FY 09 approximately 590 children were screened for vision and hearing problems with 97 identified as needing follow-up for vision and 35 needing follow up for hearing.

Letters were sent to parents as well as the school principals informing them of the results. Approximately 10% of the parents replied back to the community outreach department saying that they were planning to have further evaluation done by either their pediatrician or a specialist. Each school was notified of the parental responses and encouraged to do further follow-up on children whose parents did not respond.

Be Fit Baltimore Initiative

The Baltimore City Health Department's 2008 Health Status Report highlighted some severe disparities that exist between many Baltimore neighborhoods. In some instances there is a twenty-year life expectancy gap between neighborhoods that are less than four miles apart. In order to raise awareness regarding healthy lifestyle choices such as regular exercise and healthy diet as a means of reducing the risk of cardiovascular disease, the mayor's office and the health department created The "Be Fit Baltimore" initiative. In January, February and March three to four events were held each month at various city recreation centers. The general public was invited to come for fitness activities, healthy

nutritional education and a variety of health screenings. In partnership with the Baltimore City Health Department, Good Samaritan and John Hopkins Hospitals' Community Outreach Departments provided screenings, health information and education at these events. A total of 115 people were screened over the 3 months; 74 women and 41 men from at 23 different zip code areas. Thirty four people were identified with above normal blood pressure readings and 70 people were identified to have a high waist circumference. All those identified were given verbal education and literature by registered nurses.

The Good Health Center

The Good Health Center provides an array of free and low-cost diagnostic screenings, educational seminars and preventive medicine services for the community. Located on the hospital's campus, the Good Health Center is a comprehensive health enhancement facility that offers a proactive approach to improving well-being. A primary goal of the Center is to empower people to take control and address their health issues. Services provided by the Good Health Center include, exercise, nutrition, a diabetes support group, and other wellness programs.

GAPS IN AVAILABILITY OF SPECIALIST FOR THE UNINSURED

Physician leadership and case management staff has identified these areas of concern:

- Timely placement of patients in need of inpatient & outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse treatment
- Medication Assistance

SUBSIDIZED CARE

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

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

Category 1 Subsidies:

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

- a) Primary Care Subsidies, including Diabetes – These are clinic-based physician practices that provide primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin; however, the practice addresses a community need and supports the hospital's mission of commitment to patients, communities, physicians and

employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients' health status are achieved.

- b) OB and Pediatric Subsidies, including Breast Surgery – These represent physician practices providing health care services for obstetrics, gynecology, and pediatrics where a negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided and OB/GYN and pediatric coverage is provided 24 hours/day. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for women's health and children's services for lower income and minority families.
- c) Psychiatric/Behavioral Health Subsidies - The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2 Subsidies:

Non-Resident house staff and hospitalists

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

Category 3 Subsidies:

Coverage of Emergency Department call

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

Category 4 Subsidies:

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

No subsidies reported.

Category 5 Subsidies:

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

No subsidies reported.

Other Subsidies:

Non-Physician Subsidies

- a) Child Development Center Subsidies - Good Samaritan's Child Development Center opened in 1990 to serve a large number of employee parents by caring for their children ages two to four. The Center also serves parents in the community by providing an environment that is supportive, consistent, and attentive to their needs. Services are provided at a negative margin.
- b) Renal dialysis Program - Good Samaritan Hospital operates the largest not-for-profit dialysis center in the Baltimore area. The Program offers a complete range of renal dialysis services. A social worker is assigned to each patient to address issues such as education, transportation and support. The Program includes a monthly class where, patients and their families can learn more about hemodialysis, peritoneal dialysis and transplantation. These Program services are provided at a negative margin.
- c) Low Income Housing - Sponsored and managed by Good Samaritan Hospital, the facilities of Belvedere Green and Woodbourne Woods provide rent-subsidized apartments and many other features for its residents. Services provided include transportation to doctors' offices, social work consultation, and assistance with healthcare needs, including educational programs, health screenings, and medication schedules. These senior living services operate at a negative margin.

Appendix 1

Appendix 1

How the hospital informs patients and persons who would otherwise be bill for services about eligibility for assistance.

- ✓ All admitting registrars have been specifically trained to offer the appropriate referrals for persons needing financial help
- ✓ Registrars have also been trained to listen for clues that may indicate a person needs financial assistance
- ✓ Referral to the hospital's financial counselor and a patient advocate are available for those needing help
- ✓ Patients are also informed of and given a packet from MedStar Health financial services which includes a Maryland State Uniform Financial Assistance Application
- ✓ At each registration desk, in the emergency room area, and at various other locations there are large signs posted in English and Spanish informing patients of government financial assistance programs.

Appendix 2

Charity Care Policy

- ✓ See Corporate Appendix 2.

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines.

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

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

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

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

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

- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

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

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

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

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

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

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

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

Appendix 3

Appendix 3

Description of Mission, Vision, Values

Striving to Make Good Samaritan Hospital an Excellent Place to Stay, Visit and Work

For years, Good Samaritan has sought balance in its approach to greatness. We work toward overall excellence with thoughtful consideration to our five puzzle pieces: service, quality, people, growth and financial. When these pieces come together, we see the greater picture. For example, we can't achieve greatness without great people. And without constant improvement to service, we can't achieve the results that put us on the road to greatness as one of the nation's leading healthcare providers.

As part of our initiative to create ideal healthcare experiences, many Good Samaritans have joined one of eight teams that work on improvement opportunities throughout the hospital. These teams include:

- Inpatient Satisfaction
- Outpatient Satisfaction
- Rewards & Recognition
- Measurement
- Physician Satisfaction
- Behaviors
- Service Recovery
- Leadership Development

These teams work on issues around the hospital that fall into the categories illustrated on our five puzzle pieces: service, quality, people, growth and finance. By concentrating on these five key pieces of the puzzle, we believe the ideal healthcare experience will fall into place. You have probably noticed the results of the teams' efforts such as:

- Manager rounding
- Service recovery script cards
- Elevator etiquette signs
- Excellent stickers
- Communication boards
- Leadership retreats
- Monthly behavior signs
- Leadership Commitment

What does it mean to create an ideal healthcare experience?

It means that we have employees who look forward to coming to work, patients who will only go to Good Samaritan Hospital for treatment, physicians who are waiting to practice medicine here, leaders who empower their staff to succeed, and visitors who tell everyone about the excellent service at Good Samaritan.

Our goal is to create a culture that is ultimately focused on patient satisfaction.

We will get there by listening to suggestions, viewing complaints as gifts, measuring our successes more effectively and respecting and appreciating our fellow Good Samaritans.

Appendix 3

Good Samaritan Hospital is an organization committed to values, which are reflected in our behavior expectations: recognition, ownership, communication, courtesy, enthusiasm, and teamwork. Each employee strives to embrace these behaviors daily. In fact, to become a Good Samaritan, you must show your commitment to these behaviors by signing the Staff Promise. All Good Sam employees promise to uphold these expectations so they may know, own, energize, build and sustain our spirit of worthwhile work.

Recognition

- I show appreciation by saying “Thank you.”
- I offer verbal and written recognition for a job well done.
- I promote Good Samaritan in and outside the workplace.

Ownership

- I follow through on commitments.
- I take care of Good Samaritan property. I keep all areas clean and free of clutter.
- I am not afraid to say “I’m sorry.” I practice service recovery.

Communication

- I demonstrate respect for patient confidentiality, privacy and modesty.
- I answer the phone within three rings, smile, and identify myself and my department.
- I take time to explain and keep others informed, using key words at key times.

Courtesy

- I greet people warmly and say “Hi.”
- I knock, introduce myself, and ask permission to enter.
- I escort customers to their destination.

Enthusiasm

- I keep improving, personally and professionally.
- I speak positively and offer positive thoughts to those speaking negatively.
- I anticipate and exceed customers’ needs.

Teamwork

- I’m a team player.
- I take initiative in helping others.
- I respect personal and cultural diversity.


Appendix 4

Appendix 4

Mission, Vision and Values Statements

MedStar Health and each entity (hospital and diversified business) share a common vision and set of values. MedStar Health's common vision is to be the trusted leader, caring for people and advancing health. MedStar Health's common set of values are services, patient first, integrity, respect, innovation and teamwork. Each entity has a unique mission, or purpose for which it exists. MedStar Health's mission is to serve our patients, those who care for them and our communities. Good Samaritan Hospital's mission is we are Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.

Below is an illustration of MedStar Health's mission, vision and values for reference.



MedStar Health

Vision

*The Trusted Leader
in Caring for People
and Advancing Health.*

Mission

*To Serve Our Patients, Those
Who Care For Them, and
Our Communities.*

Values

Service
We strive to anticipate and meet the needs of our patients, physicians and co-workers.

Patient first
We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.

Integrity
We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.

Respect
We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.

Innovation
We embrace change and work to improve all we do in a fiscally responsible manner.

Teamwork
System effectiveness is built on the collective strength and cultural diversity of everyone, working with open communication and mutual respect.

Harbor Hospital FY 2009 Community Benefit Evaluation

- 1. Licensed beds: 222**
Inpatient admissions: 15,443

For more than a century, Harbor Hospital has grown alongside the communities we serve in Baltimore City, and Anne Arundel, Baltimore and Howard counties. The hospital was first established in 1903 as a small community clinic supporting the waterfront community in Baltimore. More than 100 years later, our 222-bed facility continues to offer the personal touch of a community hospital while incorporating the excellence of a high technology medical center. We were the recipient of the Delmarva Foundation's highest honor, the Excellence Award for Quality for Hospitals, in 2001, 2006, 2007 and 2008.

Harbor Hospital moved to our present location in 1968. Our institution has grown since then, and now is a proud member of MedStar Health which includes: Franklin Square Hospital Center, Good Samaritan Hospital, Union Memorial Hospital, Montgomery General Hospital, St. Mary's Hospital, Washington Hospital Center, Georgetown University Hospital and National Rehabilitation Hospital.

Each year, Harbor Hospital participates in myriad community partnerships and programs that both reflect the clinical strengths of the organization and are consistent with the health priorities identified by our local health departments. This strategic, yet caring, alignment of health care expertise with community need is one of the hallmarks of Harbor's commitment to our communities.

During our century of service, Harbor has developed – and continues to refine – a comprehensive array of programs, seminars and outreach. From our cadre of free health seminars to our attendance at health fairs and other community events, Harbor remains focused on the inherent value of providing a continuum of care.

With more than 400 physicians representing 30 medical and surgical specialties, and nearly 1,500 employees, the hospital offers a full range of health care services for patients from infancy through the senior years. Harbor Hospital's specialty areas include orthopaedics, women's services, cancer care, diabetes care, fetal assessment, cardio-pulmonary rehabilitation and treatment of chronic lung conditions. The hospital's continuum of care also includes wellness programs, outpatient services and inpatient treatment.

2. Communities We Serve:

Harbor Hospital serves a wide variety of communities, each with its own special characteristics, demographics and health care needs. The scope of differences in these communities is tremendous, and provides a portrait of great health care disparity. In fact, the differences in these communities' overall characteristics could present an opportunity for a case study in contrasts—particularly with respect to how they receive their health care information. For example, Howard County, from which we draw a portion of our patients and community participants, is one of the wealthiest counties in the entire United States. Yet, it is within 10 miles of some of the poorest neighborhoods in Baltimore City, in which many families are barely subsisting, with low wages and little or no health care coverage. Patients from both areas utilize the services and community outreach of Harbor Hospital, sometimes for very different reasons. Because their health care interests and needs are so widely varied—and because these groups do not tend to “cross pollinate” or even interact, in many cases—we work very hard to address this incredibly wide gap.

Thus, to be most effective in our community outreach, we cannot engage in cookie cutter community relations. Instead, we attempt to reach these very diverse audiences by strategically segmenting our outreach activities. As such, a review of this report will show everything from the most basic charity care and free health screenings to free seminars on sophisticated orthopaedic surgery and alternative therapies.

Below is additional information on the primary communities we serve.

- **Cherry Hill**

Cherry Hill is an historically African-American neighborhood, with roots going back to the 17th century. After World War II, more than 600 housing units were built there by the United States War Housing Administration, specifically for African-American war workers. Shortly after the war, these units were made into low-income housing. Additional low-income housing units have been added throughout the years, making Cherry Hill one of the largest housing projects east of Chicago.

Statistics gathered in the most recent census, taken in 2000, indicated that Cherry Hill's population fell by nearly 30 percent between 1990 and 2000. Also in 2000, more than 96 percent of Cherry Hill residents were African-Americans, as compared with 64.3 percent of Baltimore as a whole. Approximately 70 percent of households were families, with 58 percent of families with children headed by a single parent—again, higher than the citywide percentage of 23.3 percent. Female-headed families with children represent 54 percent of total neighborhood families.

Thirty-five percent of Cherry Hill residents ages 25 to 64 do not have a high school education, while 24 percent have had some college education. The median household income for Cherry Hill in 2000 was \$17,464, among the lowest of Baltimore neighborhoods. In fact, nearly 92 percent of families in the neighborhood, excluding married couple families, earn below the Maryland Self Sufficiency wage standard.

In terms of health care, the Cherry Hill community houses Harbor Hospital as well as a local branch of the Family Health Centers of Baltimore, which is a federally qualified organization providing health care services on a sliding fee scale. In addition, Baltimore City Health Department programs operate city-wide, and various mobile services—such as a needle exchange program, violence prevention, Maternal and Infant Nursing, lead poisoning and abatement programs and others—serve the Cherry Hill area. Yet, despite the variety of services available, statistics on mortality show very high rates from homicide and HIV/AIDS. Flu and asthma are prevalent, as is substance abuse, among this community as well.

According to the Cherry Hill Health Profile, published by the Baltimore City Health Department in partnership with the Johns Hopkins School of Public Health in October 2008, the life expectancy at birth of a Cherry Hill resident is 65.0, as compared to 70.9 in Baltimore City as a whole and 78.1 in the United States. Heart disease accounts for 23 percent of all deaths, and cancer accounts for 20 percent. Stroke, HIV/AIDS and homicide are less common but—when combined—cause 18 percent of deaths in this area.

High rates of type 2 diabetes and heart disease, including stroke, also occur in this community. For a variety of reasons, including the high poverty rate and low rate of health care insurance coverage, many Cherry Hill residents demonstrate poor preventative health care practices, and often use the Harbor Hospital emergency department as a primary care facility.

Despite the convenient neighborhood location of a federally qualified health center—Family Health Centers of Baltimore—which operates on sliding-fee scale, many residents do not utilize a primary care physician. Instead, they might wait until a chronic condition, such as diabetes or asthma, presents severe enough symptoms to warrant a trip to the emergency department. At this time, in some cases, several co-morbidities are found to be present. But without primary care follow-up, they usually cannot be addressed fully in the time allotted for the emergent issue. In other cases, patients may have symptoms of a much less serious illness—a simple cold, for example—but, since they do not have a primary health care provider, they also visit the emergency department for these ailments. As a result, many of their most basic health needs often are not met.

- **South Baltimore and Federal Hill**

These areas of Baltimore City contain numerous historical monuments, landmarks and parks (Federal Hill itself and Ft. McHenry to name just two) and a variety of populations with different health care needs. Once again, heart disease and cancer are the two most common causes of death, at 29 and 22 percent, respectively. However, this area enjoys a longer life expectancy than Cherry Hill, at 73.4 years for South Baltimore and 78.6 for Federal Hill.

South Baltimore's median household income is \$39,354, higher than the overall Baltimore City household income of \$30,078. Nonetheless, more than 30 percent of families in South Baltimore earn less than \$25,000 per year. The median household income in the Federal Hill and Inner Harbor areas—which are grouped together as one

neighborhood by the Baltimore City Department of Health and the Office of Planning—is \$51,615.

The growing presence of young urban professionals and active baby boomers with empty nests presents a strong contrast to much of the population in these neighborhoods. These populations represent individuals with access to private plan insurance, and they tend to be more proactive with regard to health—e.g., exercising more, regularly seeing a primary care physician and generally being more sophisticated health consumers.

- **Brooklyn/Curtis Bay/Hawkins Point**

This neighborhood is more racially diverse than either South Baltimore or Cherry Hill, with a 24 percent African-American population and a 69 percent Caucasian population; in Cherry Hill the percentages are 97 and one percent, while in South Baltimore they are virtually reversed at two and 95 percent. This area contains a large number of chemical plants and other industrial sites, including several Superfund-qualified locations.

The poverty level in this community is slightly higher than that of Baltimore City, with 48 percent of families earning less than \$25,000 annually, as compared to 43 percent of all Baltimore families. The life expectancy here is 69.3 years. Heart disease and cancer, once again, rate highest in terms of causes of death and years of potential life lost, causing 28 and 22 percent of deaths respectively.

- **Anne Arundel County**

One of Harbor Hospital's largest communities is Anne Arundel County, particularly the northern and western portions, encompassing Brooklyn Park, Linthicum, Glen Burnie, Pasadena and Severn. According to the 2000 U.S. Census, of the population ages 16 years and older in the county, more than 71 percent are employed. The median income for the county in 2004 was \$66,087, with 13.9 percent of households earning less than \$25,000 per year. However, the percentage of people living below the poverty line in the County was 6.5, versus 9.2 for the State of Maryland. According to estimates by the county's Department of Health, there are more than 3,000 homeless persons currently living in Anne Arundel County.

The leading causes of death for all races in Anne Arundel County include cancer and heart disease in the top two spots, followed by stroke, chronic lower respiratory disease and diabetes. African Americans and Asians in the county show a higher rate of death from diabetes and unintentional injuries than Caucasians. For Hispanics, heart disease is actually the No. 1 cause of death, followed by cancer, unintentional injuries and stroke. Anne Arundel County is twelfth in the state for cancer deaths overall. From 1998 to 2002, the incidence of lung cancer deaths, age adjusted per 100,000 persons, was 74.4 in Anne Arundel County, vs. 68 in the state.

3. Identification of Community Needs

Health statistics for our communities—like the ones cited above—inform and shape all of the decisions made by our marketing and community relations team when planning our programs each year.

The hospital engages in regular strategic planning and, annually, our executive and hospital leadership teams work together to identify our priorities for each fiscal year and from longer-term perspectives. Through this process, clinical and operational goals are addressed at various levels. As part of this effort, we factor in community needs, both current and projected, into every aspect of planning.

Our community relations team has a semi-annual planning process, during which we consider community health needs, interests and trends. Since the AVP for community relations reports to the hospital president and is a member of the executive team, the highest levels of leadership are engaged in the discussion. In addition, we involve peers in physician relations and nursing to help ensure that we are identifying key areas for outreach to meet our community's needs.

We also work closely with our planning team; our clinical specialists who focus on the community; our parish nurse; and with area health departments, as evidenced by many of the secondary data sources cited in the *References* section. In particular, we seek input and feedback from Baltimore City, Anne Arundel County and Baltimore County departments of health. This enables us to continue to assess community health needs, and identify potential roles for Harbor to play in meeting those needs. During FY 2009, our manager of community relations continued to attend department of health-sponsored meetings and trainings which help us to better understand the health needs of the communities we serve.

Community Needs Assessment—Sources of Information

While Harbor Hospital has not conducted a formal community needs assessment in recent years, we have collaborated with our neighborhood partners to ensure that our outreach is appropriate for the communities we serve. A full list of document references is provided at the end of this report, and the following is a list of the partner agencies with whom we worked to generate these conclusions:

- Anne Arundel County Health Department
- Baltimore City Health Department
- Cherry Hill Trust

In addition, the following agencies'/organizations' Web sites are referenced in gathering information:

- Centers for Disease Control and Prevention
- Maryland Department of Planning
- Maryland Department of Health and Mental Hygiene
- Maryland Vital Statistics Administration
- National Association of County and City Health Officials

4-7. Community Needs Identification, Planning, Implementation and Evaluation

Planning is a dynamic and ongoing process, the foundation of which includes Harbor's mission: we are committed to quality, caring and service for our patients and our communities.

Through this planning process, we have been able to identify the greatest community needs, including cancer, stroke, diabetes, heart disease and hypertension, and other chronic diseases. We then work closely with our local health departments and community partners to offer beneficial outreach such as free colon, breast and cervical cancer screenings; yearly prostate cancer screenings; low-cost lung scans; support groups and educational programs about diabetes and other conditions; free smoking cessation classes; and a strong Parish Nurse program that provides key outreach to our patient population.

The smoking cessation classes, for example, are a direct result of the higher-than-average rate of lung cancer in this region. Harbor Hospital has worked with Anne Arundel County Department of Health for years to offer both the classes and free nicotine replacement therapy. During FY 2009, we also had an ICU nurse who, after participating in the American Lung Association's Freedom from Smoking training, offered ongoing one-on-one counseling and group classes for those who are struggling with the habit. During FY 2009, two smoking cessation classes were offered, with 16 participants who began the class. While not everyone completed the class series, or was completely successful in staying quit, Harbor's partners at the Health Department were encouraging of our efforts.

Our parish nurse also regularly acts as a health care navigator for residents of the local communities we serve. She holds office hours at local organizations, offers blood pressure screenings and other health care information, and guides her "clients" toward any health care referrals they may need. This free service touches many lives each year. Our reach also extends further into the community through a program in partnership with the Anne Arundel County Department of Health, the Health Smart Church Program (HSCP). Through the HSCP, nurses and other trained volunteers provide blood pressure screenings to parishioners, and recommend follow up care as appropriate. This program results in many participants learning about their elevated blood pressure levels earlier than they otherwise might have, and scheduling an appointment with their own physicians—ultimately leading to a healthier church community.

During FY 2009, 618 church members participated in blood pressure screenings through the HSCP. Of those, 65 persons were found to have an elevated blood pressure of 160/100 or greater. All 65 congregants were sent letters to remind them to consult with their primary care physician within one week. The volunteer parish nurses at each faith institution followed up in person with the participants, and Harbor's parish nurse also checked in via a phone call.

As the average age of Americans increases, Harbor also is ahead of the curve in identifying and developing programs to continue to help seniors navigate the

ever-changing world of modern health care. Our Harbor Seniors is a free program for people ages 55 and older that provides free health screenings, educational seminars and opportunities to socialize. Members also get a discount at our Harbor Fitness gym, and many also participate in our free mall-walking program offered at a local mall.

As part of our evaluation efforts, we assess all our programs. Some of our outreach is funded by local, regional or national grants, with requirements to track usage rates and outcomes. For example, we can provide exact counts on the number of Baltimore City women who have had free mammograms and Pap smears through our grant with the city, as well as results (number of cancers and pre-cancers identified). We also track the number of participants in all our seminars and free screenings that are funded not by grants but from Harbor's own operating budget.

Community Collaboration

To further our understanding of community needs, a wide representation of hospital clinical staff and administrators serve on committees or participate in community health planning work groups. These activities and partnerships provide us the opportunity to work closely with representatives from the community to better understand the health needs of our constituents and to offer programs and services to meet these needs.

For example, Harbor Hospital has been actively involved with several community organizations, such as the Cherry Hill Trust, a grassroots coalition working for the betterment of the Cherry Hill community. We also are active participants in a number of other community meetings and partnerships, including the Baltimore Southern District Police and Community Relations Council, Baltimore City Planning Commission, the Glen Burnie High School Business Advisory Board, Safe Kids Baltimore, the Baltimore Traffic Safety Coalition, Northern Anne Arundel County Chamber of Commerce and the South Baltimore Community Advisory Panel. Harbor Hospital associates regularly participate in community health fairs and other events, and our community relations director has provided injury prevention information at numerous local Head Start centers, health fairs and other community activities. For the first time in many years, Harbor Hospital hosted a child safety seat checkup event in September, giving nearly 30 local families the opportunity to travel more safely with their most precious passengers.

Other activities included providing health navigation services and blood pressure screenings at the Anne Arundel County Homeless Resource Fair; presentations at local senior centers on such topics as stroke and advance directives; partnering with the Anne Arundel County Health Department for their "Girls' Night Out" breast cancer awareness event for Korean women; partnering with a local environmental organization to help clean up litter on the neighboring Gwynns Falls trail; participating in a Teen Pregnancy Prevention Workgroup; and offering job shadow/mentoring opportunities for local at-risk youth. We maintain ongoing partnerships with other health organizations such as the Juvenile Diabetes Research Foundation, American Cancer Society, March of Dimes, Arthritis Foundation, Living Legacy Foundation and the American Heart Association to provide education and outreach to their constituents. We strive to be engaged members of

our communities, where every level of interaction provides stronger ties with, and the creation of more meaningful services for, our neighbors.

An example of how the community at large benefits from our services is the 679 uninsured and underinsured women, primarily from Baltimore City, who received free mammograms, breast exams, and Pap tests last year through our Breast and Cervical Cancer program. Without programs like this, these women would not have access to this potentially life-saving screening. Other free and low-cost screenings provided include those for prostate cancer, low-cost lung CT scans, cholesterol and skin cancer.

Community Benefits Program Implementation

As articulated above, Harbor Hospital participates in myriad community partnerships and programs that both reflect the clinical strengths of the organization and are consistent with the health priorities identified by our local health departments.

As part of our comprehensive array of programs, seminars and service, Harbor Hospital's LifeResource Center served as the bricks and mortar centerpiece of our community outreach program during FY 2009. Located on the Harbor campus, it is a spacious facility where community members can learn more about health topics and practice healthy lifestyles. Each month, Harbor offers an assortment of free and low-cost education programs and lectures for every member of the family. Presenters include our physicians and other health care experts, who discuss a variety of diagnoses, diabetes and wound care, personal safety and stress relief – just to name a few. This year we have partnered with several other organizations to provide community training on child safety seat installation, driver safety education for seniors and a free glaucoma screening.

We also continue to offer free health seminars in our Baum Auditorium, as well as at convenient locations in Baltimore, Howard and Anne Arundel counties. In addition, we allow our partners in the community to utilize our facilities for meetings. This practice saves them a great deal of money on room rentals, and offers a convenient local meeting space—with free parking—for their constituents.

This past year, we have continued and enhanced our work with the Cherry Hill Learning Zone (CHLZ). This initiative is an advocacy group comprised of representatives of the city school system, Towson University, community groups and other key stakeholders in the business and faith communities. Harbor Hospital is proud to be one of the health partners for this dynamic and energetic organization. Once again this year, we worked with our CHLZ partners to offer free flu vaccinations to teachers in Cherry Hill public schools, provide a Reading Day for several elementary school classes and assist with its annual back to school programs. To enhance our outreach with the CHLZ schools this year, we sponsored a backpack drive among Harbor Hospital associates. Associates donated new backpacks, and hospital funds were used to purchase school supplies with which to fill them. Sixty full backpacks were donated to two local schools to help children in need.

Harbor Hospital's community outreach includes many layers of service to our diverse communities, focusing not only on their immediate health care needs, but also on risk prevention and becoming a proactive health care consumer. From the GED program that regularly meets, free of charge, in our *LifeResource* Center and our comprehensive annual flu vaccination clinics that result in nearly 2,000 free and low-cost vaccinations, to our attendance at health fairs and other local events, Harbor remains focused on being a true health care partner to our community members.

8. Gaps in Availability of Specialist Providers to Serve the Uninsured

This information has remained consistent with the MedStar Health fiscal year 2007 and 2008 reports. Physician leadership and case management staff continued to identify several areas of concern:

- Timely placement of patients in need of inpatient psychiatry services
- Limited availability of outpatient psychiatry services
- Limited availability of hospice care
- Limited availability of inpatient and outpatient substance abuse treatment
- Medication assistance, transportation assistance, durable medical equipment, skilled nursing services in the home and/or at rehab facilities
- Limited health care services for the homeless
- Limited health care services for undocumented residents

Explanation of Subsidies

Category 1 - Hospital-Based Physician Subsidies:

Harbor Family Care:

Harbor Family Care is a clinic-based physician practice that provides primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin. However, the practice addresses a community need and supports the hospital's mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients' health status are achieved.

Women's and Children's Services:

Physician practices provide health care services for obstetrics and gynecology. A negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided. OB/GYN coverage is provided 24 hours. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for women's health and children's services for lower income and minority families.

Pediatric Services:

Physician practices provide 24-hour health care services for pediatrics. A negative margin is generated. A large number of the patients receiving these services are from minority and low-income families. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for children's services for lower income and minority families.

Psychiatric Services:

Harbor Hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24-7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2- Non-Resident House Staff and Hospitalist Physician Subsidies:

Hospitalists:

Harbor Hospital provides physicians (hospitalists) for patients who do not have a primary care physician handling their stay. Our community includes many low-income and minority families who have this requirement. The community needs for these services are being met.

Category 3- Coverage of ED Call Physician Subsidies:

Emergency Room On-Call Services:

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

APPENDIX 1: CHARITY CARE

Harbor Hospital's Charity Care Policy is consistent with that of all the MedStar Health hospitals, and is posted in our admissions and emergency department areas. During the admissions process, if a patient is listed as "self-pay," patient advocates advise them of the availability of various payment options. Patients are screened for Medical Assistance and charity care eligibility, and the patient advocates work with them to complete the appropriate financial assistance application(s). In addition, because Harbor Hospital has physician partners and practices located throughout the Baltimore area, physicians' offices often refer patients to the patient advocates for their assistance with this process.

See **Corporate Appendix 2** for the MedStar Health/Harbor Hospital Charity Care Policy.

APPENDIX 2: CHARITY CARE POLICY

See Corporate Appendix 2.

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines.

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

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

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

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

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

- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

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

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

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

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

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

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

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

APPENDIX 3: MISSION, VISION, VALUES DESCRIPTION

As part of the refreshed MedStar Health vision and values rollout, each entity within MedStar was asked to create a mission that would help define its unique role within the system. Harbor Hospital held staff focus groups to help shape our new mission, vision and values, to ensure that associates at every level were given a voice in this important step from *good* to *great*.

Harbor Hospital's Mission

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

Quality, Caring and Service

- These are the sentinel guideposts for Harbor, forming the foundation for the hospital's journey from good to great.

Our Patients and Communities

- Our patients are our primary reason for existence. Our patients are our primary reason for existence. They are at the heart of our mission. Our communities are comprised of our employees, our physicians, other caregivers, and the residents of the areas we serve.

APPENDIX 4: MISSION, VISION, VALUES STATEMENT

MedStar Health and each entity (hospital and diversified business) share a common vision and set of values. MedStar Health's common vision is to be the trusted leader, caring for people and advancing health. MedStar Health's common set of values are service, patient first, integrity, respect, innovation and teamwork. Each entity has a unique mission, or purpose for which it exists. MedStar Health's mission is to serve our patients, those who care for them and our communities. Harbor Hospital's mission is: Harbor Hospital is committed to quality, caring and service for our patients and our communities.

Below is an illustration of MedStar Health's mission, vision and values for reference.



Prepared by Diane Caslow, VP Planning
November 16, 2009

Document References:

Cherry Hill Master Plan DRAFT, October 2007—Baltimore City Department of Planning et al

Health Profiles 2008: Brooklyn/Curtis Bay/Hawkins Point; Cherry Hill; Federal Hill/Inner Harbor; South Baltimore—Baltimore City Health Department and Johns Hopkins Bloomberg School of Public Health Sommer Scholars Program, October 2008

Health Disparities in Anne Arundel County: Bridging the Gap (presentation, October 2007)—Anne Arundel County Department of Health, Johnia J. Curtis, MPH, Epidemiologist

U.S. Census 2000—U.S. Bureau of the Census

MedStar Health Financial Assistance Policy, Revised Nov. 2008

COMMUNITY BENEFIT NARRATIVE REPORT

FISCAL YEAR 2009

Holy Cross Hospital
1500 Forest Glen Rd
Silver Spring, MD 20910

Submitted December 15, 2009

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet rely in large part on the VHA, CHA, and Lyon software community benefits reporting experience, which was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) how hospitals determined the needs of the communities they serve, (2) initiatives undertaken to address those needs, and (3) evaluations undertaken regarding the effectiveness of the initiatives.

Narrative Report:

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

During fiscal year 2009 there were 454 licensed beds and 32,022 inpatient admissions.

2. Describe the community your organization serves. The narrative should address the following topics: (The items below are based on ***IRS Schedule H, Part VI, Question 4***).

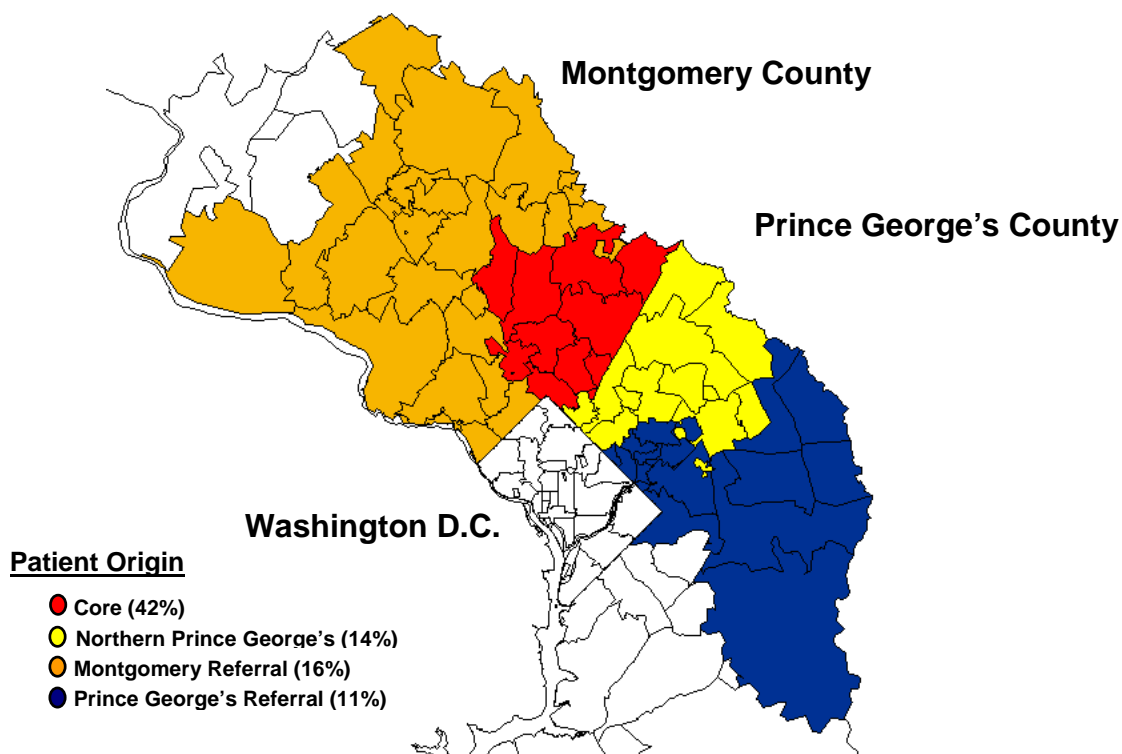
- Describe the geographic community or communities the organization serves;

Holy Cross Hospital primarily serves the residents of two racially and ethnically diverse Maryland counties, Montgomery County and Prince George's County, for a combined total population of approximately 1.8 million (U.S. Census Bureau, 2008 projections). Holy Cross Hospital identifies specific target populations within these counties based on identified critical need revealed through analysis of the social

<u>Race</u>	<u>Montgomery County</u>	<u>Prince George's County</u>
White-Non-Hispanic	507,035 (54.8%)	156,852 (18.8%)
Black Non-Hispanic	146,141 (15.8%)	530,193 (63.6%)
Asian	119,886 (13.0%)	32,593 (3.9%)
Hispanic or Latino (any race)	129,812 (14.0%)	94,476 (11.3%)
All Others	22,845 (2.5%)	19,748 (2.4%)
(U.S. Census Bureau, 2005-2007 American Community Survey)		

health determinants of the geographical areas served. Within these counties, in our primary service area, we target populations based on ZIP Codes or on the basis of the needs of specific population groups (e.g., seniors; pregnant women without health insurance; uninsured adults; uninsured women who need mammograms; racial, ethnic and linguistic minorities). Within each ZIP code, we analyze aggregated data to assess the barriers to health care and the contribution to health disparities of indicators for income, education, culture/language, insurance and housing status.

While we draw patients from both Montgomery and Prince George's Counties, we draw 83 percent of our discharges from a defined market area with four sub-areas. Our core market is defined as 11 contiguous ZIP Codes in Montgomery County from which we draw 42 percent of our discharges. An adjacent geographic area in Northern Prince George's Counties adds another 14 percent of our discharges. Together, these comprise our primary service area for 56 percent of our discharges. Our secondary service area is made up of two other areas, in northern and western Montgomery County (referral area) and southern Prince George's county (referral area). We draw the remaining 17 percent of our discharges from outside this four-market area.



Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

Holy Cross Hospital serves a large portion of Montgomery and Prince George's residents. An estimated 1.8 million people make up the total population of both counties, of which 62% are minorities. Demographic analysis reveals that areas close to Holy Cross Hospital have a large number of persons who are poor, of childbearing age, elderly, racially and ethnically diverse, and limited English speaking.

The highest population density in our area is concentrated near our hospital, especially on the southern border between Montgomery and Prince George's Counties and in Gaithersburg. Areas to the immediate south and east of Holy Cross Hospital have the lowest median income in the area, and Silver Spring and Gaithersburg are next. Areas in Silver Spring and Gaithersburg have the highest percentages of residents who speak English less than very well.

For many health conditions, minorities, especially non-Hispanic blacks, bear a disproportionate burden of disease, injury, death, and disability when compared to their white counterparts (CDC, 2005) and are more likely to be without health insurance than non-Hispanic whites. Minorities also make up a disproportionate number of persons unable to afford health care when needed (Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities, 2006).

Holy Cross Hospital strives to improve health by stewarding its resources to care for the poor and underserved residents of our communities. To meet the needs of our diverse communities, Holy Cross Hospital provides health screenings, health and wellness education, chronic disease management and prevention programs, fitness classes, and support groups to the broader community with a concentrated focus on eliminating health disparities in Montgomery and Prince George's Counties. The Holy Cross Hospital Community Health department continuously develops, implements and evaluates outreach programs and activities that promote health education, chronic disease management, prevention and wellness to support key health issues based on community need and requests for programming.

Despite its relative affluence, Montgomery and Prince George's Counties are home to an estimated 250,000 uninsured adults (SAHIE, 2006). The Holy Cross Hospital financial assistance policy provides systematic and equitable clinical services to those who have medical need and lack adequate resources to pay for services. In FY09, Holy Cross Hospital provided \$12.4 million in financial assistance. Individuals who are uninsured are

able to obtain primary health care services at two Holy Cross Hospital health centers located in Silver Spring and Gaithersburg, Maryland. The health centers provide a convenient option for uninsured residents in need of high quality, discounted medical care. In FY10, financial assistance and utilization of both health centers is expected to rise due to the current downturn in the economy and its effect on individuals finding themselves uninsured, possibly for the first time. We plan to open a third health center in Wheaton/Aspen Hill in FY10.

As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 60+ population in Montgomery and Prince George's Counties will increase by 142% (316,495) and 162% (236,973), respectively (Maryland Department of Planning Population Projections, 2008). The two counties also have the second and third highest percentage of senior minorities in the state with 24.4 percent residing in Prince George's County and 15.7 percent in Montgomery County.

The change in population demographics has prompted Holy Cross Hospital to create an environment that will meet the changing needs of the senior population. In November 2009, the Seniors Emergency Center opened its doors and Holy Cross Hospital became the first hospital in the nation to create an emergency room specifically tailored to serve a growing senior population. The six-bay Holy Cross Hospital Seniors Emergency Center is a separate, enclosed area of the main Emergency Center and provides safe, efficient emergency services designed to meet the complex needs of non-acute elderly patients and those who care for them.

Holy Cross Hospital's community benefit plan articulates overarching strategic objectives and annual initiatives to meet identified, unmet community health care needs. The hospital uses needs assessments, external review boards, population demographics and newly emerging health care needs to develop programs and initiatives that promote access and improve the health status of the community. Analysis of available demographic data such as is described here informs our decision-making.

3. Identification of Community Needs:

- a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (*based on IRS Schedule H, Part IV, Question 2*).

The following are examples of how community health needs might have been identified:

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
- Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
- Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
- Analyzed utilization patterns in the hospital to identify unmet needs;
- Surveyed community residents, and if so, indicate the date of the survey;
- Used data or statistics compiled by county, state, or federal government;
- Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);

Holy Cross Hospital identifies unmet community health needs by participating in community coalitions, partnerships, boards, committees, commissions, advisory groups, and panels. On a quarterly basis, the hospital analyzes internal patient surveys and publicly available data on the market including demographics and health services utilization. Local needs assessments and reports, such as the latest Montgomery County Department of Health and Human Services Strategic Plan 2006-2011 and the Community Needs Index developed by Catholic Healthcare West and the Healthcare Business of Thomson Reuters, are used as they became available to determine the types and locations of community benefit programs implemented.

Using the Community Needs Index, Holy Cross Hospital gathers vital socio-economic and demographic factors to support internal decision-making for resource allocation and to determine the geographic location of new programs to meet emerging needs. For each ZIP Code, the Community Needs Index methodology aggregates five socioeconomic indicators/barriers to healthcare access that are known to contribute to health disparity. The indicators are related to income (percentage of households over age 65 below poverty line; percentage of families with children under 18 below poverty line; percentage of single female families with children under 18 below poverty line), education (percentage of population over 25 without a high school diploma), culture (percentage of population that is minority including Hispanic/Latino ethnicity; percentage of population over age 5 that speaks English poorly or not at all), insurance (percentage of population in the labor force, aged 16 or more, without employment; percentage of population without health insurance), and housing (percentage of households renting their home).

For example, during fiscal 2009, we used this Community Needs Index methodology to locate our second primary care health center for uninsured adults in the second most needy ZIP code in Montgomery County. The opening of this second health center was the most significant addition to Holy Cross Hospital's community benefit activities during fiscal 2009, a year of the greatest economic downturn in decades, and the use of the Community Needs Index methodology helped us to meet the most pressing needs.

During FY09, in addition to the continued use of the Montgomery County Department of Health and Human Services Strategic Plan 2006-2011, we also use a range of other available needs assessments to identify and respond to local needs, some of which became available in fiscal 2009 and some of which were used as references, including:

- Blueprint for Latino Health in Montgomery County Maryland, 2008-2012
- Asian American Health Priorities, A Study of Montgomery County, MD, Strengths, Needs, and Opportunities for Action, 2008
- African American Health Program Strategic Plan Toward Health Equity, 2009-2014
- Fetal/Infant Mortality Review & Community Action Team FY2009 Annual Update
- Montgomery County Local Public Health Assessment Performance Assessment, Summary Report of Findings, 2009
- Montgomery County Commission on Aging Annual Report 2008
- Chair's Report, Public Health Services, to the Montgomery County Commission on Health
- Latino Health Initiative Annual Report, Educating, Mobilizing and Empowering our Latino Community, Fiscal Year 2007
- The Children's Agenda 2007 Data Book, Montgomery County Collaboration Council for Children, Youth and Families
- Partnering Toward a Healthier Future 2007 Progress Report, Eliminating Health Disparities in Frederick, Montgomery and Prince George's Counties in Maryland, Center on Health Disparities, Adventist Health Care
- The Maryland Comprehensive Cancer Control Plan, Executive Summary 2004-2008
- Governor's Commission on Hispanic Affairs 2007 Annual Report
- Federal Interagency Forum on Aging-Related Statistics, "Older Americans 2008, Key Indicators of Well-Being"
- Healthy Women, Healthy Babies, An Issue Brief from the Trust for America's Health

- The State of Health Care Quality 2007, National Committee for Quality Assurance, Washington, D.C.
- Montgomery County Government, Department of Health and Human Services FY08 Annual Report, “Building a Healthy, Safe and Strong Community – One Person At A Time”

Holy Cross Hospital participates in needs assessment processes driven by the local health department. In FY09, Holy Cross Hospital provided \$25,000 to the broadly collaborative and community-driven Montgomery County Community Health Improvement Process (CHIP). The purpose of the process is to assure that all County residents have access to needed health care services and to identify and reduce health disparities. CHIP will implement an ongoing process to gather information and inventory current needs assessments and resources, conduct a comprehensive county-wide needs assessment, make better data available, set priorities, and evaluate, develop and implement improvement plans and monitor the achievement of improvements in community health. We have assigned a senior executive to participate on the Steering Committee of that effort.

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

For the fifth year in a row during fiscal 2009, Holy Cross Hospital invited an external group of participants to review our annual community benefit plan, which includes representatives from the local health department. In fiscal 2009, both the director of the Montgomery County Department of Health and Human Services (MCDHHS or health department) and the Montgomery County Health Officer attended this review.

Holy Cross Hospital works closely with our local health department and is able to nimbly respond to emerging health care needs. For example, Holy Cross Hospital was informed by the Montgomery County health department that the Montgomery County Women’s Cancer Control Program (WCCP) was to close to new enrollees in July 2008 due to state and county budget cuts. The Montgomery County WCCP serves medically underserved low-income Montgomery County residents in need of breast and cervical cancer screenings and follow-up care. Upon learning this, Holy Cross Hospital immediately partnered with the MCDHHS, the Montgomery County Primary Care Coalition, and other Montgomery Cares clinics to fill this gap in services.

During fiscal year 2009, Holy Cross Hospital provided free screenings for early breast cancer detection and links to treatment as needed to 288 women ineligible for WCCP enrollment. During fiscal year 2009 the aggregate numbers of new patients referred for

gynecology was 709, with 1,188 return visits. A total of 262 gynecological procedures (26 endometrial biopsies, 220 colposcopies and 16 Loop electrical surgical excision procedures) were performed.

These services take place at the hospital and include clinical breast examinations, mammography and other diagnostics and pap tests and other gynecological procedures (as described above). All patients received financial assistance and were linked to treatment as needed. Today, the WCCP remains closed to new applicants and we continue to offer these services.

In addition to clinical screenings, Holy Cross Hospital provides health education and outreach in the form of one-on-one encounters, in small group sessions to patients enrolled in the Montgomery Cares Clinics (the Holy Cross Health Centers at Montgomery College in Silver Spring and in Gaithersburg, People's Community Wellness Center and Projecto Salud) and out in the community. The outreach is provided through the Ethnic Health Promotion Program where participants are educated on the importance of disease prevention and early detection, chronic disease management, healthy lifestyles, and tobacco cessation. Medically underserved and uninsured community members are often referred to Holy Cross Hospital's free breast cancer screening program and to free or low-fee primary care at the Holy Cross Hospital Health Centers or other Montgomery Cares clinics.

In consultation with the MCDHHS, our local health department, about filling this gap in services in fiscal 2009, we also discussed the importance of a rapid referral system for breast cancer screenings. Holy Cross Hospital has a successful rapid referral model already in place and we are working with a local coalition on a process improvement plan for the County that incorporates our rapid referral system.

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

Based on the above needs assessments, the major community needs identified for fiscal year 2009 were:

- 1.) The need to increase access to quality health care, especially for children, pregnant women, uninsured adults and seniors.
- 2.) The need to obtain medical care for the underserved by enrolling eligible residents in Medicaid, MHIP and other insurance programs and by building a better system of care for the uninsured.

- 3.) The need to eliminate racial and ethnic health disparities by providing culturally and linguistically competent care and target diseases that are more prevalent in minority populations.
- 4.) To provide health education, disease prevention and chronic disease management (including obesity) programs to improve the health status of the community.

In summary, our activities focus primarily on positively impacting the health of our community with programs that are culturally and linguistically tailored to meet the unmet needs of women, infants, seniors, and racial and ethnic minorities.

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

Holy Cross Hospital's interdepartmental leadership, executive management, and its board of trustees plan, monitor and evaluate the hospital's community benefit efforts. Initiatives are thoughtfully planned to ensure that links exist between the hospital's clinical expertise and unmet community needs. To determine the needs of the community, Holy Cross Hospital has a Chief Executive Officer Review Committee on Community Benefit (an internal, interdepartmental committee) that utilizes available data (e.g., needs assessments, hospital patient data, Community Needs Index) and community input to develop the hospital's Community Benefit Work Plans.

Once a year, an external group of community leaders (including the local health department in Montgomery County) is invited to review the annual community benefit plan and our progress to help us determine our direction for the next year. The work plans describe the goals and objectives the hospital expects to meet during the fiscal year. Once approved by the Holy Cross Hospital board of trustees, the Chief Executive Officer Review Committee on Community Benefit meets on a quarterly basis to review progress toward the expected outcomes. The board of trustee's Mission and Strategy Committee provides quarterly governance oversight.

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

- 1.) The need to increase access to equitable and quality health care, especially for children, pregnant women, uninsured adults and seniors. Our services include:
 - Medical Adult Day Center - Provides social and cognitive stimulation, recreational and rehabilitative services for medically disabled and senior adults

- Discharge assistance program - Provides assistance for entrance fees for recuperative care beds for the homeless and discharge equipment needs for the medically underserved, underinsured and uninsured
 - Transportation assistance – Provides appropriate medical transportation (ambulance and taxi vouchers) for safety-net patients and those who are underinsured/uninsured
 - Homecare services – Provides consultations (medication management, health referrals, follow-up post-partum and newborn care), health screenings (blood pressures) and health information to uninsured, underinsured individuals
 - Holy Cross Hospital OB/GYN Clinic – Provides services for the medically underserved and uninsured, including gestational diabetes education
 - Outpatient Lactation Services – Provides lactation education, support and breast-pump rentals for low-income, uninsured or underinsured mothers
 - Community health education – Provides chronic disease management and prevention programs
- 2.) The need to obtain medical care for the underserved by enrolling eligible residents in Medicaid, MHIP and other insurance programs and by building a better system of care for the uninsured.
- Charity Care – Guided by the hospital’s charitable care policy, provides free or discounted health care services to eligible patients of Holy Cross Hospital, Holy Cross Hospital OB/GYN Clinic, and Holy Cross Health Centers at Montgomery College (Silver Spring) and in Gaithersburg
 - Financial counseling – assists uninsured patients with enrollment into Medicaid in a linguistically and culturally sensitive manner
 - Maryland Health Insurance Program (MHIP) – Provides enrollment assistance
 - School-based health center health fairs –provides education and screenings to five elementary schools in Montgomery County
 - Free health screenings for disease prevention and detection with links to treatment
- 3.) The need to eliminate racial and ethnic health disparities by providing culturally and linguistically competent care and targeting diseases that are more prevalent in minority populations.
- Health fairs and screenings with links to treatment – Provides health education and screening programs targeted at those who are uninsured or underinsured
 - Chronic disease management and prevention classes and programs
 - Cancer program research – Increases racial and ethnic group enrollment in clinical trials
 - Ethnic Health Promoters program – Provides culturally and linguistically competent community and organizational capacity building around disease prevention and early detection, cancer control and tobacco cessation, health

education and clinical (screening, diagnostic and primary care) referrals in the community to eliminate racial and ethnic health disparities

- 4.) To provide health education, disease prevention and chronic disease management (including obesity) to improve the health status of the community.
- Faith Community Nursing – Provides outreach, wellness and chronic disease management and health education
 - Community Health – Provides culturally competent outreach, health and wellness education, chronic disease management and prevention, and physical fitness programs
 - Holy Cross Hospital Senior Source – Provides culturally competent outreach, health and wellness education, chronic disease management and prevention, and mind/body fitness programs targeted at the population aged 55 and over
 - Perinatal Education – Provides outreach and education targeted at pregnant women and those of child-bearing age
 - *Kids Fit* – Provides free children’s multi-component exercise program at Housing Opportunities Commission properties
 - *Senior Fit* – Provides free multi-component evidence-based exercise program at 19 locations
 - *Diabetes Prevention Program* – Provides weight loss, exercise and behavioral change assistance to prevent or delay the onset of diabetes or cardiovascular disease
 - *Diabetes Education and Support Group* – Provides support and education to improve health outcomes of those who have been diagnosed with diabetes
 - Falls Prevention – Assess and educates seniors at risk for falling in an effort to prevent injuries associated with falls
 - Heart Failure Workshop – Provides congestive heart failure prevention and management classes for those at risk or suffering from heart failure
 - Chronic Disease Self-Management – Utilizes the Stanford University evidence-based model that provides those diagnosed with chronic disease(s) support and skills to manage their health and help them keep active in their lives.
 - “Memory Academy” – an evidence based program that helps seniors adapt to changes that normally come with age using various memory techniques and activities

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

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

- a. Name of initiative:
- b. Year of evaluation:

- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or
- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Program One

- a. Name of initiative: Senior Initiative: *Senior Fit*, a free 45-minute multi-component exercise class for adults age 55 and older that focuses on increasing strength, endurance and flexibility. It is offered in partnership with Kaiser Permanente, the Montgomery County Department of Recreation and Maryland National Capital Parks and Planning. A total of 2,707 seniors have participated in Senior Fit from the time it was founded in 1997. In FY09, Senior Fit had an unduplicated enrollment of 1,449 seniors. Each week at 19 sites, 56 classes were held, with a total of 71,105 encounters.
- b. Year of evaluation: 2008 Senior Fit Assessments (Rikli and Jones, 2001)
- c. Nature of the evaluation: The evidence-based Rikli and Jones Senior Fitness assessment Tool (2001) is unique because it measures physiologic parameters using functional movement tasks, such as standing, bending, lifting, reaching and walking. The tool assesses changes in the participants. The biannual Holy Cross Hospital *Senior Fit* assessments include the chair stand (measures lower body strength), arm curl (measures upper body strength), back scratch, (measures flexibility) and the 8-foot up and go test (measures agility and balance).
- d. Result of the evaluation: Fitness Assessment Results

A comparison of two annual fitness assessments (April 2008 and March 2009), with a matched data sample of 296 seniors (236 women and 60 men, ages range from 60-94 years), found the following: an increase in those that performed “above standard” was demonstrated in Arm Curl 90% (198), with an increase from 68% (149).

A separate comparison of two semiannual fitness assessments (September 2008 and March 2009), with a matched data sample of 323 seniors (254 women and 69 men, ages range from 60-94 years) found the following: an increase in those that performed “above standard” was demonstrated in Arm Curl 84% (259), with an increase from 82% (253) and Back Scratch 38% (112), with an increase from 37% (110).

The Senior Fitness Test is conducted on a biannual basis. More than 11 years of data have been collected, including samples of matched data for biannual comparison for participant progress and/or health maintenance. This data is also used to evaluate instructor performance and demonstrate effectiveness to support program growth across Montgomery County. The success of the program has

resulted in a national rollout of Senior Fit programs at seven sites (six sites outside of Maryland) within the Trinity Health network. In October of 2008, Senior Fit received an “Excellence and Innovation Award” from Trinity Health for rapid replication of the program.

Program Two

- a. Name of initiative: Maternal and Child Health Initiative: *Kids Fit*. In partnership with the Housing Opportunities Commission of Montgomery County, Holy Cross Hospital provides *Kids Fit*, a free multi-component exercise class that is specially designed for children ages 6 – 12. A one-hour class that meets twice per week includes tips on healthy lifestyle, an evidence-based and fun exercise program, and a nutritious snack. A total of 125 children are enrolled in the program at five sites.
- b. Year of evaluation: Kids Fit: December 2008 and June 2009
- c. Nature of the evaluation: The biannual fitness assessments take place every fall and spring and utilize the evidence-based President’s Challenge program. The results are scored using norms for age and sex.
- d. Result of the evaluation: Fitness Assessment Results; December 2008 compared with June 2009.
- e. Comparative data was available for a total of 51 participants, 26 girls and 25 boys. The average scores for girls declined by 20% in the push up test, declined by 8% on the curl up test and declined by 5% on the shuttle run. Results on the sit and reach stayed the same. The average scores for boys declined 4% in the push-up test, remained the same for curl-ups, improved by 3% in the shuttle run and improved by 4% in the sit and reach.

Results from the testing showed a need for increased activity in the areas of speed and agility (cardiovascular exercise), abdominal strength (core conditioning) strength training and flexibility (stretching) for the girls. Priorities for the boys include increased cardiovascular training and strength training work.

Program Three

- a. Name of initiative: Chronic Disease Management Initiative: Diabetes Prevention and Self-Management Class

The Diabetes Prevention Program is designed to help the pre-diabetic make lifestyle changes that include weight loss and exercise to prevent or delay the onset of diabetes or cardiovascular disease. This free twelve-week classroom program is followed by six months of telephone support. Blood tests that document pre-

diabetes, or blood pressure or cholesterol elevations that indicate risk for cardiovascular disease are required for inclusion.

- b. Year of evaluation: Outcome measurements: January and July 2008
- c. Nature of the evaluation: Monitoring the following:
 - 1.) Class attendance
 - 2.) Weight control
 - 3.) Exercise regimen
 - 4.) HgbA1c (HgbA1c >6 = pre-diabetic)
 - 5.) Lipid profile
- d. Result of the evaluation: Outcome measurements are as follows
 - 1.) Class attendance
 - 27 individuals began and 23 completed the two classes offered in FY08
 - 86% attended at least 80% of classes
 - 47% attended 100% of classes
 - 2.) Weight Control
 - Weight loss was achieved by 93% of attendees
 - 13% met the 7% weight loss goal
 - 13% met the 5% weight loss goal
 - 3.) Exercise regimen
 - 47% (11) increased their exercise level from pre-program levels
 - 34% (8) met the program exercise goal (at least 150 minutes/week)
 - 4.) HgbA1c
 - HgbA1c levels improved in 100% of participants
 - 5.) Lipid profile
 - Lipid levels improved in 80-100% of participants

Program Four

- a. Name of initiative: Chronic Disease Management - Heart Failure

An interactive workshop that offers practical information about the early signs and symptoms of heart failure, a lecture on heart-healthy nutrition, medication review, blood pressure screening, and exercise techniques for individuals living with heart failure. A heart-healthy cooking demonstration with lunch is also provided.

- b. Year of evaluation: July 2009, completion of five classes for FY08

- c. Nature of the evaluation:

A qualitative and quantitative evaluation included the following information: Demographics (age, income and zip code), reason for attendance (not all participants were diagnosed with heart failure), number of times hospitalized, how they heard about the program, and recommendations for change.

A sample class response: 4 participants

25% of the participants were completely confident that they could control symptoms by modifying food choices and activity level at the start of class, compared to 50% at the end of the workshop.

- d. Result of the evaluation (was the program changed, discontinued, etc.):

A pre-and post- test measures the participant's knowledge/attitudes prior to and upon completion of the class.

- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

A more comprehensive evaluation that reflects the learning is in progress.

Program Five

- a. Name of initiative: Maternal and Child Health Initiative: Managing Gestational Diabetes in Latino Patients

This program was developed due to the prevalence of gestational diabetes in Latinos at a rate of two to three times higher than the general population. Approximately 83% of the obstetrical and gynecological clinic patients at Holy Cross Hospital OB/GYN Clinic are Latina. Many of these patients become at-risk during their pregnancy due to inadequate glycemic control.

- b. Year of evaluation: November 12, 2007 – February 18, 2008
- c. Nature of the evaluation: To monitor dietary intake and glucose levels

Patients recorded diary entry four times per day to document their glucose levels and the number of times they exercised per week.

Nurses entered the glucose levels into a software program that provided graphs of:

- The patient's glycemic averages
- Pre- and post-intervention glucose levels
- Individual exercise patterns

Data was summarized on a pre- and post-implementation line graph comparing the average aggregate of weekly glucose levels. Exercise levels were summarized as percentage of patients who exercised one-to-two times per week, three-to-four times per week, or greater than four-times per week.

- d. Results of the evaluation:

During the period of November 12, 2007 through February 18, 2008, the clinic patients showed a three percent decrease in the aggregate average weekly glucose levels as compared to the 14 weeks prior to the data collection period.

During this same period, 59% of the patients reported participating in moderate exercise three or more times a week.

- 8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

There is reluctance by non-hospital based medical staff to care for the uninsured, especially by "on call" specialty physicians in the emergency center, despite the fact that the "on call" specialists have agreed to care for the uninsured as part of their hospital privileges. Many of the physicians feel the liability and financial burden of caring for these patients is too great.

Inpatient specialty care is provided by hospital employed, specialty care physicians, hospitalists, and other professional staff that provide care in the following specialties: Neurology, cardiology, pulmonary, orthopedics, dermatology, infectious disease, oncology, hematology, medical imaging, laboratory, infusion center, wound center, anesthesiology, pre surgical testing, surgery, obstetrics, gynecology, physical therapy, home care, hospice, patient education, pharmacy, sleep lab, electrocardiogram, and pain

management. Gaps will occur when the ratio of uninsured patients to insured patients threatens sustainability.

Uninsured outpatients have access to hospital services but are in need of outside resources for most of their specialty care. Both of the Holy Cross Hospital Health Centers are fortunate to have experienced, full-time physicians that are able to treat and manage many of the patients requiring specialty care. The Holy Cross Hospital Health Centers are able to provide specialty care in neurology, orthopedics, and otorhinolaryngology on-site, on a limited basis. These specialists can accommodate the immediate needs of the health centers. Nurses report having a difficult time referring patients for gastroenterology and urology. Nurses are also concerned that the ophthalmology co-pay and travel distance present financial and geographical barriers to access. Physicians are also concerned that there is limited referral access to gastroenterology and hematology.

9. If you list physician subsidies in your data, please provide detail.

In order to meet the needs of the uninsured/underinsured population, Holy Cross Hospital has approximately 100 physician contracts for the provision of on-call clinical services as needed. These services are provided on a 24-hour/7-day a week basis, operate on a negative margin and are frequently used by the uninsured/underinsured population. If subsidies were discontinued, the following services would not be available and patients would need to be transported to other facilities or have unmet needs:

- Emergency Department
 - Includes General Surgery, Orthopedic Surgery, Neurology/Stroke Care, Neurosurgery, ENT, Oral Surgery, Interventional Cardiology, Plastic Surgery, Urology, Ophthalmology, Vascular Surgery, Thoracic Surgery, and Psychiatry
- Anesthesiology
- Internal Medicine House Officers, Critical Care physicians and Hospitalists
- Pediatric Hospitalists

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To Be Attached as Appendices:

Describe your Charity Care policy (taken from IRS Schedule H, Part VI, Question 3):

Appendix 1

- 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.

Appendix 1

Charity Care Policy Description

All Holy Cross Hospital registration, financial counseling and customer service staff members are trained to be familiar with the availability of financial assistance and the criteria for such assistance.

In addition:

- The financial assistance application and information about the program are prominently displayed in all registration areas, the emergency center and each cashier's office. The information available is offered in both English and Spanish, the predominant languages in our patient population at Holy Cross Hospital.
- Material describing the financial assistance program and an application are to be given or sent to all patients who request this information.
- Staff is responsible for being particularly alert to those who are registered as self-pay patients and provide them with information on how to contact a financial counselor or provide them financial assistance information. All self-pay inpatients are screened for eligibility for federal, state or other local programs before financial assistance is offered.
- All financial counselors are bilingual (English/Spanish).
- The financial assistance application is accessible through the hospital's external website
- Notice of financial assistance availability is indicated on all hospital billing statements
- Holy Cross Hospital uses Ethnic Health Promoters that inform community members about our financial assistance policy on a one-on-one basis or in group settings where people gather in the community (e.g., hair salons, churches, community centers).
- A written notice is published annually in local newspapers in English and Spanish typically during national Cover the Uninsured Week to advise the public of our financial assistance policy.

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

Appendix 2

Title: **Patient Financial Assistance for indigent patients**

Purpose: It is part of the Holy Cross Hospital mission to make necessary medical care available to those in our community who are in need regardless of their ability to pay. The Hospital maintains a formal financial assistance program to equitably and efficiently provide access for those who cannot pay. Since all care has associated cost, any "free" or "discounted" service provided through this program results in that cost being passed on to other patients and their payers. Holy Cross Hospital therefore has a dual responsibility to cover those in need while ensuring that the cost of care is not unfairly transferred to individuals, third party payers and the community in general.

It is the purpose of this policy to:

- Ensure a consistent efficient and equitable process to provide free or discounted medical services to patients who reside in the state of Maryland or who present with an urgent, emergent or life-threatening condition and do not have the ability to pay.
- Ensure regulatory agencies and the community at large that the hospital documents the financial assistance provided to these patients so that their eligibility for the assistance is appropriately demonstrated.
- Protect a minimal level of each patient's assets from hospital collection.

Applies to: All Financial Counselors and Revenue Cycle Personnel

Policy Overview: Patient Financial Assistance at Holy Cross: In those cases where patients have fully cooperated with and availed themselves of all programs for medical coverage (including Medicare, Medicaid, commercial insurances, workers compensation, and other state and

local programs) and do not have sufficient income or assets to pay for their care, the financial assistance policy of the Hospital applies in two ways - each of which has its own application and documentation requirements.

- **Holy Cross provides assistance for patients who have a current or anticipated need for significant inpatient or outpatient medical care. Significant services are defined as services whose total is expected to exceed \$5,000.** This assistance requires completion of a full application and provision of documentation. Once approved, such financial assistance remains in effect for a period of six months after the determination unless the patient's financial circumstances change or they become eligible for coverage through insurance or available public programs during this time.
- **Holy Cross also makes available *presumptive financial assistance* for routine outpatient services. Routine outpatient services are defined as services that are not expected to aggregate to \$5,000 of charges.** This assistance is based on the same financial assistance eligibility schedule, but normally requires a less extensive documentation process. This program is focused on services provided within Holy Cross Health Centers and the Maternity Clinic as well as Outpatient services provided at the Hospital, Hospice and Home Care services, and the Hospital's Emergency Center. In some cases both the eligibility and documentation requirements will reflect the processes and policies of county or other public programs for financial assistance. ***Should a patient who is granted presumptive status for routine outpatient care have a need for more substantial services or inpatient services, more extensive documentation will be required, and a redetermination of eligibility will be made.*** *The documentation requirements and processes used for each routine area are listed in the billing, financial assistance and collection procedures maintained by the Revenue Cycle Management division.*

Within two business days of the receipt of a completed application for financial assistance, medical assistance or both, a determination

of probable eligibility will be made.

Covered Services: The financial assistance policy applies only to hospital charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Hospital; i.e., inpatient, emergency service, clinic, home care, hospice, Health Center. It does not apply to services that are operated by a “joint venture” or “affiliate” of the hospital. Hospital contracted physicians (Emergency Center, Anesthesia, Pathology, Radiology, Hospitalists, Intensivists and Neonatologists are contracted) also honor scheduled financial assistance determinations made by the hospital. Financial assistance is only applicable when a patient takes advantage of the most appropriate cost effective setting to obtain their care.

Provision of services specifically for the uninsured: In the event that Holy Cross provides a more cost effective setting for needed services (such as the obstetrics and gynecology clinic or the Health Centers for uninsured patients), in cooperation with community groups or contracted physicians, specific financial assistance and payment terms apply that may differ from the general Holy Cross Hospital financial assistance program. In these heavily discounted programs, patients are expected to make the minimum co-payments that are required regardless of the level of charity care for which the patient would otherwise be eligible. Those minimum obligations are not then eligible to be further reduced via the scheduled financial assistance policy. However, if the total obligation of a patient reaches \$5,000 even under these circumstances, a request for an exception may be made.

Services not covered by the financial assistance policy:

1. Private physician services or charges from facilities in which Holy Cross Hospital has less than full ownership.
2. Cosmetic, convenience, and/or other Hospital services, which are not medically necessary. Medical necessity will be determined by the SVP of Medical Affairs after consultation with the patient’s physician and must be determined prior to the provision of any non-emergent service.
3. Services for patients who do not cooperate fully to obtain coverage for their services from County, State, Federal, or

other assistance programs for which Holy Cross believes they are eligible.

Eligibility: Holy Cross provides assistance for Maryland residents whose income is less than 300% of the federal poverty level and whose assets (excluding up to \$50,000 in equity in their primary residence, personal tools used in their trade or business, and deferred retirement plan assets) do not exceed \$10,000 as an individual or \$25,000 within a family.

In addition, any individual who currently owes \$5,000 or more in Holy Cross balances may request an individualized determination of the need for financial assistance from the financial counseling manager. In such cases the total financial circumstances including debt and medical requirements will be considered in addition to the individual's income and assets. The financial counseling manager will assemble the patient's documentation and request and present it to the financial assistance exception committee (comprised of the Vice President, Mission Services, the Chief Financial Officer, and the Senior Vice President, Corporate Development) for consideration.

In any case where the patient's statements to obtain financial assistance are determined to be materially false, all financial assistance that was based on the false statements or documents will be rescinded, and any balances due will be processed through the normal collection processes.

The scheduled financial assistance program provides free care to those most in need – patients who have income less than 200% of the federal poverty level. It also provide for a 60% reduction in charges for those whose income is between 201% and 250% of the poverty level, and 30% assistance from 251% to 300% of the federal poverty level.

Continuing financial obligation of the patient: Patients who receive partial financial assistance have been determined to be capable of making some payment for their care. Unless a specific patient financial assistance exception request is made and approved, or hospital management formally adopts a procedure that exempts collection processes for particular services, patients are expected to pay the amount of the reduced balance. In cases other than the above, any patient who fails to pay their reduced share of the

account in question will have that account processed through our normal collection procedures, including the use of outside agencies and credit reporting. However, the hospital will not pursue a judgment against anyone who has legitimately qualified for any scheduled level of Holy Cross Hospital financial assistance.

Notice of Financial Assistance: The financial assistance program is to be actively publicized to patients of Holy Cross Hospital to whom it may apply. The information will be made available via the following methodologies:

1. Notice of the availability of financial assistance will be posted in the inpatient registration areas (admitting office), all outpatient registration areas (emergency center, ambulatory testing and surgical areas, health centers, and maternity clinic) and the cashier's area (business office).
2. All registration forms, admitting forms, and "self-pay" bills and patient statements will include a notice of the availability of financial assistance with a reference to the web site and a phone number where inquiries can be made.
3. When pre-registrations are completed by phone or Internet, patients will be advised of the existence of the financial assistance program.
4. Information regarding eligibility and an application for financial assistance will be mailed to any patient who requests it at any time – including after referral to collection agencies.
5. A notice will be published each year in a newspaper of wide circulation in the primary service area of the hospital.

This attachment (while referred to in the policy) is not a part of the policy itself and the table will be updated annually within the existing structure as new federal poverty levels are publicized.

Family Size	Federal Poverty Level	Multiple of the Federal Poverty Guideline		
		150%	250%	300%
		100%	60%	30%
1	\$10,830	\$16,245	\$27,075	\$32,490
2	\$14,570	\$21,855	\$36,425	\$43,710
3	\$18,310	\$27,465	\$45,775	\$54,930
4	\$22,050	\$33,075	\$55,125	\$66,150
5	\$25,790	\$38,685	\$64,475	\$75,000
6	\$29,530	\$44,295	\$75,000	\$75,000
7	\$33,270	\$49,905	\$75,000	\$75,000
8	\$37,010	\$55,515	\$75,000	\$75,000
9	\$40,750	\$61,125	\$75,000	\$75,000
10	\$44,490	\$66,735	\$75,000	\$75,000

Revised: 02/23/09

\$ 10,830 is the 2009 Poverty level for 1 person

\$ 3,740 is the additional amount per person

\$ 75,000 is the limit of scheduled financial assistance

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

Appendix 3

Description of Holy Cross Hospital Mission, Vision and Value Statement

When Holy Cross Hospital opened its doors in 1963, it began a tradition of opening doors to health care for our community.

At our founding, the Congregation of the Sisters of the Holy Cross established a commitment to meeting community need and to improving the health of all those we serve, with particular emphasis on accessibility of services to our most poor and vulnerable populations. This commitment is brought to life through our community benefit ministry. Our community benefit efforts include all of the services we provide to community members at no cost or subsidize as part of our mission to be the most trusted provider of health care services in our area.

In meeting this commitment, we focus our efforts on improving health care access. Our proven approach is to systematically identify significant health care needs in our evolving community that are not adequately met because of financial, geographic, racial or cultural barriers. Then we propose and develop innovative solutions to address these needs in ways that can be sustained in the future.

One of our strengths is our ability to collaborate with other organizations to maximize our collective positive impact. We continuously bring together resources toward shared goals by partnering with local, state and federal government agencies; associations; community-based social service organizations; faith communities; charities and others.

a. Attach a copy of the statement (label appendix 4).

Appendix 4

Holy Cross Hospital Mission, Vision and Value Statement

Our Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.

Our Core Values

- Respect
- Social justice
- Compassion
- Care of the poor and underserved
- Excellence

Our Role

Holy Cross Hospital in Silver Spring, Maryland, exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area.

Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit



Fiscal

Reflecting on the Past, Envisioning the Future

A Five-Year Report of Holy Cross Hospital's Commitment to Improving Access to Health Care



HOLY CROSS HOSPITAL

A MEMBER OF  TRINITY HEALTH



Holy Cross Hospital's proposal to partner with Montgomery College-Germantown to build a not-for-profit teaching hospital upcounty will improve access to health care for everyone and help train the next generation of nurses and health care workers.

December 2009

We live in a time when our community's medical needs have become increasingly complex and a record number of people do not have health insurance. We live in a place where our neighborhoods have become more diverse and our aging community members require a growing amount of health care services. Now is the time to reflect on how Holy Cross Hospital has met – and will continue to meet – the complex health care needs of our evolving community.



At Holy Cross Hospital, we have a history of identifying health care needs that, because of financial, geographic, racial or cultural barriers, are not adequately met. And as a not-for-profit hospital we have a track record of reinvesting our profits into innovative and sustainable programs to improve the health of all those we serve, with particular emphasis on the poor and vulnerable.

We have demonstrated our commitment to meeting our community's health care needs with consistent dedication and ever-increasing investments since we first opened our doors almost 50 years ago. In fact, in the past five fiscal years alone, we provided more than \$115 million in community benefit including more than \$48 million in financial assistance, according to reporting guidelines of the Maryland Health Services Cost Review Commission.

As a result, the services we provide to the community extend far beyond what is traditionally expected of a hospital. With efforts focused on improving access to health care, we have built a network of primary care health centers for uninsured adults, developed programs to empower minority communities, provided more maternity and oncology care to uninsured women than any other provider in the area, and pioneered innovative wellness programs that otherwise would not be offered.

This report celebrates milestones of these and other community benefit programs that we offer at no or low cost as part of our mission to be the most trusted provider of health care services in our area.

As our community's population continues to grow and age, we remain committed to improving access to high-quality, convenient health care services. We continue to advance our plans to expand hospital capacity and clinician training opportunities through our proposals to build a hospital on the Germantown Campus of Montgomery College and to enhance our existing hospital in Silver Spring. We also plan to continue to move forward with improving access to care for people without insurance by opening a third primary care health center and a second OB/GYN clinic.

With our significant past experience, and our sound vision for the future, we stand ready to continue to meet our community's health care needs – today and tomorrow.

Kevin J. Sexton
President and CEO
Holy Cross Hospital

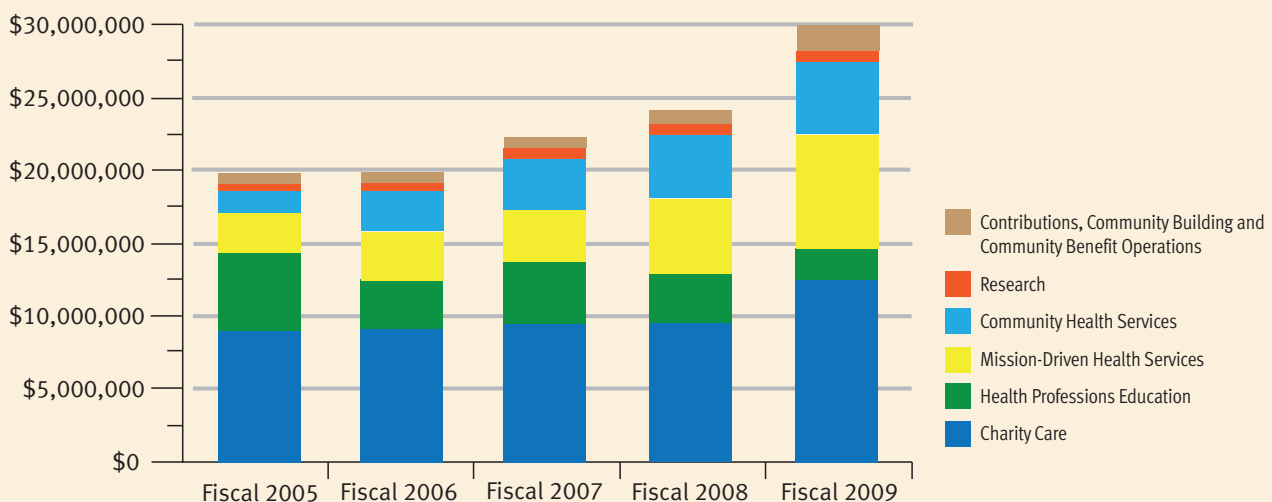
Highlights of Fiscal 2009 Quantifiable Community Benefits*

In fiscal 2009,** Holy Cross Hospital provided more than \$30 million in community benefit including more than \$12 million in financial assistance.

				ENCOUNTERS	NET COMMUNITY BENEFIT
Charity Care <i>Providing services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay.</i>				23,089	\$12,358,867
Health Professions Education <i>Hosting physician residency programs, training students of nursing and other disciplines, and operating a School of Radiologic Technology.</i>	DIRECT COST	INDIRECT COST	OFFSETTING REVENUE	1,682	\$2,503,999
	\$2,553,556	\$1,345,469	\$1,395,026		
Mission-Driven Health Services <i>Offering services that otherwise would not be provided in the community.</i>	\$6,192,110	\$3,262,623	\$1,820,439	12,576	\$7,634,294
Community Health Services <i>Providing health screenings with links to treatment, education, lectures and exercise programs.</i>	\$3,774,942	\$1,989,017	\$263,184	194,867	\$5,500,775
Research <i>Participating in studies on health care delivery and clinical trials sponsored by government agencies, universities and foundations.</i>	\$305,774	\$161,112	\$0	141	\$466,886
Contributions, Community Building and Community Benefit <i>Supporting community organizations by providing in-kind services and hospital space.</i>	\$1,119,008	\$493,066	\$0	12,588	\$1,612,074
				221,854	\$30,076,895

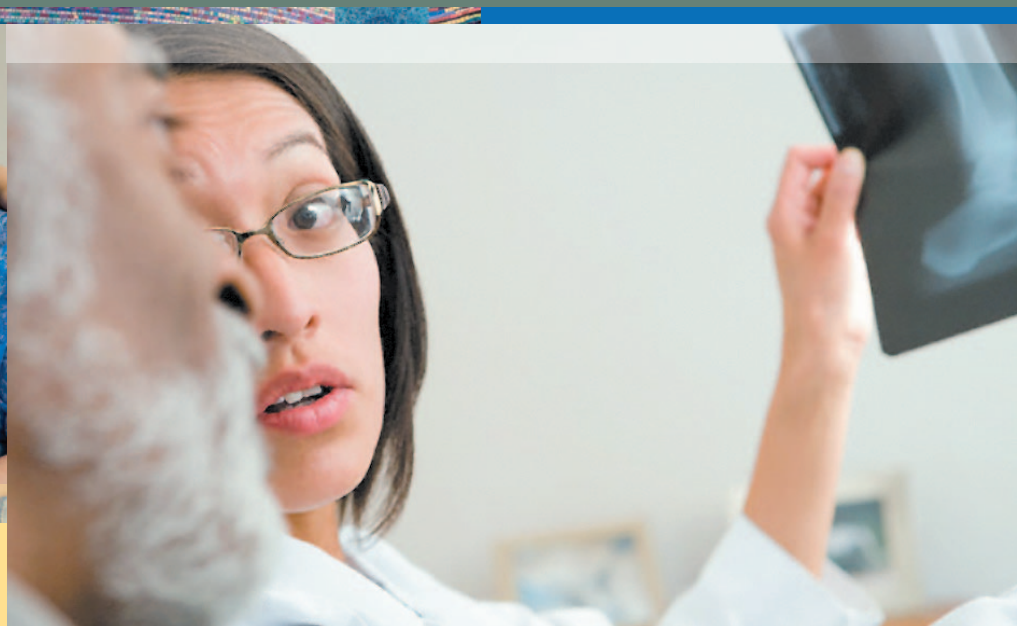
A Tradition of Meeting the Needs of the Community

In the past five fiscal years, Holy Cross Hospital has provided more than \$115 million in community benefit.*



*Prepared according to guidelines established by the Maryland Health Services Cost Review Commission.

**Fiscal 2009 began on July 1, 2008, and ended on June 30, 2009.



Building a Network of Primary Care Health Centers for Low-Income, Uninsured Adults

A Five-Year Reflection

Approximately 100,000 to 120,000 adults who live in Montgomery County do not have health insurance. People who lack financial resources often postpone seeing a health care provider until their medical problems reach critical levels. As a result, they may require emergency services or more complex and expensive care.

“Holy Cross Hospital saw that the health care needs of uninsured adults were not being adequately met,” said Elise C. Riley, MD, interim medical director, Holy Cross Hospital Community Care Delivery. “Helping people who are underserved is at the heart of Holy Cross Hospital’s mission, so we looked for ways to ease access to quality, affordable medical care for people who face financial barriers.”

● Fundraising Efforts Support the Health Centers

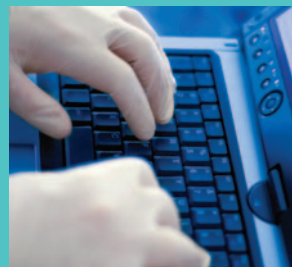
The 2009 Holy Cross Hospital Gala was hosted on September 26, 2009, by the Holy Cross Hospital Foundation. More than \$580,000 was raised to support the health centers in Silver Spring and Gaithersburg.

In the past five years, Holy Cross Hospital opened two health centers that provide affordably priced care to low-income, uninsured Montgomery County adult residents. Plans are in place to open a third center in fiscal 2011.

“With the development of our network of health centers, we serve as one of the leading safety net providers in Montgomery County,” said Calvin Robinson, executive director, Holy Cross Hospital Community Care Delivery. The health centers participate in Montgomery Cares, a public/private partnership that provides care to low-income, uninsured county residents through a network of clinics.

The Holy Cross Hospital health centers provide primary medical care, annual screenings, chronic disease management, behavioral health, preventive care, health education, and follow-up care for emergency room and hospital visits. Skilled medical professionals staff the centers, including physicians, nurse practitioners, physician assistants and registered nurses. Most of the staff at both locations are bilingual in English and Spanish, and interpretation and translation services are available for other languages.

(Continued on page 4)





"I have my own business and I work hard, but I do not have health insurance. Since I had a stroke, the Holy Cross Hospital Health Center in Silver Spring has taken great care of me. Dr. Riley and the staff taught me how to control my diabetes and take better care of myself. Today, I'm back to work, I eat right, I exercise and I always take my medications."

– Peter Wilson, 49

“Our health centers redirect uninsured patients who need primary care away from very high-priced emergency care to a lower-cost outpatient alternative, which eases crowding in area emergency rooms and also helps control overall health care costs,” said Robinson. *“But most importantly, the centers improve the quality, efficiency, continuity and equity of care that uninsured people receive.”*

A Visionary Primary Care and Education Center in Silver Spring

In 2004, Holy Cross Hospital opened its first health center for uninsured adults in the Health Sciences Center on Montgomery College’s Takoma Park/Silver Spring Campus. Since it opened more than five years ago, the center has provided 32,308 patient visits, including 7,656 patient visits in fiscal 2009.

“Holy Cross Hospital and Montgomery College’s unique arrangement creates a special learning opportunity for students of nursing and other allied health programs,” said Dr. Riley. *“Students can participate in rotations at this primary care center.”*

Making Care More Convenient in Gaithersburg

More than 15 percent of the patients who used the Holy Cross Hospital Health Center in Silver Spring were traveling from Gaithersburg, Germantown, Rockville or Montgomery Village. To better serve these communities, Holy Cross Hospital opened a second health center in Gaithersburg in February 2009.

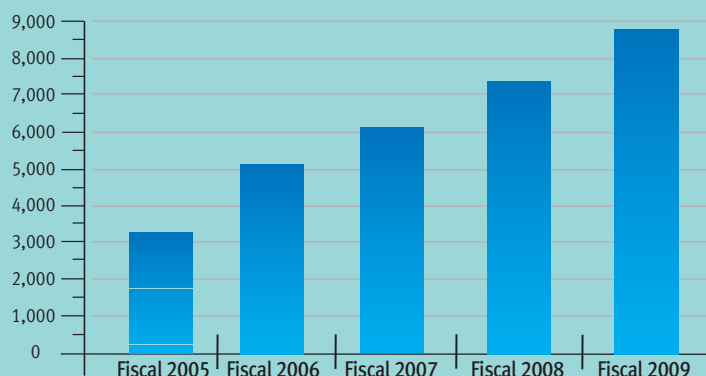
“We placed this second health center where there was the greatest need,” said Robinson. *“The center is located in a Montgomery County ZIP code with more socioeconomic and medical needs than any other except one.”*

The Holy Cross Hospital Health Center in Gaithersburg is capable of handling more than 10,000 patient visits a year with at least 5,000 encounters expected in the first year.

The development of the 5,600 square foot facility was supported by the Montgomery County government. Partial operational funding is provided by Montgomery County through Montgomery Cares and by Suburban Hospital.

Holy Cross Hospital Health Center Patient Visits

In the past five fiscal years, the Holy Cross Hospital health centers have provided 30,847 patient visits.



Vision for the Future: A Third Health Center in Wheaton

“We expect that the need for financial assistance and the utilization of both of our existing health centers will rise due to the downturn in the economy,” said Robinson. *“More people may find themselves uninsured, possibly for the first time.”*

To meet this need, Holy Cross Hospital plans to open a third health center in Wheaton in fiscal 2011. The center will be the same size and scope of the center in Gaithersburg, greatly increasing Montgomery County’s capacity to serve uninsured residents.



A Healthy Start for Expectant Mothers and Newborns

A Five-Year Reflection

Expert care during pregnancy helps to ensure a healthy mother and baby. But for women without health insurance, maternal care can bring huge financial burdens.

“Women who don’t receive care during their pregnancies because they can’t afford it are less likely to have healthy babies,” said Nancy Nagel, RN, senior director, Women and Children’s Services, Holy Cross Hospital. *“Our goal is to ensure that all women have access to the care they need for their health and the health of their babies.”*

With this commitment in mind, Holy Cross Hospital has provided prenatal, obstetric and gynecologic care to women regardless of their ability to pay since 1963. The hospital delivers more babies than any other in Maryland or the District of Columbia, making it uniquely equipped to provide this specialized care. Today, through its OB/GYN Clinic, Holy Cross Hospital remains Montgomery County’s leading provider of these services for uninsured women.

2004 Renovation to Provide a Single Standard of Care

Between 1999 and 2004, the community’s need for prenatal and obstetric services grew dramatically. The number of uninsured women who delivered babies at Holy Cross Hospital grew 50 percent during that period.

“We decided to redesign our maternity areas to meet the growing demand for OB/GYN services,” said Nagel. *“Our redesign combined our expertise in maternity care with our commitment to community benefit to ensure that our resulting facilities would meet the community’s need.”*

The 2004 renovation created nine new delivery rooms for a total of 24 private, homelike labor, delivery and recovery rooms. The renovation also created 68 private postpartum maternity suites – more than any other area hospital. Each spacious delivery room and postpartum suite offers a private bathroom, sleeper sofa and other amenities for all patients regardless of their ability to pay.

The renovation also relocated the hospital’s OB/GYN Clinic for uninsured women to the second

floor of the hospital. The spacious and sophisticated center was conveniently placed near the hospital’s other maternity services.

“As a result of the renovation, Holy Cross Hospital has been able to provide OB/GYN care to more women over the past five years, and to ensure a single standard of care for all women,” said Nagel.

Prenatal Care for Those in Need

Uninsured women may enter the hospital’s OB/GYN Clinic for prenatal care at any point during pregnancy, though most have nine visits leading up to their deliveries. Women with complications such as HIV, diabetes, premature labor and hypertension are followed closely during their pregnancies and deliveries.

Many clinic patients are not native English speakers, therefore staff members are bilingual to provide culturally competent quality care. An extensive perinatal community education program includes classes in Spanish, and follow-up care also is provided in the home.

The Holy Cross Hospital OB/GYN Clinic expanded 10 years ago through the Maternity Partnership with the Montgomery County Department of Health and Human Services, a program that provides every uninsured woman in the county with the opportunity to receive prenatal care. Since 1999, Holy Cross Hospital has provided care to nearly 15,000 women in the Maternity Partnership Program.

During the past five fiscal years, the clinic has provided 89,993 patient visits, including 14,987 patient visits in fiscal 2009 alone.

“If not for Holy Cross Hospital,” said Nagel, *“many women might not receive the care that they need.”*

Vision for the Future: A Second Clinic

To better serve uninsured women throughout the county, Holy Cross Hospital plans to build a second OB/GYN clinic in the full-service hospital planned for Germantown.





Improving Access to Breast Health Services for Low-Income Racial and Ethnic Minorities

A Five-Year Reflection

Women of any income, race or ethnicity can develop breast cancer – one of the most common cancers.

“But women who are racially and ethnically diverse face documented disparities in care,” said Shelly Grant, manager, Community and Minority Health, Holy Cross Hospital.

“Women who are uninsured and have low incomes are more likely to be diagnosed with advanced breast cancer and are less likely to survive.”

Seeing the need to improve access to breast health care including education, screening, treatment and support services for low-income, medically underserved, uninsured or underinsured racial and ethnic minorities, Holy Cross Hospital developed the Komen Foundation Community Collaboration to Battle Breast Cancer (KFCC-BBC), also known as Mammogram Assistance Program Services (MAPS), in 2004.

This community collaboration is a partnership among Susan G. Komen for the Cure, Holy Cross Hospital, Holy Cross Hospital Foundation and other community organizations, including the Montgomery County Department of Health and Human Services’ African American Health Program and Asian American Health Initiative.

Success Through Culturally Sensitive Outreach

“For years we have worked to decrease the risk of breast cancer disease and death,” said Grant. *“We target vulnerable community members where they live and work, providing culturally sensitive and linguistically appropriate breast health information with links to free breast care services.”*

KFCC-BBC provides women and men in need with breast cancer education, screening, links to treatment, navigation services, follow-up care, and support services such as medical case management, support group referrals, dependent care and transportation. Emotional support, interpretation and translation also are provided during educational sessions, clinical examinations and treatment.

Each year, outreach has expanded through the commitment of Holy Cross Hospital’s ethnic health promoters, who are specially trained to provide target populations with effective breast health education and links to appropriate resources.

“We are meeting an essential and previously unmet need for people who face cultural and linguistic barriers to breast health services and are ineligible for local or state government cancer control programs,” said Grant.

Since its inception, KFCC-BBC has taught more than 30,000 underserved community members the importance of breast health and the early detection of breast cancer – including how to perform a breast self-examination. The program has provided 1,500 free breast screenings.

Vision for the Future

Building on \$522,500 of grant support since 2002, in 2009, Susan G. Komen for the Cure granted Holy Cross Hospital \$823,750 for a three-year continuation and expansion of the program.

“This generous grant recognizes our success and will allow us to expand the initiative,” said Grant. *“We plan to establish a ‘medical home’ for women so that we can address additional health needs.”*



"I never expected to be diagnosed with breast cancer at my age. And since I don't have health insurance, I don't know what I would have done without Holy Cross Hospital. Everyone at the hospital who helped me get treatment and all of my doctors have been wonderful and supportive. I feel blessed and have learned that you have to put your health first for your family."

— Normaly Cabrera, 31



Seniors Staying Independent Through Exercise

A Five-Year Reflection

As people age, their risk for illness and injury naturally increases. Exercise can slow the aging process and help people become stronger and more resilient. Although older adults are often familiar with the benefits of exercise, starting a fitness regimen can be overwhelming.

"Many seniors are intimidated by traditional fitness facilities that can be expensive and often offer activities that are targeted toward younger audiences," said Sarah McKechnie, manager, Community Fitness, Holy Cross Hospital. *"Senior Fit removes these barriers by offering a financially and geographically accessible program specifically designed for older adults."*

Breaking Down Barriers to Fitness

Senior Fit is a free 45-minute multi-component exercise program for adults ages 55 and older. Based on American College of Sports Medicine guidelines, the innovative program promotes health and flexibility, prevents disease and helps maintain independence.

Holy Cross Hospital created *Senior Fit* in 1995, and the program has grown steadily over the years. In fiscal 2009, more than 1,800 seniors actively participated more than 71,000 times.

Classes are offered at 19 locations throughout Montgomery and Prince George's counties and the District of Columbia, through a partnership among Holy Cross Hospital, Kaiser Permanente, Maryland National Capital Parks and Planning Commission, Montgomery County Department of Recreation and local churches.

Recognized Results

In recent years, *Senior Fit* has received multiple awards of excellence. In 2003, the National Council on Aging identified

Senior Fit as one of the top 10 physical activity programs for older adults in the country.

A year later, it was selected by the National Council on Aging as one of three sites for an impact study on exercise effectiveness in older adults.

"The study demonstrated that community exercise classes for seniors help to improve upper body strength, lower body strength and that seniors are highly motivated to exercise," said McKechnie.

Replicating Senior Fit Across the Nation

Holy Cross Hospital is a member of Trinity Health, a health care system that operates 44 acute-care hospitals in seven states.

"In 2007, Senior Fit became the first community health initiative to be rolled out through Trinity Health," said McKechnie. *"To date, our Senior Fit model has been replicated by five hospitals across the country."*

Trinity Health awarded Holy Cross Hospital's *Senior Fit* program an Excellence and Innovation Award for Outstanding Achievement in Support of Rapid Replication in 2008.

Vision for the Future

"We look forward to assisting with the replication of Senior Fit in other communities and expanding our program at home to meet the steady demand for new classes," said McKechnie. *"When it comes to preventing and managing chronic illnesses, exercise makes a world of difference."*





"Before Senior Fit, I couldn't turn my head comfortably, which interfered with my ability to drive. Now, I can turn my head easily and my upper body strength is improving – I can even do pushups! My instructor challenges me to do more than I think I can, and as a result I feel better than I did when I began the class two years ago."

– Claudia Baker, 67



Educating and Empowering Minority Communities

A Five-Year Reflection

As communities throughout Montgomery County grow more diverse, certain populations continue to experience poorer health and disproportionate rates of illness and death. Holy Cross Hospital has pioneered innovative efforts to better meet the needs of vulnerable and underserved populations, including racial, ethnic and linguistic minorities.

“We are committed to understanding the cultures in our community and tailoring care to be sensitive to the beliefs, customs and behaviors of the people we serve,” said Wendy Friar, RN, vice president, Community Health, Holy Cross Hospital. *“That is the only way we can eliminate the health disparities that exist in our area.”*

“We are committed to understanding the cultures in our community and tailoring care to be sensitive to beliefs, customs and behaviors of the people we serve.”

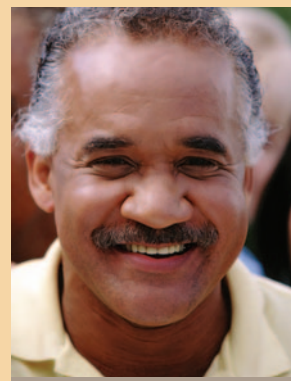
The Minority Communities Empowerment Project

Holy Cross Hospital increased its role in addressing the unmet needs of racial and ethnic minority populations when the hospital became the lead agency of the Minority Communities Empowerment Project in 2004. This multi-organizational collaborative effort aims to reduce tobacco use among minorities and reduce health disparities in cancer mortality and morbidity through community and organizational capacity building.

“In addition to raising awareness about tobacco-related illnesses and linking community members with local cancer screening opportunities, we also have been recruiting and training minorities to actively participate in and advocate for the health service needs of their communities,” said Friar. *“Empowering people to speak out about their needs and to ask for help is a crucial element of the effort to resolve disparities in care.”*

Participating organizations include the Montgomery County Asian American Health Initiative and African American Health Program, CASA of Maryland, Inc., Community

(Continued on page 12)





"As an ethnic health promoter, I take health and wellness information to people where they gather in my community, like beauty salons, churches and community centers. At the Gwendolyn E. Coffield Community Center, I educate children on the importance of exercise, nutrition and tobacco avoidance. It's inspiring to educate people in a way that empowers them to become more health conscious for themselves and their families."

– Ayana Wylie, 28

Ministries of Rockville, and the Maryland Commission on Indian Affairs. The project is supported by Minority Outreach and Technical Assistance (MOTA), which the Maryland General Assembly established as a part of the Statewide Public Health Component of the Cigarette Restitution Fund Program. The Cigarette Restitution Fund Program aims to decrease the incidence of cancer and deaths caused by cancer, and prevent and control tobacco use in minority communities throughout the state.

Since fiscal 2005, participating organizations in the Minority Communities Empowerment Project have facilitated approximately 75,000 health educational encounters, including 21,576 health educational encounters at 692 outreach sessions in fiscal 2009 alone. Holy Cross Hospital's ethnic health promoters facilitated 6,937 of those fiscal 2009 education encounters at 161 outreach sessions.

A Cultural Connection

"Our ability to serve as the lead agency for the Minority Communities Empowerment Project is based on our commitment and expertise in health promotion among racial and ethnic minority populations," said Friar. "For the past eight years our ethnic health promoters have targeted racial and ethnic minority populations that may have reduced access to care because of financial or geographical constraints, varying cultural practices, or lack of knowledge of the U.S. health care system."

Holy Cross Hospital established its Ethnic Health Promoter program in 2001 in collaboration with the Montgomery County Cancer Crusade.

"Our ethnic health promoters are African American, Asian American, Latino American and Russian American," said Friar. "They are culturally and linguistically competent and they live in the communities where they provide outreach. This makes them uniquely qualified to provide effective, understandable and respectful care that is compatible with cultural beliefs and practices."

The health promoters provide information about health maintenance and wellness, disease prevention and the importance of early disease detection. They also create links to and offer support during disease screening, diagnosis and treatment. Their outreach takes them to community centers, faith-based institutions, barbershops, beauty salons, Metro stations, ethnic grocery stores, health fairs and community gatherings.

"Our success is a direct result of the ability of our ethnic health promoters to earn the trust of the communities where they work," said Friar. "They successfully develop and sustain trusting relationships with communities members and provide information and services that otherwise wouldn't be accessible."

Holy Cross Hospital provides the Ethnic Health Promoter program with support from the Holy Cross Hospital Foundation, the Maryland Department of Health and Mental Hygiene and Susan G. Koman for the Cure.

Since fiscal 2005, Holy Cross Hospital's ethnic health promoters have had approximately 89,000 encounters with the community, including 19,280 encounters in fiscal 2009 alone.

Vision for the Future

"Cultural, ethnic and racial minorities in our community are no longer hard-to-reach populations," says Friar. "Our efforts cannot be just about how we reach our diverse community members, but how well we establish relationships in a culturally and linguistically sensitive manner as we strive to provide equity in care in the most respectful way we can."



Unique and Innovative Programs

Holy Cross Hospital offers a wide range of services that are a direct result of our commitment to our mission. Many of these programs are unique in the community and would not otherwise be available. These programs meet important community needs and are not expected to generate a positive financial return.

- **Senior Source** – Health and wellness classes, health screenings and intellectually stimulating programs for people age 55 and older. *12,748 encounters**
- **Perinatal Education** – English and Spanish classes to help expectant parents prepare for birth and the care of a newborn. *10,205 encounters**
- **Medical Adult Day Center** – Social, recreational and rehabilitative services for medically disabled or older adults. *5,865 encounters**
- **Caregiver Resource Center** – Free classes, support groups and a resource library for those who care for medically challenged or aging individuals. *4,387 encounters**
- **Kids Fit** – Free children's multi-component exercise program at Housing Opportunities Commission properties. *4,117 encounters**
- **Nicotine Dependence Center** – Inpatient bedside quitting support, outpatient group counseling program and a support group to help people stop smoking. *2,467 encounters**
- **Pharmacy Programs** – Discounted prescriptions for low-income inpatients and outpatients of the OB/GYN Clinic. *1,383 encounters**
- **Diabetes Programs** – Diabetes prevention programs, self-management education and support groups. *1,232 encounters**
- **Home Care Nurses** – Postnatal home visits to uninsured mothers to create a bridge from birthing care to pediatric care. *1,120 encounters**

**Fiscal 2009*



• Faith Community Nursing Program: Caring for Body, Mind and Spirit

"Health is created in communities as well as medical settings," said Carmella Jones, RN, FCN, manager, Faith Community Nurse Program, Holy Cross Hospital. *"Building on that belief, faith community nursing has a broad vision of 'whole health' that focuses on the connection between spirituality and health."*

Since 1993, the Holy Cross Hospital Faith Community Nurse Program has assisted faith community nurses and health ministry teams in educating, empowering and equipping members of their faith communities in the pursuit of health, healing and wholeness. Today, more than 60 faith communities that are diverse in denomination, size, race and ethnicity partner with the Faith Community Nurse Program.

As a local, regional and national model, the program offers health education programs, preventive screenings, chronic disease management education, wellness counseling, patient advocacy, resource referral, support group development, services and prayers for healing, and home and hospital visitation programs. In fiscal 2009, the program had 6,370 encounters with community members.

Access to Financial Assistance

An estimated 250,000 adults in Montgomery and Prince George's counties have no health insurance. Many cannot get the care they need for urgent or chronic health problems because they cannot afford it.

Holy Cross Hospital is committed to reducing financial barriers to health care services for people who are poor or underinsured. Our financial assistance policy provides a systematic and equitable way to provide necessary services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay.

In fiscal 2009, Holy Cross Hospital provided more than \$12.4 million in financial assistance to 6,113 patients. In the past five fiscal years, the hospital provided more than \$48 million in financial assistance.



About Holy Cross Hospital

Holy Cross Hospital is one of the largest hospitals in Maryland. Founded in 1963 by the Congregation of the Sisters of the Holy Cross, today Holy Cross Hospital is a 450-bed, not-for-profit teaching hospital. Holy Cross Hospital is a member of Trinity Health, a national health system.

Community Benefit Planning and Oversight

Holy Cross Hospital's community benefit plan is driven by identified unmet community needs. Our activities focus on positively impacting the health of our community with a continuum of care that is tailored to meet the unique needs of women, infants, seniors, and racial, ethnic and linguistic minorities.

In fiscal 2009, Holy Cross Hospital identified unmet community health needs by participating in community coalitions, commissions, committees, boards, partnerships, advisory groups and panels. Holy Cross Hospital also works closely with the Montgomery County Department of Health and Human Services and supports Montgomery County's Community Health Improvement Process (CHIP), a collaborative program that addresses access to care and health disparities.

In each of the last five years, Holy Cross Hospital has invited representatives of these groups to review its community benefit plan and provide recommendations for the hospital's community benefit focus. The hospital also analyzed needs assessments and data about the market, demographics, socio-economic factors and health service utilization.

Holy Cross Hospital's interdepartmental leadership, CEO review committee on community benefit, and board of trustees plan, monitor and evaluate the hospital's community benefit efforts. Each year the board of trustees approves the plan and the board's mission and strategy committee provides quarterly governance oversight. Initiatives are thoughtfully planned to ensure links between areas in which the hospital has a demonstrated clinical competence and unmet community needs. The hospital also participates with other organizations in the community to leverage community resources toward mutual goals.

For additional information about Holy Cross Hospital Community Benefit, contact Kimberley McBride, coordinator, Community Health, at 301-754-7149 or mcbrik@holycrosshealth.org.

Trinity Health's Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us. Our core values are respect, social justice, compassion, care of the poor and underserved, and excellence.

Holy Cross Hospital's Role

Holy Cross Hospital exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area. Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit



A MEMBER OF  TRINITY HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910
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www.holycrosshealth.org

Howard County General Hospital

Community Benefit Narrative

COMMUNITY BENEFIT NARRATIVE
Howard County General Hospital
Fiscal Year 2009

1. **Key Statistics.** In FY 2009, Howard County General Hospital (HCGH or Hospital) was licensed to operate 209 beds. During the same period, the Hospital had 14,341 inpatient admissions and 3,084 births.
2. **The Community** served by HCGH includes all of Howard County, Maryland, and selected surrounding areas. The community includes 27 contiguous zip codes where nearly 80% of the Hospital's patients reside. These zip codes include

20701 Annapolis Junction	20777 Highland	21046 Columbia
20724 Laurel	20794 Jessup	21075 Elkridge
20755 Fort Meade	21029 Clarksville	21150 Columbia
21163 Woodstock	21036 Dayton	21723 Cooksville
21104 Marriotsville	21041 Ellicott City	21737 Glenelg
21784 Sykesville	21042 Ellicott City	21738 Glenwood
20723 Laurel	21043 Ellicott City	21765 Lisbon
20759 Fulton	21044 Columbia	21794 West Friendship
20763 Savage	21045 Columbia	21797 Woodbine

Howard County has been one of Maryland's fastest-growing regions, increasing its population by 34% over the past decade. Its population is projected to grow to 327,635 by 2035, according to the Howard County Department of Planning and Zoning. Currently, the County's citizens are the wealthiest in Maryland and among the most affluent in the nation. According to the 2007 American Community Survey, Howard County's Median Household Income of \$101,672 ranked third in the country.¹ A summary of key demographics of the HCGH Service Area (HCGH SA) defined above follows.

Table 1 shows that the HCGH SA is growing at a rate faster than the country as a whole, and that its average household income is 70% greater than the national average.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS

	HCGH Service Area	USA
2000 Total Population	316,486	281,421,906
2009 Total Population	355,662	306,624,699
2014 Total Population	376,465	322,320,436
% Change 2009 – 2014	5.8%	5.1%
Average Household Income	\$118,100	\$69,376

¹ Howard County Economic Development Authority

Table 2 below reinforces the economic strength of the community, largely driven by a strong government employment sector. Also noteworthy is the projected decline, albeit slight, in the population of women of childbearing age. This is the first time in the hospital's history that it will witness a decline in this population segment, signaling a need to redeploy certain resources.

TABLE 2. HCGH SERVICE AREA POPULATION

	2009	2014	% Change
Total Male Population	177,585	187,618	5.6%
Total Female Population	178,077	188,847	6.0%
Females, Child Bearing Age (15-44)	72,877	71,786	-1.5%
% Unemployment	2.7%		
% USA Unemployment	5.6%		

Table 3 illustrates the shift in demographics projected over the next five years in the HCGH SA. The largest growth will be in the 65+ and 55-65 age cohorts respectively, while the younger age cohorts are flat or in decline. This transformation will call for a reprioritization of community benefit resources towards an emerging senior population.

TABLE 3. POPULATION DISTRIBUTION

Age Group	Age Distribution				USA 2009 % of Total
	2009	% of Total	2014	% of Total	
0-14	72,272	20.3%	71,316	18.9%	20.1%
15-17	17,632	5.0%	18,007	4.8%	4.3%
18-24	31,871	9.0%	36,155	9.6%	9.8%
25-34	43,088	12.1%	44,949	11.9%	13.3%
35-54	115,341	32.4%	110,536	29.4%	28.4%
55-64	41,410	11.6%	50,383	13.4%	11.3%
65+	34,048	9.6%	45,119	12.0%	12.9%
Total	355,662	100.0%	376,465	100.0%	100.0%

Table 4 shows the disproportionate share of high-income households in Howard County. Despite its affluence, the community also includes pockets of poverty, particularly in the eastern and southeastern edges of the county.

TABLE 4. HOUSEHOLD INCOME DISTRIBUTION

2009 Household Income	Income Distribution		
	HH Count	% of Total	USA % of Total
<\$15K	4,402	3.5%	12.4%
\$15-25K	3,901	3.1%	10.4%
\$25-50K	16,475	13.1%	26.0%
\$50-75K	20,462	16.3%	19.6%
\$75-100K	20,641	16.4%	12.3%
Over \$100K	59,877	47.6%	19.3%
Total	125,758	100.0%	100.0%

The well-regarded public education system has attracted a sizable number of foreign born, particularly of Asian descent, as seen in Table 5 below. This education system also attracts a disproportionate share of well-educated residents with nearly twice the rate of college graduates as the national average.

TABLE 5. RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution		
	2009 Pop	% of Total	USA % of Total
White Non-Hispanic	226,088	63.6%	65.0%
Black Non-Hispanic	66,099	18.6%	12.2%
Hispanic	17,308	4.9%	15.5%
Asian & Pacific Is. Non-Hispanic	36,104	10.2%	4.5%
All Others	10,063	2.8%	2.8%
Total	355,662	100.0%	100.0%

TABLE 6. EDUCATION LEVEL

2009 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA % of Total
Less than High School	6,257	2.7%	7.5%
Some High School	13,024	5.6%	11.9%
High School Degree	43,566	18.6%	28.3%
Some College/Assoc. Degree	58,320	24.9%	27.7%
Bachelor's Degree or Greater	112,720	48.2%	24.7%
Total	233,887	100.0%	100.0%

Despite many of these very positive indicators, there remains a segment of the HCGH service area population that is less affluent, less educated and in need of health services. This population has been the target of many of the hospital's community benefit initiatives.

The most significant projected changes in the composition of HCGH SA residents that indicate evolution of community health needs are:

- **Aging of the population:** Between 2009 and 2019, the segment of service area population over age 65 is projected to increase by over 60%, reaching an estimated 55,370. The 65+ segment will grow from 9.6% to 13.7% of the total service area population.
- **Increase in foreign-born population:** Howard County has witnessed significant influx of foreign born, specifically of Asian, Latino and African descent. Each segment of foreign-born brings to the county a unique set of health care needs as well as communication and acculturation challenges.

3. Identification of Community Needs

- a. HCGH uses a variety of methods for determining health needs within its community. These methods include:

- i. Analysis of utilization patterns for health care services both within the hospital and within the broader community;
- ii. Analysis of data and reports compiled by county and state government agencies examining health care services within the Howard County community. Examples of information reviewed include:
 - 1. Howard County Human Services Master Plan
 - 2. Howard County Emergency Incident Command Plan.
- iii. Consultation with community leaders and various stakeholders concerning unmet health needs within the Hospital's marketplace. The list of organizations/individuals consulted by hospital leaders in FY 2009 concerning various community health needs includes:
 - 1. Howard County Health Officer and other Howard County Health Department staff
 - 2. Howard County Council
 - 3. Howard County Office on Aging
 - 4. Howard County Office of Citizen Services
 - 5. Howard County Fire and Rescue Services
 - 6. Howard County Police Department
 - 7. Howard County Mental Health Authority
 - 8. Howard County Economic Development Authority
 - 9. Horizon Foundation
 - 10. Chase Brexton Health Services (Federally Qualified Community Health Center)
 - 11. National Alliance for Mentally Ill, Howard County Chapter
 - 12. Korean American Citizen's Association of Howard County
 - 13. Howard County Citizen's Association
 - 14. Gilchrist Hospice
 - 15. Numerous private practice physicians across many specialties serving Howard County
 - 16. HCGH Community Relations Council (a diverse collection of county residents representing the community who meet quarterly to provide feedback to hospital leaders about community needs)
 - 17. League of Women Voters, Howard County Chapter
 - 18. Association of Community Services
 - 19. United Way of Central Maryland
 - 20. Maryland Department of Mental Hygiene
 - 21. Howard County Chamber of Commerce
- iv. Comprehensive Community Health Needs Assessment: in 2001, the Hospital participated in and supported a comprehensive community health needs assessment sponsored by the Howard County Health Department (HCHD). The assessment included a review of secondary data (e.g. demographics, state health department data, local health department data, hospital discharge

- data, and data from the Behavioral Risk Factor Surveillance System) as well as administration of a detailed health survey.
- b. HCGH has been in regular discussion with the Howard County Health Department (HCHD) concerning health needs. In fact, HCGH and HCHD have closely collaborated to implement strategies to reduce the rolls of citizens without health insurance through the Healthy Howard program. Additionally, the two entities have worked closely to plan emergency response to the H1N1 influenza pandemic and to address public concern with MRSA infection threats, among other shared community health issues.
4. **Major community health needs identified during FY 2009 planning consultations included:**
 - a. A comprehensive plan to address the acute care health needs of the burgeoning senior population in Howard County. HCGH has subsequently engaged the Division of Geriatric Medicine at the Johns Hopkins University School of Public Health to assist in the formulation of such a plan for the Hospital.
 - b. More accessible and timely interpreter services at HCGH for patients with Limited English proficiency (LEP). During FY 2009, HCGH incurred more than \$200,000 of expenses to purchase and provide translation services.
 - c. Access to basic health screening and information, particularly for low income and uninsured populations. During FY 2009, HCGH made substantial investment in community wellness screening and education programming.
 - d. Access to prenatal care for uninsured populations.
 5. **Decision Making Process.** Input concerning community health needs is compiled and submitted for consideration to the HCGH Executive Management Team (EMT). The EMT evaluates identified needs within the context of the Hospital's strategic priorities, available resources (financial, human, facilities, etc.) and collaboration opportunities to leverage hospital initiatives with other community resources. Decisions concerning outlay of significant funds rest with the Executive Management Team. Community benefit activities are reviewed by the Board of Trustees.
 6. Several **community benefit initiatives** address needs identified in #4 above, including:
 - a. Healthy Howard (HH): HCGH is a major partner in the "health access plan" conceived and launched by the current county executive and his administration. HCGH has contributed in kind hospital services for all uninsured residents signing up for the HH Access Plan. During FY 2009

and for the first six months the program was in place, HCGH provided nearly \$100,000 free care to Healthy Howard members. For the first five months of FY 2010, free care to Healthy Howard members has increased to more than \$220,000.

- b. **Mall Wellness Fairs:** HCGH has sponsored themed community health fairs (e.g. heart health, children's health, fitness, cancer) at the Mall in Columbia for the past two years. Each event, generally 4 hours long on a Saturday, brings together hospital healthcare providers, community physicians, and representatives from local health and human service agencies to provide screenings, conduct health education and disseminate information about community health resources. Several hundred participants have registered and taken advantage of the health offerings at each event.
- c. **Ethnic Health Fairs:** In response to the unique health needs of emerging foreign-born populations, HCGH has sponsored or co-sponsored several "ethnic targeted" health fairs each year for the past 4 years. Specific health fairs, usually held in community locations outside of the hospital considered "safe" by foreign borns, have been specifically targeted to address needs of Latino, Korean, Muslim and Asian populations, as well as the indigent population in the southeast corner of the county.

7. **Evaluation** of community benefit efforts must be improved in order to better target increasingly scarce resources. Efforts to evaluate the effectiveness of the community benefit program initiatives are presently inconclusive. A few examples follow:

- a. **Healthy Howard:** Enrollments number less than 400. However, more than one thousand individuals previously without health insurance have been determined eligible for other forms of government-subsidized insurance, including Medical Assistance.
- b. **Mall Health Fairs:** Registered participants are provided a "passport" to carry with them from screening to screening, where the passport is signed off by the person administering the screening. Completed passports are submitted for a drawing. The passport tool encourages participation, and provides basic demographics about participants. Each mall fair that yields at least 200 registered participants has been considered successful. However, the hospital has been challenged to garner significant information (education, income levels) about those participating in health fairs.
- c. **Ethnic Health Fairs:** These events have used a similar strategy as employed at the Mall Health Fairs to learn about participants and needs. Noteworthy of these events is that nearly each event has had several participants identified with significant underlying health issues (extreme hypertension, breast lumps ultimately identified as breast cancer, etc) who were then referred on for treatment. In nearly every case participants were matched with providers able to deliver charity care (including HCGH), or patients were matched with supporting programs.

8. **Gaps in the availability of specialist providers to serve the uninsured cared for by Howard County General Hospital.** HCGH has subsidized physicians in several specialties to incentivize them to accept on-call coverage responsibilities in the Hospital's Emergency Department (ED). One of the issues (but certainly not the only issue) compelling physicians to refuse ED call without financial subsidy, is the burden of uninsured patients. Specialties currently subsidized by HCGH to accept ED call coverage include general surgery, otolaryngology, orthopedic surgery, urology, cardiology, oral and maxillofacial surgery, neurology, obstetrics/gynecology, and anesthesiology.

Physicians in nearly every specialty practicing in Howard County either limit the number of uninsured patients or do not accept non-paying patients. The hospital's precise knowledge of this practice in the outpatient setting is limited to information that physicians voluntarily report on their registration screens of the Hospital's physician referral service. Nonetheless, patients will occasionally call the hospital's physician referral service or visit the ED and report that they have been unable to find a physician willing to accept an uninsured patient without the ability to pay.

9. **Physician Subsidy Detail:** Howard County General Hospital provides subsidy to physicians for a range of services that they would otherwise not furnish to the hospital. In FY 2009 HCGH paid a total of \$6,491,013 in subsidy to physicians for the following services, much of which was for call coverage in the emergency department (ED).

Psychiatry (ED and inpatient coverage)	Obstetrics/Gynecology (ED and inpatient coverage)
General Surgery (ED)	Orthopedic Surgery (ED)
Anesthesiology	Primary Cardiac Angioplasty (ED)
Intensive Care Medicine	House Staff Coverage
Otolaryngology (ED)	Stroke Center/Neurology (ED)
Oral Surgery (ED)	Urology (ED)

Appendix 1

Charity Care Policy Description

Appendix 1. Charity Care Policy Description

HCGH provides necessary emergency medical care to all people regardless of their ability to pay. Financial assistance is available for those patients who cannot pay the total cost of hospitalization due to the lack of insurance coverage and/or inability to pay. If you do not have insurance, our financial counselors will schedule an interview with you to determine payment arrangements and/or assist you in completing a Medical Assistance application. Non-resident aliens are also eligible for financial assistance. For additional information, call a financial counselor at 410-740-7675. (Source: HCGH Patient Welcome Book)

HCGH informs its patients about the Charity Care policy through a number of tactics, including:

- Signs in English and Spanish are posted in patient waiting and registration areas that summarize the charity care policy (see Appendix 2.1.)
- A copy of the charity care policy or a summary thereof with financial assistance contact information, is provided to every patient upon admission.
- A summary of the charity care policy, with contact information for financial counselors, is provided to every patient without insurance who presents to the Emergency Department.
- All patients indicating a need for charity care are referred to a financial counselor who reviews with them the availability of various government benefits and programs, and assists them with application to such programs.


Appendix 2

Charity Care Policy

Appendix 2:

Appendix 2.1. Copy of Charity Care Policy

Appendix 2.2. Example of Patient Communication in Both English and Spanish.

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POLICY

This policy applies to Howard County General Hospital, Inc. (HCGH).

Purpose

HCGH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

It is the policy of Howard County General Hospital, Inc. (HCGH) to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.


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

PROCEDURES

1. An evaluation for Financial Assistance can be commenced in a number of ways.


For example:

- A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
 - A patient presents at a clinical area (includes emergency department) without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - A physician or other clinician refers a patient for charity care evaluation for potential admission.
2. Each Clinical or Business Unit will give patients the Financial Assistance application or refer them to the HCGH website to print a copy. They may also refer patients seeking Financial Assistance to the Financial Counselor in the Admitting Department.
 3. When a patient requests Financial Assistance, the Financial Counselor will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.
 - a. All hospital applications submitted will be processed within two business days of receipt and a determination will be made as to probable eligibility. In order to determine probable eligibility an applicant must provide family size and family income (as defined by Medicaid regulations). If applicable, a notice of conditional approval will instruct the applicant of the documentation necessary to complete the application process for a final determination of eligibility.
 - b. Applications received will be faxed to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line A written determination of probable eligibility,


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approval or denial will be issued to the patient by Patient Financial Services.

4. The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.
 - c. All insurance benefits have been exhausted.
5. There will be one application process for all of HCGH. The patient is required to provide the following:
 - a. A completed Financial Assistance Worksheet (see example in Appendix 1) and Patient Profile Questionnaire.
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of disability income (if applicable).
 - f. Reasonable proof of other declared expenses.
 - g. Non-U.S. citizens must complete the Financial Assistance Worksheet. In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor taking the application will review and analyze the application and make a recommendation to the Patient Financial Services Department for final determination of eligibility based on HCGH guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.

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- b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director, Revenue Cycle and/or Chief Financial Officer. The Director, Revenue Cycle and/or CFO will have decision-making authority to approve or reject applications for charity care. It is expected that an application for Financial Assistance, which is reviewed by the Director, Revenue Cycle and/or CFO will have a final determination made no later than 30 days from the date it was considered complete. The Director, Revenue Cycle and/or CFO will perform his/her evaluation of financial need based on HCGH guidelines.
7. A department can continue to use a government sponsored application process and associated income scale, as it is required by terms of a program grant or other outside authority governing that program. (i.e.: Psychiatry Program).
8. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. The write-off will be done by performing a transaction code adjustment. These cases will not be updated to the various financial assistance plan codes. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
- active Medical Assistance pharmacy coverage
 - QMB coverage/SLMB coverage
 - PAC coverage
 - Homelessness
 - Maryland Public Health System Emergency Petition patients,
 - Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.
 - active enrollees of the Chase Brexton Health Center (See Appendix C)
 - active enrollees of the Healthy Howard Program (See Appendix D)
 - Participation in Women, Infants and Children Programs (WIC)
 - Food Stamp eligibility
 - Eligibility for other state or local assistance programs
 - Patient is deceased with no known estate
 - Health Department moms-For non-emergent outpatient visits not covered by medical assistance
9. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to the Director of Revenue Cycle. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months.

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11. Once a patient is approved for partial Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to HCGH. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
12. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the CFO.HCGH, through the Public Relations Department, will annually publish the hospital's Financial Assistance Policy guidelines in the local newspaper and will post notices of availability in the emergency center and in the Admissions/Business office as well as the Billing Office. Notice of availability will also be sent to patients on patient statements. A Patient Billing and Financial Assistance Information Sheet will be provided to Inpatients and Emergency Room patients upon registration and will be available to all patients upon request.

REFERENCE¹

HCGH Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually in February), Federal Register

RESPONSIBILITIES - HCGH

Financial Counselor

Understand current criteria for Assistance qualifications.

Identify prospective candidates or follow-up with referred patients; initiate application process when required.


Review preliminary application and make probable eligibility determination within two business days of receipt of preliminary application. Notate patient account comments.

Review and ensure completion of final application.
If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Director for review.

Deliver completed final application, with recommendation, to Director Revenue Cycle, Patient Financial Services or CFO, as appropriate.

Document all transactions in all applicable patient account's comments.

¹ NOTE: Standardized applications for financial assistance have been developed. For information on ordering, please contact the Patient Financial Services Department. A copy is attached to this policy as Exhibit A.

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Send notification to PFS to mail letter of final determination to the patient.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application; Monitor those accounts that do not require an application.

Deliver completed final application, with recommendation, to Director, Revenue Cycle, Patient Financial Services or CFO, as appropriate.

Document all transactions in all applicable patient account's collection record.

Send notification to PFS to mail letter of final determination to the patient.

Director, Patient Financial Services,
Director, Revenue Cycle or CFO

Review completed final application; determine patient eligibility.

Review and approve Financial Assistance applications and accounts for which no application is required and which do not write-off automatically in accordance with signature authority established in Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

Request Financial Counselor to send letter of final written determination to patient or to advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.

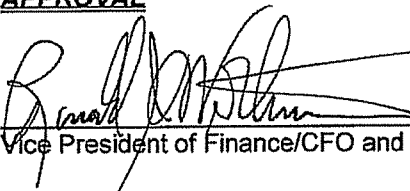
SPONSOR

CFO (HCGH)
Director of Revenue Cycle, HCGH
Senior Director, Patient Finance (JHHS)


REVIEW CYCLE

Three (3) years

APPROVAL



 Vice President of Finance/CFO and Treasurer, JHHS

7-1-09
 Date

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PROCEDURES - HCGH**1. Financial Counselor**

- a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
- b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
- c. Identify prospective candidates and follow-up with referred patients for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
- d. Initiate the Financial Assistance Application process with the patient/guarantor when applicable. As necessary, assist patient/guarantor in completing the application.
- e. If patient meets Presumptive Financial Assistance Eligibility criteria that does not require that a Financial Assistance Application to be completed, note the patient account comments, complete a write-off request signature form and submit to the Director of Revenue Cycle.
- f. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
- g. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
- h. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor. For non-U.S. citizens contact U.S. Consulate of patient's resident country for background on financial status.
- i. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
- j. Make recommendation to approve/disapprove applications and forward application, supporting documentation and recommendation to Director, Revenue Cycle, Director, Patient Financial Services or CFO for approval. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.


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NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Vice President, Finance/CFO for further consideration.

- k. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - l. Document all transactions involving the application process.
 - m. Send all original paperwork to PFS, Alpha Commons. PFS will scan and retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

- 2. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Financial Counselor for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. Initiate transactions to offset revenue on approved applications.
 - e. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Vice President, Finance/CFO for further action.
 - f. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.


- 3. Director, Revenue Cycle, Vice President, Finance/CFO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications; return finalized applications (approvals/denials/requests for additional information) back to Sr. Financial Counselor for final processing.

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APPENDIX A

FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

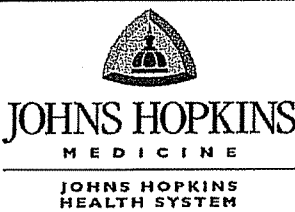
1. ***Notice of the availability of the HCGH Financial Assistance Program will be posted in the Emergency Department and in the Admission/Business office, Billing Office, and other areas identified by HCGH as was as presented to patients upon request.
2. Each person requesting Financial Assistance must complete an HCGH Financial Assistance application and Patient Profile Questionnaire. Exception: when there is Presumptive Financial Assistance Eligibility.
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
 - (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.
5. An individual will be eligible for Financial Assistance if the maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed HCGH's standard related to the Federal poverty guidelines, and they do not own liquid assets which would be available to satisfy their affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by HCGH.
8. HCGH will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The Financial Counselor will issue the final eligibility determination.

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9. Documentation of the final eligibility determination will be made on all (open-balance) patients' account. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance will remain valid for a period of six (6) months for all necessary affiliate services provided based on the initial date of the determination letter. Patients will not be required to reapply for Financial Assistance if they are currently receiving Financial Assistance from another affiliate.
11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of HCGH.
12. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. The write-off will be done by performing a transaction code adjustment. These cases will not be updated to the various financial assistance plan codes. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
 - (a) active Medical Assistance pharmacy coverage
 - (b) QMB coverage/SLMB coverage
 - (c) PAC coverage
 - (d) Homelessness
 - (e) Maryland Public Health System Emergency Petition patients,
 - (f) Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.
 - (g) active enrollees of the Chase Brexton Health Center (See Appendix C)
 - (h) active enrollees of the Healthy Howard Program (See Appendix D)
 - (i) Participation in Women, Infants and Children Programs (WIC)
 - (j) Food Stamp eligibility
 - (k) Eligibility for other state or local assistance programs
 - (l) Patient is deceased with no known estate
 - (m) Health Department moms-For non-emergent outpatient visits not covered by medical assistance
13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to The Director of Revenue Cycle Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	Howard County General Hospital, Inc. Policy & Procedure	<i>Policy Number</i>	FIN034H
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*Liquid Assets are defined as cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, and life insurance policies with cash surrender values, pension benefits, accounts receivable or other property immediately convertible to cash.

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APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The Financial Assistance Program.
 - Other forms of assistance available through affiliates.
3. The patient cannot repay the self-responsible portion of the affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$5,000)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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Definitions


Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, pension benefits, accounts receivable or other property immediately convertible to cash.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.

Exceptions

1. HCGH has the right to refuse treatment for elective procedures, which may result in catastrophic medical debt.
2. The Vice President, Finance/CFO may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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Note: If the below worksheet is electronically available to preparer, double-click on worksheet and fill in required amounts in highlighted fields only. The worksheet will automatically compute rest of the fields.

FINANCIAL ASSISTANCE WORKSHEET

Patient

Name: _____

History #: _____

LINE #	PARTICULAR	AMOUNT
Net Current Medical Debt:		
1	Current Medical Debt	\$ -
2	Total Liquid Assets	\$ -
3	Asset Exclusion (Fixed Amount)	\$ 5,000
4	Net Liquid Assets [If Line 2 > Line 3, then Line 2 - Line 3, otherwise amount is zero "0"]	\$ -
5	Net Current Medical Debt [Line 1 - Line 4]	\$ -

Total Annual Expenses:		
6	Living Expenses	\$ -
7	Projected Medical Expenses	\$ -
8	Total Annual Expenses [Line 6 + Line 7]	\$ -


Annual Income Available:		
9	Income (Net Take Home Pay)	\$ -
10	% Income Available [100% - (Line 8 divided by Line 9 x 100)] [If Line 8 is > Line 9, then % Income Available is zero "0"]	-%
11	Annual Income Available [Line 9 x Line 10]	\$ -

SELECT PATIENT PAYMENT PERIOD PLAN

Patient Payment in 1-Year Period Plan:		
12	Income Available in 1 Year [Line 11]	\$ -
13	Income Available in 1 Year plus Net Liquid Assets [Line 12 + Line 4]	\$ -
14	Monthly Patient Installment Payment within 1 Year [Line 13 / 12 Months]	\$ -
15	Financial Assistance Amount [If Line 1 > Line 13, then Line 1 - Line 13. This is the Financial Assistance Amount] [If Line 1 < Line 13, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 2-Year Period Plan:		
16	Income Available in 2 Years [Line 11 x 2 Years]	\$ -
17	Income Available in 2 Years plus Net Liquid Assets [Line 16 + Line 4]	\$ -
18	Monthly Patient Installment Payment within 2 Years [Line 17 / 24 Months]	\$ -
19	Financial Assistance Amount [If Line 1 > Line 17, then Line 1 - Line 17. This is the Financial Assistance Amount] [If Line 1 < Line 17, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 3-Year Period Plan:		
20	Income Available in 3 Years [Line 11 x 3 Years]	\$ -
21	Income Available in 3 Years plus Net Liquid Assets [Line 20 + Line 4]	\$ -
22	Monthly Patient Installment Payment within 3 Years [Line 21 / 36 Months]	\$ -
23	Financial Assistance Amount [If Line 1 > Line 21, then Line 1 - Line 21. This is the Financial Assistance Amount] [If Line 1 < Line 21, then the Financial Assistance Amount is zero "0"]	\$ -

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APPENDIX C FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are un-or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify us of their participation in this program.

Inpatient/Outpatient cases

All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, and FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:

FAR.PENDIN
FARB20
FARN40
FARN50
FARN70
FARN80
FAR100

Charity Care


Pending Verification
20% of charges
40% of charges
50% of charges
70% of charges
80% of charges
100% of charges

Patient to pay:


80% of charges
60% of charges
50% of charges
30% of charges
20% of charges
0% of charges

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc.) to be pulled forward.
2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.
3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

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4. The Sr. Financial Counselor is responsible for updating the insurance code to reflect the proper level of charity care and collecting the patient balance (if any).
5. The Sr. Financial Counselor is responsible for entering a from and through date into Meditech that the patient is eligible to receive this level of charity care.
6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

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APPENDIX D FINANCIAL ASSISTANCE FOR HEALTHY HOWARD PATIENTS

Purpose

The Healthy Howard Access Plan is a new program effective January 1, 2009, designed to connect Howard County residents to affordable health care services and help the community overcome barriers to healthy living. The Plan is not insurance, but offers basic medical and preventative care to eligible residents who would otherwise not be able to afford or obtain health insurance.

This procedure is for Howard County General Hospital registration sites, verification and scheduling, and Patient Financial Services. It outlines the treatment of patients that are enrolled in the Healthy Howard Plan.

Inpatient/Outpatient cases

It is the policy of HCGH to accept Healthy Howard plan patients for referred scheduled services, and emergent/urgent services.

It is the responsibility of the patient to provide their Healthy Howard identification card or inform the registration/scheduling staff of Healthy Howard coverage at the time of service or scheduling.

It is the responsibility of the HCGH registration/authorization staff to verify that coverage is still active by checking eligibility via MCNET (a web based system administered by JHHC).


For Healthy Howard patients utilizing the emergency department, \$100 co-pay is due. However; if admitted or placed into observation the co-pay is waived.

The patient should be registered using the insurance code HLTH.HOW.

The HLTH.HOW insurance code has been programmed to automatically write off the charges to the financial assistance code when the final bill is released.

Procedure

1. When a patient presents for services at HCGH and either presents a Healthy Howard insurance card or notifies the registration staff that they are a member of Healthy Howard the registrar should verify eligibility using MCNET to validate the patient is an active enrollee.
2. If active, the Admission Counselor will register the patient with the insurance code HLTH.HOW.
3. If not active, notify the patient of ineligibility and ask if there is other insurance or means to pay. If not, provide the patient with the HCGH financial assistance application.
4. The Sr. Financial Counselor prints a report on a daily basis of all patients registered with HLTH.HOW.
5. The Sr. Financial Counselor will review all patients on the report to validate they are active with Healthy Howard.
6. The Sr. Financial Counselor is responsible to monitor Healthy Howard in-house inpatient admissions to determine if at some point the patient may become eligible for MD Medical Assistance. If so, the Sr. Financial Counselor will meet with the patient to assist in the application process.
7. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be corrected as appropriate.

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**TABLE FOR DETERMINATION OF
FINANCIAL ASSISTANCE ALLOWANCES**

Effective 2/2/09

# of Persons in Family	Income Level	Upper Limits of Income for Allowance Range				
1	\$ 16,245	\$ 19,494	\$ 21,119	\$ 24,368	\$ 25,992	\$ 29,241
2	\$ 21,855	\$ 26,226	\$ 28,412	\$ 32,783	\$ 34,968	\$ 39,339
3	\$ 27,465	\$ 32,958	\$ 35,705	\$ 41,198	\$ 43,944	\$ 49,437
4	\$ 33,075	\$ 39,690	\$ 42,998	\$ 49,613	\$ 52,920	\$ 59,535
5	\$ 38,685	\$ 46,422	\$ 50,291	\$ 58,028	\$ 61,896	\$ 69,633
6	\$ 44,295	\$ 53,154	\$ 57,584	\$ 66,443	\$ 70,872	\$ 79,731
7	\$ 44,905	\$ 53,886	\$ 58,377	\$ 67,358	\$ 71,848	\$ 80,829
8*	\$ 55,515	\$ 66,618	\$ 72,170	\$ 83,273	\$ 88,824	\$ 99,927
Allowance to Give:						
	100%	80%	70%	50%	40%	20%

EXAMPLE: Annual Family Income \$50,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$33,075
 Upper Limits of Income for Allowance Range \$52,920 (40% range)
 \$50,000 is less than the upper limit of income; therefore patient is eligible for financial assistance.

*For family units with more than eight (8) members, add \$5,610 for each additional member.

Exhibit A

Howard County General Hospital
 5300 Alpha Commons/Suite 300
 Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
 First Middle Last

Social Security Number _____ - ____ - ____
 US Citizen: Yes No

Marital Status: Single Married Separated
 Permanent Resident: Yes No

Home Address _____

Phone _____

 City State Zip code

 Country

Employer Name _____

Phone _____

Work Address _____

 City State Zip code

Household members:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Exhibit A***I. Family Income***

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

PATIENT NAME: _____

PATIENT ADDRESS: _____
 (Include Zip Code)

MEDICAL RECORD #: _____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

Family Size:

Individual: \$2,500.00

Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
 If not a Maryland resident, in what state does patient reside? _____
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:

Medical Assistance Pharmacy Only	Yes or No
QMB coverage/ SLMB coverage	Yes or No
PAC coverage	Yes or No
13. Is patient employed? Yes or No
 If no, date became unemployed. _____
 Eligible for COBRA health insurance coverage? Yes or No

Financial Assistance Policy

If unable to pay for medical care, you may qualify for financial assistance if you:

- Exhausted all insurance options
- Were denied medical assistance through all other available means
- Meet other criteria for financial assistance

For help, more information or an application for financial assistance, contact:

**HCGH Admitting
Department,
410-740-7675**

If you feel you have been improperly denied free or reduced charged care, call the Compliance Office,
1-877-WE COMPLY
(1-877-932-6675)

Asistencia Financiera

Si usted es incapaz de pagar por sus servicios médicos, se puede calificar para asistencia financiera:

- Si ha agotado todas las opciones de los seguros
- Si le ha sido negado ayuda médica a través de todas las formas disponibles
- Si puede cumplir otro criterio para asistencia financiera

Si usted necesita ayuda, o desea información adicional o un formato para aplicar para asistencia financiera, por favor comuníquese con

**HCGH Admitting
Department,
410-740-7675**

Si usted siente que le han sido negado los cargos gratuitos o los costos reducidos, llame Compliance Office,
1-877-932-6675



HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

Appendix 3

Mission, Vision, and Value Statement Description

Appendix 3:
HCGH Mission Vision and Values:

The hospital mission, consistent with that of its parent organization the Johns Hopkins Health System, is to provide high quality healthcare to everyone in the community that we serve, in a manner that ensures patient safety, and is respectful of the diverse elements of our community. It was reviewed and approved by the HCGH Board of Trustees in 2008.

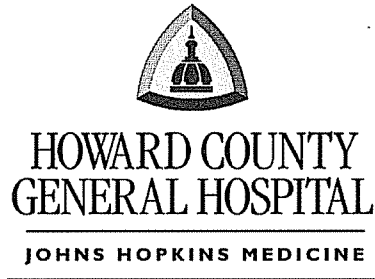
Our vision, again, consistent with the excellence that Johns Hopkins Medicine (JHM) represents, is to be the premier community hospital in Maryland. Although we do not share the teaching and research missions of JHM, we absolutely share the vision to exceed in the delivery of health care.

Our values are rooted in providing unsurpassed service to everyone we encounter – patients, their families and caregivers, and our co-workers. These values – Communication, Anticipation of and Response to others needs, Respect, and Engagement with others – reduced to the acronym CARE, are our credo for interactions with our patients and visitors as well as our co-workers.

Appendix 4

Mission, Vision, and Value Statement

Appendix 4: Statement of Mission, Vision and Values



Our Mission

Provide the highest quality care to improve the health of our entire community through innovation, collaboration, service excellence, diversity and a commitment to patient safety.

Our Vision

To be the premier Community Hospital in Maryland.

Our Values

Communicate

Anticipate and Respond

Respect

Engage

Johns Hopkins Bayview Medical Center

Community Benefit Narrative

**COMMUNITY BENEFIT NARRATIVE
Johns Hopkins Bayview Medical Center
Fiscal Year 2009**

1. **Key Statistics.** In fiscal year (FY) 2009, Johns Hopkins Bayview Medical Center was licensed to operate 345 acute hospital beds, 45 bassinets, 190 comprehensive care beds and 123 special hospital services (CIR, Chronic, etc). The acute hospital had 20,849 admissions, excluding newborns.
2. **Primary Service Area.** The Medical Center serves the communities in Southeast Baltimore City and County and Northeast Baltimore City and County. We also serve a broader area for our regional and statewide services. The demographics of the population served varies significantly by geographic area. (See attached.) A growing Hispanic population is one area of focus, and we use language interpreters and our Care-a-Van program to help us address the needs of these patients. 19.14% of the hospital's patients are uninsured, and 7.75% receive Medicaid benefits. Some areas of our community have a high concentration of elderly residents, as well. 32.49% of our patients have Medicare. In our primary service area (where 65% of our patients live), 19.3% of individual households are below the poverty line, and 24.2% of residents are uninsured.
3. **Identification of Community Needs.**

We rely on a number of means to determine the health needs of our community:

COMMUNITY HEALTH ASSESSMENTS: We last conducted a formal community needs assessment in FY05. The assessment was a follow-up to a 1996 needs assessment that spearheaded JHBMC's Community Health Action Project (CHAP), the goal of which was to reduce the incidence of heart disease in the medical center's catchment area by ten percent over ten years. The assessment also filled a gap in information that was not being provided by the local city and county health departments. CHAP remains an active outgrowth of JHBMC's original needs assessment.

In FY09, a needs assessment was completed for the southeast area of the county, sponsored by a group of service providers with the support of Baltimore County Office of Community Conservation and Franklin Square Hospital Center.

HEALTH DEPARTMENT STATISTICS: We review information available from Baltimore City and Baltimore County Health Departments regarding morbidity and mortality and health trends for those jurisdictions. Baltimore City Planning Department also develops community profiles which are reviewed and considered. Because JHBMC serves parts of both areas, it is difficult to determine the health needs of our particular service areas from this data, but is helpful in indicating general population status.

In FY 09, the Baltimore City Health Commissioner convened a series of discussions regarding community needs and the Health Department's plans to address priority areas. This discussion focused on cardiovascular disease and three health department initiatives

intended to reach out into the community to address it. The hospital's outreach programs in this area complement the health department's plans.

Baltimore City Health Department's Major Health Indicators Summary (Baltimore City Health Status Report 2008) indicates that the heart disease mortality rate in the city is 31% higher than that for the State of Maryland. 28% of city residents smoke, as compared to 17% of Marylanders. Adolescent obesity is 41% higher and adult obesity 33% higher in the city than for the state as a whole. The cancer mortality rate for Baltimore City is 25% higher than the state rate.

DIRECT COMMUNITY CONTACT: The Medical Center has several community advisory boards and our Community Health Action Project that provide us with information and feedback regarding community health needs. Additionally, Community Relations staff members routinely attend a great number of community association meetings around our service area to help assess community needs and offer the hospital's resources. We also respond to requests to participate in health fairs, community events, provide screenings or speakers, etc.

ANALYSIS OF HOSPITAL PROGRAMS: A key factor in assessing the community's health needs is to look at demand for and utilization of clinical programs. Our review of markets, market-share, patient demographics, business trends and other clinical data inform our thinking with respect to defining community needs. For example, a Patient First urgent care center was opened in November, 2007 to offset the increasing Emergency Department volumes. ED visits has increased an average 5% per year, for last 5 years. Also, continued demand for primary care and specialist visits prompted construction of additional outpatient clinical space. Outpatient clinic visits growth has averaged 4% per year, for last 5 years. During the last 18 months, the Medical Center assessed the unmet needs of the surrounding community and established new or expanded clinical programs. The programs address the unique needs of the East Baltimore community and the resources available at the Medical Center. New programs were established to address the following conditions: Alzheimer's, women's cardiovascular health, pelvic disorders and osteoporosis.

As the population ages, the frequency of dementia and memory loss is increasing. Because of the growing senior population in our service area, the Medical Center established a Memory and Alzheimer's Treatment Center in 2008 to provide diagnostic and treatment services to patients with memory disorders. It is estimated that 13% of persons 65+ have Alzheimer's.

Cardiovascular diseases, such as heart attack and stroke, remain the #1 killer of women. However, women can substantially reduce their risk factors for heart disease and stroke with lifestyle changes. To help women fight heart disease, the Medical Center established a new Women's Cardiovascular Health Center, a multidisciplinary program including cardiology, psychology and nutrition to meet the unique needs of women.

Female pelvic floor dysfunction refers to disorders of the pelvic organs, including the lower urinary tract, vagina and lower gastrointestinal tract. By age 55, nearly half of all women will have some type of pelvic floor condition, and many will suffer in silence with the uncomfortable, embarrassing and sometimes life-altering symptoms such as incontinence or pelvic discomfort.

The new Women's Center for Pelvic Health brings together a team of gynecologists, urologists and rehabilitation specialists offering both surgical and non-surgical treatments.

Men and women of all ages suffer from metabolic bone diseases, disorders of bone strength such as osteoporosis, osteomalacia and Paget's disease. When untreated, it can lead to fragility fractures, bone deformities and serious disability. In 2008, the Medical Center established the Metabolic Bone Center where specialists from different areas of medicine (endocrinology, geriatrics and orthopedics) collaborate to ensure the best treatment plan.

Lung cancer is the second most common cancer and remains the leading cause of cancer related death for both men and women. The incidence of lung cancer in the East Baltimore community has been higher than national rates given the high smoking rates, past concentration of manufacturing facilities and other environmental factors unique to this community. The Medical Center has been actively planning to expand its lung cancer clinical services and research in the coming years working with Johns Hopkins experts in pulmonology, thoracic surgery, medical oncology and radiation oncology.

4. Major Community Health Needs. As explained above, major community health issues identified include:

- a. Cardiovascular disease
- b. Geriatric services, including memory loss services
- c. Overcoming barriers to care for the Hispanic population
- d. Psychiatric services, including substance abuse
- e. Injury prevention and treatment

5. Decision Making Process. Decisions regarding community benefit activities are made with input from our Board of Trustees, Executive and clinical leadership and, with regard to outreach activities, community relations staff. We also consult our community advisory boards. An effort is made to coordinate our clinical programs to meet community needs with those at The Johns Hopkins Hospital, since some of our service area is the same. Additional input is sought from primary care physicians serving our immediate community including Baltimore Medical System and Johns Hopkins Community Physicians.

6. Addressing the Community Needs.

Cardiovascular disease: In addition to the new women's program, we continue to provide blood pressure screenings monthly in the community, and continue to operate our cardiac disease prevention program (Food Re-Education for School Health – FRESH) in the elementary schools and for the Girl Scout troops in our area. In addition, with the high incidence rate of coronary artery disease the Medical Center was approved to participate in the C-PORT E Trial study, which enables hospitals without an open-heart surgery program to perform elective angioplasty. The Medical Center is one of nine elite hospitals in Maryland chosen to be part of this study in 2009. Our Community Health Action Program, a partnership with the community to promote health, has had a Smoke-Free Families effort in place for several years and provides a resource guide distributed at the hospital and in the community.

Geriatric services: The Memory Center provides a resource for memory-loss patients with a strong focus on the well-being of the caregiver. We continue outreach to senior centers with screenings and special events.

Hispanic population: The hospital has a full time staff of Spanish interpreters to facilitate high quality treatment. Our Community Psychiatry Program has recently added the capacity to provide therapy in Spanish. Our Care-a-Van, a free mobile health unit, has bilingual staff that provide neighborhood-based care to many Latino residents. 73% of the patients cared for on the Care-A-Van speak Spanish and 82% of the patients are Latino. 40% report a weekly income of \$200 or less, with 26% reporting no weekly income.

Psychiatric Services: We continue to provide a full range of psychiatric and addictions treatment programs for the community. We are working across clinical disciplines (geriatrics, psychiatry, neurology) to continue to develop programs like the Memory Center.

Injury prevention: As the state's Burn Center, we have a number of community benefit activities around burn care and burn prevention education. We educate other health care providers about burn wound care, and have a program to train Air Force staff caring for burn victims in the military. We have a retired firefighter who teaches burn prevention in area schools, and a Safe Babies program which provides new mothers with burn prevention items and information to reduce risk for their new babies. Several members of our staff are certified Child Safety Seat technicians, who offer their services to the community to assure that child safety seats are correctly installed. We also participate in other initiatives designed to heighten safety awareness and prevent injuries.

7. Evaluation.

- a. **Name of initiative:**
- b. **Year of evaluation:**
- c. **Nature of the evaluation (i.e., what output or outcome measures were used);**
- d. **Result of the evaluation (was the program changed, discontinued, etc.)' or**
- e. **If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?**

Initiative	Year evaluated	Measure	Results	Future Evaluation options
Food ReEducation for School Health	Annual	<ul style="list-style-type: none"> Children's knowledge pre/post testing Teacher evaluations 	Program continues	n/a
Kiwanis Burn Prevention Educ.	Annual	<ul style="list-style-type: none"> Children's pre/post test Teacher evaluations 	Program continues	Continue routine evaluations
Care-a Van	Annual	<ul style="list-style-type: none"> Numbers of patients 	Program continues	

	2009	<ul style="list-style-type: none"> • Patient Satisfaction survey 		
Community Health Action Project	2008-2009	Self-assessment by participants; strategic planning	Shifted focus to diabetes and obesity	Repeat Community Needs Assessment at some future time
Community Development Support (Southeast CDC, Greentown CDC, Dundalk Renaissance Corp.)	Annual	Review of annual reports (program and financials) of community development corporations receiving hospital funds	We have a staff member from the hospital serving on each organization's Board, with on-going input into how these agencies meet community needs	Continue current practice

8. **Gaps in the Availability of Specialist Providers.** We are not aware of any gaps in the availability of specialist providers to serve the uninsured, as they are routinely cared for by the hospital (primarily in substance abuse, psychiatry and obstetrical services). Inability to pay is sometimes a barrier for patients needing "elective" services, but we have a process to evaluate these needs and address them. There are some specialty services which JHBMC does not offer, such as cardiac surgery, transplant surgery, radiation oncology, bone marrow transplant, gynecology and pediatric sub-specialty care which are routinely referred to Johns Hopkins Hospital.
9. **Physician Subsidies.** We provide financial support to Baltimore Medical System for their primary care services in the community, and to two Johns Hopkins Community Physician sites for their teaching services and for their care of disadvantaged patients. The hospital's Joint Agreement also provides funds for on-call physicians and assists with support of uncompensated care provided by the physicians to community members in our programs. This support is key to our ability to transcend financial barriers to care for disadvantaged patients, including Hispanic patients, especially in the areas of Emergency, Obstetrics, and Trauma. We support physician on-call costs for these three services.

Attachment: JHBMC primary service area demographics

	X	X	X	X	X	X	X	X	X	X	X	X
	21205	21206	21213	21219	21220	21221	21222	21224	21231	21234	21236	21237
Total Pop	18440	50154	38442	9178	36551	42567	54923	48536	15734	69100	37779	25414
Race Hispanic	1.6%	1.3%	0.7%	0.6%	1.5%	2.2%	1.4%	4.6%	9.8%	1.5%	1.7%	2.1%
Race White	20.7%	42.6%	9.5%	92.9%	83.0%	75.0%	87.9%	69.5%	45.8%	76.8%	86.3%	76.7%
Race Black	75.1%	53.5%	88.1%	5.3%	12.8%	19.5%	8.3%	21.0%	39.6%	16.9%	5.9%	16.2%
White pop.	3817	21366	3652	8526	30337	31925	48277	33733	7206	53069	32603	19493
Race - all other %												
Median Hshld Inc.	\$21,922	\$36,360	\$26,801	\$47,254	\$42,238	\$35,688	\$39,866	\$30,489	\$30,121	\$44,554	\$53,534	\$47,581
Below poverty line	34.4%	13.8%	26.4%	6.5%	8.5%	11.8%	9.3%	22.0%	27.5%	6.9%	4.1%	4.7%
Household Income												
<\$10,000	23.9%	11.1%	20.7%	7.7%	6.8%	10.7%	8.7%	16.2%	22.0%	6.3%	3.9%	4.2%
10,000-14,999	11.4%	6.7%	8.2%	6.7%	4.9%	7.4%	6.7%	9.2%	8.6%	4.9%	3.1%	5.1%
15,000-24,999	19.8%	15.7%	18.2%	9.2%	12.5%	16.3%	14.7%	15.5%	13.5%	11.8%	9.3%	12.3%
25,000-34,999	16.6%	14.2%	14.3%	13.6%	16.3%	14.7%	14.0%	16.1%	11.7%	13.9%	10.4%	13.0%
35,000-49,999	12.0%	18.0%	16.5%	15.3%	18.8%	15.3%	18.8%	15.5%	15.4%	18.8%	18.9%	18.8%
50,000-74,999	8.9%	19.9%	13.9%	23.5%	23.1%	20.5%	22.8%	15.0%	15.9%	23.0%	26.8%	24.9%
75,000-99,999	4.9%	9.8%	4.8%	13.8%	10.7%	9.6%	8.9%	7.4%	5.5%	11.9%	14.4%	13.3%
100,000-149,999	1.4%	3.8%	2.3%	6.9%	5.5%	4.7%	4.3%	3.6%	4.8%	7.4%	10.0%	6.6%
150,000-199,999	0.3%	0.4%	0.5%	2.4%	0.8%	0.6%	0.5%	0.6%	1.2%	1.2%	2.0%	1.3%
200,000+	0.9%	0.4%	0.7%	0.9%	0.7%	0.3%	0.5%	0.8%	1.4%	0.7%	1.2%	0.7%
Median	\$21,922	\$36,360	\$26,801	\$47,254	\$42,238	\$35,688	\$39,866	\$30,489	\$30,121	\$44,554	\$53,534	\$47,581
Unemployed	10.5%	3.4%	7.7%	1.7%	2.8%	4.3%	3.6%	4.8%	6.8%	3.1%	1.7%	2.0%
Below Poverty Line	34.4%	13.8%	26.4%	6.5%	8.5%	11.8%	9.3%	22.0%	27.5%	6.9%	4.1%	4.7%
Race												
Hispanic/latino	1.6%	1.3%	0.7%	0.6%	1.5%	2.2%	1.4%	4.6%	9.8%	1.5%	1.7%	2.1%
White	20.7%	42.6%	9.5%	92.9%	83.0%	75.0%	87.9%	69.5%	45.8%	76.8%	86.3%	76.7%
Black	75.1%	53.5%	88.1%	5.3%	12.8%	19.5%	8.3%	21.0%	39.6%	16.9%	5.9%	16.2%
Native American	1.2%	0.8%	0.6%	0.3%	0.9%	1.2%	1.0%	1.0%	1.0%	3.4%	4.7%	3.3%
Asian							0.7%	1.3%	1.4%			
HI/Pacific Island				0.2%								
Other	0.1%	0.2%	0.1%		0.1%	0.2%	0.1%	0.2%	0.4%	0.1%	0.1%	0.2%
Multi	0.9%	1.4%	0.8%	0.5%	1.2%	1.5%	1.0%	2.3%	2.0%	1.2%	1.1%	1.3%
Age/Sex												
Male	45.9%	46.8%	45.2%	49.5%	48.7%	48.0%	47.7%	47.5%	49.5%	46.5%	47.9%	48.4%
Female	54.1%	53.2%	54.8%	50.5%	51.3%	52.0%	52.3%	52.5%	50.5%	53.5%	52.1%	51.6%
Median Age	31.5	34.7	34.8	41.1	35.8	36.4	39.3	36.3	32.8	38.4	36.6	36.8
</												

Appendix 1

Charity Care Policy Description


Appendix 1

Charity Care Policy Description

The financial policies of the Johns Hopkins Bayview Medical Center are explained in policies of the Johns Hopkins Health System. We have a general financial assistance policy and, due to dramatic growth in pregnancy care for uninsured mothers over the past 5 years, a policy regarding pregnancy care as well. Our patient handbook spells out how patients may access information about their bills and the process to follow in order to qualify for free or reduced-cost medically necessary care.

Appendix 2

Charity Care Policy

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POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC).

Purpose

JHHS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

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

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.


JHHS hospitals have seen an increase in Emergency Room visits from residents of the East Baltimore Community who are not eligible for or do not have any insurance coverage and have demonstrated significant difficulty in paying for healthcare services. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor and disenfranchised, JHHS' hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the JHHS hospitals' commitment to their mission to provide healthcare to those residing in the neighborhoods surrounding their respective hospitals, the JHHS hospitals reserve the right to grant financial assistance without formal application being made by patients residing in the respective hospital's primary service area as defined by the Johns Hopkins Strategic Planning and Marketing Research definition. The zip codes for the JHH primary service area include: (21202, 21205, 21213, 21224, 21231). The zip codes for the JHBMC primary service area include: (21205, 21219, 21222, 21224). The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage.

PROCEDURES


1. An evaluation for Financial Assistance can begin in a number of ways:

For example:


- A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
- A patient presents at a clinical area (includes emergency department) without insurance and states that he/she cannot afford to pay the medical expenses associated with their

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- current or previous medical services.
 - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.
- 2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, JHOPC first-floor administrative staff, Customer Service, etc.
- 3. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
 - b. Applications received will be faxed daily to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.
- 4. To determine final eligibility, the following criteria must be met:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review the alternative of offering a payment-plan agreement.
 - c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - d. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).
 - e. All insurance benefits must have been exhausted.
- 5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:
 - a. A completed Financial Assistance Application and Patient Profile Questionnaire.
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

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- d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of U.S. citizenship or lawful permanent residence status (green card).
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
 - b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on CPA, JHH and BMC guidelines.
 7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
 8. A department can continue using an adjustment to total charges (sliding scale) without the completion of Financial Need Assessment paperwork if the resulting adjustment is consistent with the Adjustments and Courtesy for Clinical Services policy. The use of a sliding scale in this manner applies only to the specific service involved; it does not automatically apply to any other services.
 9. Specific departments operating programs under a grant or other outside governing authority (such as JHBMC Addiction Treatment Services) may continue to use a government-sponsored application process and associated income scale.
 10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may extend to three years.
 11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of

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the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- PAC coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- Participation in Women, Infants and Children Programs (WIC)
- Food Stamp eligibility
- Eligibility for other state or local assistance programs
- Patient is deceased with no known estate
- The Access Partnership Program at Hopkins

12. Patients who present to the Emergency Departments but are not admitted as inpatients and who reside in the hospitals' primary service area need not complete a Financial Assistance Application but will be granted financial assistance based upon the following criteria:

1. Reside in primary service area (address has been verified)
2. Not have any health insurance coverage
3. Not enrolled in Medical Assistance for date of service
4. Indicate an inability to pay for their care

Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

REFERENCE¹

JHHS Finance Policies and Procedures Manual


Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually) in Federal Register

¹ NOTE: Standardized applications for Financial Assistance and Patient Profile Questionnaire have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A and B.

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RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service
 Collector Admissions Coordinator
 Any Finance representative designated to accept applications for Financial Assistance

Understand current criteria for Assistance qualifications.

Identify prospective candidates; initiate application process when required. (BMC Community Psychiatry completes the "Application for Financial Hardship and Fee Adjustment" form)

On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility.

Review preliminary application and Patient Profile Questionnaire to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.

Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient accounts comments.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application.


Deliver completed final application to Patient Financial Services management.

Document all transactions in all applicable patient accounts collection record.

Management Personnel
 (Supervisor/Manager/Director)

Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient.

Advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.]

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Financial Management Personnel
 (Senior Director/Assistant Treasurer
 or affiliate equivalent)
 CPP Director and Management Staff

Review and approve Financial Assistance applications and
 accounts for which no application is required and which do not
 write off automatically in accordance with signature authority
 established in JHHS Finance Policy No. FIN017 - Signature
 Authority: Patient Financial Services.


SPONSOR

Senior Director, Patient Finance (JHHS)
 Director, PFS Operations (JHHS)

REVIEW CYCLE

Three (3) years


APPROVAL


 Vice President of Finance/CFO and Treasurer, JHHS

6-19-09
 Date

PROCEDURES - JHH

1. Financial Counselor/Patient Financial Services Representative/Counselor
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications, Patient Profile Questionnaires and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
 - d. Initiate the Financial Assistance Application process with the patient/guarantor when applicable. As necessary, assist patient/guarantor in completing the application.
 - e. If patient meets Presumptive Financial Assistance Eligibility criteria that does not require that a Financial Assistance Application to be completed, notate the patient account comments and place into financial assistance code for system writeoff.
 - f. Review preliminary application and communicate a determination of probable eligibility to patient within two

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business days.

- g. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
- h. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor.
- i. Document all transactions involving the application process.

2. Supervisor


- a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
- b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
- c. Approve/disapprove financial assistance applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.

- d. If recommending approval of financial assistance applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
- e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
- f. Initiate transactions to offset revenue on approved applications.
- g. Scan records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

3. Director, Patient Financial Services

- a. Review applications according to signature authority established in Finance Policy No. FIN017, or those applications forwarded because of extenuating


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circumstances.


- b. Approve/disapprove financial assistance applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications and approvals to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than authorized amount, forward to Senior Director, Patient Financial Services for further action.
4. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications and approvals to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.
5. Vice President, Finance/CFO and Treasurer or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove financial assistance; return finalized applications and approvals to Senior Director for final processing.

PROCEDURES – JHBMC

1. Financial Counselor (Inpatient and Outpatient) and Collector CPP Admissions Coordinator and Clinical Staff
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications, Patient Profile Questionnaires and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance.
 - d. Initiate the Financial Assistance application process with the patient/guarantor when applicable. As necessary, assist patient/guarantor in completing the application.

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- e. If patient meets Presumptive Financial Assistance Eligibility criteria that does not require that a Financial Assistance Application be completed, notate the patient account comments and place into financial assistance code for system writeoff.
 - f. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - g. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - h. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to the application; place in a file folder marked "Financial Assistance;" deliver file to designated Manager or responsible party.
 - i. Document all transactions in the application process.
2. Supervisor, Patient Financial Services
CPP Director/Managers
- a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove financial assistance applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application that does not meet the Financial Assistance Guidelines as set forth in Appendix A.
- NOTE:** Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.
- d. If recommending approval of financial assistance applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.


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- g. File records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

- 3. Associate Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of Financial Assistance amounts written off. Return finalized applications and approvals to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.
 - e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.


- 4. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance as authorized.
 - c. Return finalized applications and approvals to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval for financial assistance applications greater than amount authorized, forward to affiliate Senior Director, Patient Financial Services, for further action.

- 5. Vice President, Finance/CFO or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove financial assistance applications and return finalized applications and approvals to Director, Patient Financial Services.

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APPENDIX A FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. ***Notice of the availability of the JHHS Financial Assistance Program will be posted at patient registration sites, Admissions/Business Offices, Billing Office and at the emergency department within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance must complete a JHM/Financial Assistance application and Patient Profile Questionnaire. Exception: when there is Presumptive Financial Assistance Eligibility or patient resides in hospital's primary service area and is ED patient. (see below)
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior-year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets *in excess of \$5,000 which would be available to satisfy their JHHS affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the hospital.
8. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of the day when the application was satisfactorily completed and submitted. The Manager or designated responsible party will issue the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial

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Assistance from another affiliate.

11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.
12. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
 - Active Medical Assistance pharmacy coverage
 - QMB coverage/ SLMB coverage
 - PAC coverage
 - Homelessness
 - Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
 - Maryland Public Health System Emergency Petition patients
 - Participation in Women, Infants and Children Programs (WIC)
 - Food Stamp eligibility
 - Eligibility for other state or local assistance programs
 - Patient is deceased with no known estate
 - The Access Partnership Program at Hopkins
13. Patients who present to the Emergency Departments but are not admitted as inpatients and who reside in the hospitals' primary service area need not complete a Financial Assistance Application but will be granted financial assistance based upon the following criteria:
 1. Reside in primary service area (address has been verified)
 2. Not have any health insurance coverage
 3. Not enrolled in Medical Assistance for date of service
 4. Indicate an inability to pay for their care

Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

14. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

*Liquid Assets are defined as cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, pension benefits, accounts receivable or other property immediately convertible to cash.

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APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The JHM Financial Assistance Program
 - Other forms of assistance available through JHM affiliates
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$5,000)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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Definitions

Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash.
Living Expenses	Per-person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e., drugs, co-pays, deductibles and durable medical equipment.)
Take-Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports.

Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

***150% of Poverty Guidelines**

*For family units with more than eight (8) members, add \$5,610 for each additional member.

Exhibit A

Johns Hopkins Hospital
5300 Alpha Commons/Suite 300
Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____
US Citizen: Yes No

Marital Status: Single Married Separated
Permanent Resident: Yes No

Home Address _____

Phone _____

City State Zip code

Country _____

Employer Name _____

Phone _____

Work Address _____

City State Zip code

Household members:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Exhibit A***I. Family Income***

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Exhibit A

Johns Hopkins Bayview Medical Center
 5300 Alpha Commons/Suite 300
 Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
 First Middle Last

Social Security Number _____ - ____ - ____
 US Citizen: Yes No

Marital Status: Single Married Separated
 Permanent Resident: Yes No

Home Address _____ Phone _____

City _____ State _____ Zip code _____ Country _____

Employer Name _____ Phone _____

Work Address _____

City _____ State _____ Zip code _____

Household members:

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

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Exhibit A***I. Family Income***

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

Family Size:

Individual: \$2,500.00


Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
If not a Maryland resident, in what state does patient reside? _____
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:

Medical Assistance Pharmacy Only	Yes or No
QMB coverage/ SLMB coverage	Yes or No
PAC coverage	Yes or No
13. Is patient employed? Yes or No
If no, date became unemployed. _____
Eligible for COBRA health insurance coverage? Yes or No

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POLICY

This policy applies to the Johns Hopkins Bayview Medical Center (JHBMC).

PURPOSE

JHBMC has witnessed the dramatic growth in pregnancy care for expectant mothers within the East Baltimore Community who are not eligible for any insurance coverage, and have demonstrated significant difficulty in paying for healthcare services. JHBMC recognizes the need to establish a policy pertaining to this population to ensure appropriate care during and immediately following pregnancy. Prenatal services and one postpartum visit are covered by this policy.

Eligibility Criteria:

1. Positive pregnancy test with no other obstetrical healthcare provider;
2. Not eligible for any other insurance benefits or exhausted her insurance benefits;
3. Not eligible for any other sources of funding;
4. Demonstrates inability to pay to Financial Representatives;
5. Resides in the JHBMC primary service area as defined by the 2004 Johns Hopkins Strategic Planning and Market Research definition. The zip codes for the JHBMC primary service area include: (21205, 21206, 21213, 21219, 21220, 21221, 21222, 21224, 21231, 21237).

PROCEDURE

Expectant mothers will be seen in the JHBMC outpatient OB/GYN practice for pregnancy care. Expectant mothers are required to meet with a financial counselor to determine their financial eligibility. Following a review of financial eligibility according to policy, FIN 034A; a determination of need will be made.

SPONSOR

Senior Vice President, Medical Affairs (JHBMC)
Vice President, Finance (JHBMC)

REVIEW CYCLE

Three (3) years

APPROVAL

Vice President of Finance/CFO and Treasurer, JHHS

Date

About Your Bill

Maryland's Health Services Cost Review Commission sets and approves rates and charges for Johns Hopkins Bayview Medical Center. The commission's purpose is to control hospitals' charges and to protect patients from unjust and unfair costs.

Before admission, all non-emergency patients will be asked for evidence of hospital and medical insurance. Many insurance carriers require us to contact them for approval before admission.

If you do not have health insurance and believe you are entitled to Medical Assistance or if you have questions about your account before or during your stay, call our financial counselor at ext. 0-0830. Unless other arrangements have been made, payment in full for services is due on receipt of your final bill. The Medical Center accepts MasterCard, VISA, Discover and American Express.

Insurance carriers, Medicare and Medicaid require separate billings for professional fees from physicians and hospital charges. The bills are outlined in the sections that follow.

Your hospital bill

Your Medical Center bill includes room and associated charges, X-rays, laboratory work, medicines and other medical supplies. If you have both inpatient and outpatient services, these will be billed separately.

Your doctor's bill

Your doctor's bill includes fees for examinations, care and interpretation of diagnostic tests. You may receive several bills if more than one physician is involved in your care. Bills should be paid according to arrangements made during the admission process.

- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For more information about Maryland Medical Assistance, contact your local department of social services at 1-800-332-6347, TTY 1-800-925-4434, or visit: www.dhr.state.md.us

Hoja informativa sobre la Facturación de pacientes y la Asistencia financiera

Los cobros de los médicos no se incluyen en las facturas del hospital, son facturados aparte

Los derechos y obligaciones de la facturación

No todos los costos médicos son cubiertos por el seguro. El hospital hace todo lo posible para estar seguro de que usted reciba la factura correcta. Depende de usted proveer la información completa y precisa sobre su cobertura de seguro médico cuando la traen al hospital o cuando visita la clínica ambulatoria. Esto ayudará asegurar que se manden las facturas a su compañía de seguros a tiempo. Algunas compañías de seguro requieren que se manden las facturas tan pronto como usted recibe el tratamiento, de lo contrario pueden no pagarlas. Su factura final reflejará el verdadero costo de su cuidado, menos cualquier pago que se haya recibido y haya hecho al momento de su visita. Todo cobro no cubierto por su seguro es responsabilidad suya.

Asistencia financiera

Si usted no puede pagar por su cuidado médico, es posible que califique para cuidado médicamente necesario gratuito o de bajo costo si usted:

- Es ciudadano Estadounidense o residente permanente viviendo en los Estados Unidos por un periodo no menos que un año
- No tiene otras opciones de seguro
- Le ha sido negado la asistencia médica, o no cumple con todos los requisitos de elegibilidad
- Cumple con criterios financieros específicos

Si usted no califica para la Asistencia Médica de Maryland o la asistencia financiera, es posible que se elegible para un sistema de pagos extendidos para sus facturas médicas.

Llame a 410-502-2289 con preguntas referentes a:

- Su factura del hospital
- Sus derechos y obligaciones en cuanto a su factura del hospital
- Cómo inscribirse para cuidado gratuito o de bajo costo
- Cómo inscribirse para la Asistencia Médica de Maryland u otros programas que le pueden ayudar a pagar sus facturas médicas

Para más información sobre la Asistencia Médica de Maryland Por favor llame a su departamento local de Servicios Sociales 1-800-332-6347. TTY 1-800-925-4434 O visite al: www.dhr.state.md.us

Patient Billing and Financial Assistance Information

Physician charges are not included in hospital bills and are billed separately.

Billing rights and obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought into the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial assistance

If you are unable to pay for medical care, you may qualify for free or reduced-cost medically necessary care if you:

- Are a U.S. citizen or permanent resident living in the U.S. for a minimum of one year
- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Maryland Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call 410-502-2289 with questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill

Appendix 3

Mission, Vision, and Value Statement Description

Appendix 3

The mission and vision statements for Johns Hopkins Bayview Medical Center were developed with broad input from dozens of staff members, physician leaders and the Board of Trustees. Each statement captures the qualities that make Johns Hopkins Bayview unique, as well as reflecting the unique history and community commitment of our legacy. The statements not only echo our purpose as a health care organization, but also inspire Medical Center employees, medical staff members and volunteers to give their best each day. In addition, we adopted the core values of The Johns Hopkins Health System and Johns Hopkins Medicine. The core values succinctly share the ideals to which we all aspire.

Appendix 4

Mission, Vision, and Value Statement

Johns Hopkins Bayview Medical Center Hospital Administrative Policies	
Mission/Values Policy	Policy No.: 100 Original Date: 09/93 Reviewed/Revised Date: 01/09 Page 1 Of 2

I. Johns Hopkins Bayview Medical Center

- A. The mission of Johns Hopkins Bayview Medical Center is:

Johns Hopkins Bayview Medical Center, a member of Johns Hopkins Medicine, provides compassionate health care that is focused on the uniqueness and dignity of each person we serve. We offer this care in an environment that promotes, embraces and honors the diversity of our global community. With a rich and long tradition of medical care, education and research, we are dedicated to providing and advancing medicine that is respectful and nurturing of the lives of those we touch.

- B. Vision: Making the Best Even Better

The Johns Hopkins Bayview Medical Center will be widely recognized for innovation and excellence in clinical care, education and research in medicine. As a leading academic medical center, we will provide an enriching environment for our employees and an exceptional health care experience for our patients and their families.

II. Johns Hopkins Medicine

- A. The **mission** of Johns Hopkins Medicine is to improve the health of the community and the world by setting the standard of excellence in medical education; research and clinical care. Diverse and inclusive, Johns Hopkins Medicine educates medical students, scientists, health care professionals and the public; conducts biomedical research; and provides patient-centered medicine to prevent, diagnose and treat human illness.

- B. Johns Hopkins Medicine Vision:

Johns Hopkins Medicine provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides medical leadership to the world.

Johns Hopkins Bayview Medical Center Hospital Administrative Policies	
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C. Core Values

1. Excellence & Discovery
2. Leadership & Integrity
3. Diversity & Inclusion
4. Respect & Collegiality

Originator: Director of Community Relations
Reviewed by: Board of Trustees
References:

Gregory F. Schaffer
President

The Johns Hopkins Hospital

Community Benefit Narrative

COMMUNITY BENEFIT NARRATIVE
The Johns Hopkins Hospital
Fiscal Year 2009

1. Key Statistics. In fiscal year (FY) 2009, The Johns Hopkins Hospital (JHH or Hospital) was licensed to operate 979 acute care beds. During the same period, the hospital had 47,275 inpatient admissions.

2. Primary Service Area. The Hospital's primary service area includes Baltimore City, Anne Arundel, Baltimore County, Harford County, and Howard County. This area accounts for 63.4% of total discharges. The Hospital's secondary service area includes all other areas and Western Maryland. This area accounts for 16.7% of total discharges. The table below shows the primary and secondary service areas' population, average household income, percent of households below the poverty line, percent of residents uninsured, and percent of residents who are covered by Medicaid/Medicare.

PSA=Primary Service Area; SSA= Secondary Service area, all of Maryland minus the PSA.

Metric	PSA	SSA
Population	2,626,674	3,041,709
Average household income	\$ 82,794	\$ 93,180
Percent of households below poverty line(Families/Individuals)	5.90%	5.00%
Percent of residents who are uninsured	16.9%	12.0%
Percent of residents who are covered by Medicaid/Medicare	14.5%	12.3%

Table 1 shows that the JHH primary service area is growing at a slower rate than the country as a whole.

TABLE 1. DEMOGRAPHIC CHARACTERISTICS		
	Selected Area	USA
2000 Total Population	2,500,129	281,421,906
2009 Total Population	2,620,674	306,624,699
2014 Total Population	2,688,556	322,320,436
% Change 2009 - 2014	2.6%	5.1%
Average Household Income	\$82,794	\$69,376

Table 2 illustrates the projected increase in the male and female population. There is a slight decrease in the number of females of childbearing age. The primary service area population has a high unemployment rate.

TABLE 2. Primary Service Area Population			
	2009	2014	% Change
Total Male Population	1,262,733	1,298,132	2.8%
Total Female Population	1,357,941	1,390,424	2.4%
Females, Child Bearing Age (15-44)	544,685	525,095	-3.6%
% Unemployment	4.8%		
% USA Unemployment	5.6%		

Table 3 shows the demographic shifts projected over the next five years in the JHH primary service area. The largest growth will be in the 65+ and 55-65 age groups, respectively. The younger age groups remain the same or decrease over the next five years.

TABLE 3. POPULATION DISTRIBUTION					
Age Group	Age Distribution				USA 2009
	2009	% of Total	2014	% of Total	% of Total
0-14	508,569	19.4%	510,890	19.0%	20.1%
15-17	116,724	4.5%	110,073	4.1%	4.3%
18-24	253,828	9.7%	261,054	9.7%	9.8%
25-34	329,781	12.6%	336,569	12.5%	13.3%
35-54	776,890	29.6%	736,878	27.4%	28.4%
55-64	306,257	11.7%	352,684	13.1%	11.3%
65+	328,625	12.5%	380,408	14.1%	12.9%
Total	2,620,674	100.0%	2,688,556	100.0%	100.0%

Table 4 demonstrates the distribution of household income in the JHH primary service area. Almost 40% of households earn \$50,000 or less. Ten percent of households had an income of \$15,000 or less.

TABLE 4. HOUSEHOLD INCOME DISTRIBUTION			
2009 Household Income	Income Distribution		
	HH Count	% of Total	USA % of Total
<\$15K	98,877	9.8%	12.4%
\$15-25K	76,920	7.6%	10.4%
\$25-50K	216,540	21.5%	26.0%
\$50-75K	190,878	19.0%	19.6%
\$75-100K	146,351	14.6%	12.3%
Over \$100K	276,083	27.5%	19.3%
Total	1,005,649	100.0%	100.0%

Table 5 shows the racial/ethnic distribution in the JHH primary service area. The communities surrounding JHH are predominantly Black, double the national percentage.

TABLE 5. RACE/ETHNICITY			
Race/Ethnicity	Race/Ethnicity Distribution		
	2009 Pop	% of Total	USA % of Total
White Non-Hispanic	1,611,500	61.5%	65.0%
Black Non-Hispanic	762,349	29.1%	12.2%
Hispanic	87,247	3.3%	15.5%
Asian & Pacific Is. Non-Hispanic	103,453	3.9%	4.5%
All Others	56,125	2.1%	2.8%
Total	2,620,674	100.0%	100.0%

The JHH primary service area is located near many colleges and universities. In 2009, more than 80% of residents had a high school degree or higher.

TABLE 6. EDUCATION LEVEL			
2009 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA % of Total
Less than High School	91,988	5.3%	7.5%
Some High School	214,449	12.3%	11.9%
High School Degree	466,733	26.8%	28.3%
Some College/Assoc. Degree	447,620	25.7%	27.7%
Bachelor's Degree or Greater	520,763	29.9%	24.7%
Total	1,741,553	100.0%	100.0%

3 (a). **Community Needs.** The Johns Hopkins Hospital's FY2009 Community Benefit Report includes a number of initiatives that supports its efforts to meet the needs of the community. These initiatives are decentralized and use a variety of methods to identify community needs.

As highlighted in last year's Community Benefit Report, The Johns Hopkins Hospital (JHH) conducted a formal needs assessment of the East Baltimore in 1997. In 2000, the Johns Hopkins Urban Health Institute (UHI) was created to address the health care needs of the community. The UHI was created with significant input from the community, with collaborative groups meeting over several months to identify goals and needs. The mission of UHI is to marshal the resources of the Johns Hopkins Institutions as well as other, external resources to improve the health and well-being of the residents of East Baltimore and Baltimore City, and to promote evidence-based interventions to solve urban health problems nationwide.

In FY2005, a community needs assessment was conducted that include the community around JHH, and provided additional information for both JHH and the Johns Hopkins Bayview Medical Center to identify community needs and develop targeted initiatives. Other major community benefit initiatives include the New EastSide Project and the Historic East Baltimore Community Action Coalition (HEBCAC). Both initiatives have included significant involvement of community members, nonprofit organizations, government representatives and the business community.

HEBCAC, a nonprofit community-based organization, was developed in 1993 to address the needs of the East Baltimore community by a coalition that included representatives from JHH, local community, business, nonprofit organizations and governmental agencies. The HEBCAC developmental process included a community needs assessment which was conducted over a 12 month period.

The New EastSide Project is a long term community redevelopment initiative to renew neighborhoods north of the JHH campus. The project started in 2001 and is an ongoing collaborative process that includes identifying and assessing community needs. A comprehensive community assessment and needs analysis was conducted over several years. This process involved community representatives and stakeholders from a number of community sectors.

3 (b). **Community Consultation.** The Hospital consulted with the local and state health departments as needed in developing the community assessment processes included above.

4. **Major community health needs identified** during FY 2009 include the following:

- Substance Abuse

- Cardiovascular Disease
- Diabetes
- Violence
- Inadequate Housing
- High Unemployment
- Economic Development
- Enhancement of Educational Services for youth

5. Decision Making Process. Stakeholders from various sections within the community were involved in the process including the following:

- Community associations that represent neighborhoods in JHH's service area
- Nonprofit organizations such as the Annie E. Casey Foundation and the France Merrick Foundation
- Governmental Agencies including law enforcement, housing, community development and economic development
- Local business association
- Political representatives (local, state and federal)
- Representatives from JHH

6. Addressing the Community Needs. JHH has several programs to address the community needs described above including the following:

Cardiovascular

- The Cardiology Department developed a community benefit initiative titled "Heart Hype 2009". The initiative is focused on preventing sudden death among athletes in the community. Clinical staff spend time in the community providing screening, evaluations and follow-up treatment for those athlete identified to be at risk.

Substance Abuse

- JHH has a number of community benefit initiatives that provide substance abuse services for community members in need. One initiative provides substance abuse housing for men in need of shelter that are going through recovery. JHH supports several housing areas in the local community. In addition, a JHH comprehensive substance abuse program provides services to community representatives in need of support and treatment.

Diabetes

- The JHH Comprehensive Diabetes Center has established a monthly support group to assist patients and community members in managing their diabetes. The support group has been instrumental in assisting individuals in coping with a disease that is prevalent in the community.

Violence

- In partnership with the local health department, JHH has supported an initiative titled "Safe Streets Program" that attempts to address the gun violence in East Baltimore. The departments of Emergency Medicine and Social Work provide support by identifying

individuals at-risk for violence that seek treatment at the Hospital. Intervention services are than provided to prevent violent activities in the community.

Community Building Activities (Inadequate housing, high unemployment, economic development, enhancement of educational services for youth)

- JHH has been a significant partner in establishing major initiatives to address the need for community redevelopment in the surrounding neighborhoods. As mentioned previously, the New EastSide Project is an initiative to redevelop the community north of the JHH campus. The goal is to develop a vibrant community with new and rebuilt housing, employment opportunities, a new community school, and to attract commercial and retail business into the area. The project is also providing a comprehensive range of services for East Baltimore residents, from job training and financial counseling to health care and youth employment assistance.
- In partnership with the community, JHH has also played a leadership role in establishing the Historic East Baltimore Community Action Coalition (HEBCAC). A community-based organization established to improve the Historic East Baltimore community which surrounds the JHH campus. Over the years, HEBCAC has been instrumental in spearheading a variety of community improvement projects including those that have enhance housing opportunities, employment, youth development and the quality of the environment.

7. Evaluation. The evaluations of several major initiatives are included below:

- a. Name: Access Partnership
 Year of Evaluation: 2009
 Nature of Evaluation: Number of completed appointments; # of closed referrals and number of no show appointments
 Result: Program continues to be evaluated
- b. Name: Breast Health Awareness
 Year of Evaluation: 2009
 Nature of Evaluation: Evaluation of the effective of display; review of questions; comments and request for information
 Result: Incorporate requests for information and comments
- c. Name: Ask the Expert Information Table
 Year of Evaluation: 2009
 Nature of Evaluation: Staff analysis of types of information and resources requested by patient, family and community participants
 Result: Identified educational content and theme for weekly in information table
- d. Name: Martin Luther King Early Head Start
 Year of Evaluation: 2009
 Nature of Evaluation: The tool used to conduct the assessment was the Head Start Protocol which is designated by the grantee agency
 Result: Continuation of program
- e. Name: Clinical Pastoral Education intern Group
 Year of Evaluation: 2009
 Nature of Evaluation: Outcome measures per standards of ACPE

Result:	Reviewed by professional advisory group, developed a quality improvement plan including exit interview updates and improved communication issues addressed
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8. Gaps in the Availability of Specialist Providers. Description of the gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

As stated in its Financial Assistance policy, The Johns Hopkins Hospital is committed to providing medically necessary care to uninsured and underinsured patients with demonstrated financial need. We recognize, however, that specialty care, particularly outpatient, can be difficult to access for some uninsured patients with significant financial need despite the hospital's stated policy. In FY2009, JHH implemented a program to address these barriers to outpatient specialty care for uninsured patients living in the zip codes that surround the hospital. The Access Partnership—Specialty Care is a pilot program that provides facilitation and coordination of specialty referrals for uninsured East Baltimore Medical Center ("EBMC") primary care patients. Patients in the program receive support through the referral process with scheduling, appointment reminders, and follow-up. The Hospital provides specialty care as charity care, at no charge to the patient other than a nominal fee for participation in the program. From May 1-October 31, 2009, only patients living in zip codes 21213 and 21205 receiving care at EBMC were eligible for the program. As of November 1, 2009, the program was expanded to include zip codes 21231, 21224, and 21202.

9. Physician Subsidies. We provide support for two Johns Hopkins Community Physician sites for their teaching services and for their care of disadvantaged patients. The hospital's Joint Agreement also provides funds for all on-call physicians and assists with support of uncompensated care provided by the physicians to community members in our programs.

Appendix 1

Charity Care Policy Description

Appendix 1

Charity Care Policy Description

The Hospital provides necessary emergency medical care to all people regardless of their ability to pay. Financial assistance is available for those patients who are unable to pay for necessary medical care. A patient may qualify for financial assistance if they meet the following requirements:


- Are U.S. citizens or permanent resident living in the United States for a minimum of one year. (Patients need not be U.S. citizens or permanent residents to qualify for financial assistance at Howard County General Hospital)
- Have exhausted all insurance options.
- Have been denied Medical Assistance or do not meet eligibility requirements.
- Meet other criteria for financial assistance, which is based on information you will be asked to provide regarding your income, assets and outstanding debt.

The Hospital informs patients who would otherwise be billed for services about the hospital's financial assistance policy in the following manner:

- Signs in patient waiting and registration areas
- Posted on the Hospital website
- All patients indicating a need for financial assistance are referred to a financial counselor who reviews with them the availability of assistance under federal, state, or local government programs.

Appendix 2

Charity Care Policy

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POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC).

Purpose

JHHS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

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

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.


JHHS hospitals have seen an increase in Emergency Room visits from residents of the East Baltimore Community who are not eligible for or do not have any insurance coverage and have demonstrated significant difficulty in paying for healthcare services. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor and disenfranchised, JHHS' hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the JHHS hospitals' commitment to their mission to provide healthcare to those residing in the neighborhoods surrounding their respective hospitals, the JHHS hospitals reserve the right to grant financial assistance without formal application being made by patients residing in the respective hospital's primary service area as defined by the Johns Hopkins Strategic Planning and Marketing Research definition. The zip codes for the JHH primary service area include: (21202, 21205, 21213, 21224, 21231). The zip codes for the JHBMC primary service area include: (21205, 21219, 21222, 21224). The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage.

PROCEDURES


1. An evaluation for Financial Assistance can begin in a number of ways:

For example:


- A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
- A patient presents at a clinical area (includes emergency department) without insurance and states that he/she cannot afford to pay the medical expenses associated with their

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- current or previous medical services.
 - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.
- 2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, JHOPC first-floor administrative staff, Customer Service, etc.
- 3. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
 - b. Applications received will be faxed daily to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.
- 4. To determine final eligibility, the following criteria must be met:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review the alternative of offering a payment-plan agreement.
 - c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - d. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).
 - e. All insurance benefits must have been exhausted.
- 5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:
 - a. A completed Financial Assistance Application and Patient Profile Questionnaire.
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

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- d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of U.S. citizenship or lawful permanent residence status (green card).
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines.
- a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
 - b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on CPA, JHH and BMC guidelines.
7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
8. A department can continue using an adjustment to total charges (sliding scale) without the completion of Financial Need Assessment paperwork if the resulting adjustment is consistent with the Adjustments and Courtesy for Clinical Services policy. The use of a sliding scale in this manner applies only to the specific service involved; it does not automatically apply to any other services.
9. Specific departments operating programs under a grant or other outside governing authority (such as JHBMC Addiction Treatment Services) may continue to use a government-sponsored application process and associated income scale.
10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may extend to three years.
11. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of

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the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- PAC coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- Participation in Women, Infants and Children Programs (WIC)
- Food Stamp eligibility
- Eligibility for other state or local assistance programs
- Patient is deceased with no known estate
- The Access Partnership Program at Hopkins

12. Patients who present to the Emergency Departments but are not admitted as inpatients and who reside in the hospitals' primary service area need not complete a Financial Assistance Application but will be granted financial assistance based upon the following criteria:
1. Reside in primary service area (address has been verified)
 2. Not have any health insurance coverage
 3. Not enrolled in Medical Assistance for date of service
 4. Indicate an inability to pay for their care

Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

REFERENCE¹

JHHS Finance Policies and Procedures Manual


Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually) in Federal Register

¹ NOTE: Standardized applications for Financial Assistance and Patient Profile Questionnaire have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A and B.

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RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service
 Collector Admissions Coordinator
 Any Finance representative designated to accept applications for Financial Assistance

Understand current criteria for Assistance qualifications.

Identify prospective candidates; initiate application process when required. (BMC Community Psychiatry completes the "Application for Financial Hardship and Fee Adjustment" form)

On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility.

Review preliminary application and Patient Profile Questionnaire to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.

Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient accounts comments.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application.


Deliver completed final application to Patient Financial Services management.

Document all transactions in all applicable patient accounts collection record.

Management Personnel
 (Supervisor/Manager/Director)

Review completed final application; monitor those accounts for which no application id requires; determine patient eligibility; communicate final written determination to patient.

Advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.]

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Financial Management Personnel
(Senior Director/Assistant Treasurer
or affiliate equivalent)
CPP Director and Management Staff

Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.


SPONSOR

Senior Director, Patient Finance (JHHS)
Director, PFS Operations (JHHS)

REVIEW CYCLE

Three (3) years


APPROVAL


Vice President of Finance/CFO and Treasurer, JHHS

6-19-09
Date

PROCEDURES - JHH

1. Financial Counselor/Patient Financial Services Representative/Counselor
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications, Patient Profile Questionnaires and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
 - d. Initiate the Financial Assistance Application process with the patient/guarantor when applicable. As necessary, assist patient/guarantor in completing the application.
 - e. If patient meets Presumptive Financial Assistance Eligibility criteria that does not require that a Financial Assistance Application to be completed, notate the patient account comments and place into financial assistance code for system writeoff.
 - f. Review preliminary application and communicate a determination of probable eligibility to patient within two

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business days.

- g. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
- h. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor.
- i. Document all transactions involving the application process.

2. Supervisor


- a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
- b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
- c. Approve/disapprove financial assistance applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.

- d. If recommending approval of financial assistance applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
- e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
- f. Initiate transactions to offset revenue on approved applications.
- g. Scan records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

3. Director, Patient Financial Services

- a. Review applications according to signature authority established in Finance Policy No. FIN017, or those applications forwarded because of extenuating


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circumstances.


- b. Approve/disapprove financial assistance applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications and approvals to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than authorized amount, forward to Senior Director, Patient Financial Services for further action.
4. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications and approvals to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.
5. Vice President, Finance/CFO and Treasurer or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove financial assistance; return finalized applications and approvals to Senior Director for final processing.

PROCEDURES – JHBMC


1. Financial Counselor (Inpatient and Outpatient) and Collector CPP Admissions Coordinator and Clinical Staff
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications, Patient Profile Questionnaires and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance.
 - d. Initiate the Financial Assistance application process with the patient/guarantor when applicable. As necessary, assist patient/guarantor in completing the application.

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- e. If patient meets Presumptive Financial Assistance Eligibility criteria that does not require that a Financial Assistance Application be completed, notate the patient account comments and place into financial assistance code for system writeoff.
 - f. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - g. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - h. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to the application; place in a file folder marked "Financial Assistance;" deliver file to designated Manager or responsible party.
 - i. Document all transactions in the application process.
2. Supervisor, Patient Financial Services
CPP Director/Managers
- a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove financial assistance applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application that does not meet the Financial Assistance Guidelines as set forth in Appendix A.
- NOTE:** Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.
- d. If recommending approval of financial assistance applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.


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- g. File records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.
- 3. Associate Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of Financial Assistance amounts written off. Return finalized applications and approvals to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval of financial assistance for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.
 - e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.
- 4. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove financial assistance as authorized.
 - c. Return finalized applications and approvals to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor. Notices will not be sent to Presumptive Eligibility or ED Financial Assistance recipients.
 - d. If recommending approval for financial assistance applications greater than amount authorized, forward to affiliate Senior Director, Patient Financial Services, for further action.
- 5. Vice President, Finance/CFO or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove financial assistance applications and return finalized applications and approvals to Director, Patient Financial Services.

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APPENDIX A FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. ***Notice of the availability of the JHHS Financial Assistance Program will be posted at patient registration sites, Admissions/Business Offices, Billing Office and at the emergency department within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance must complete a JHM/Financial Assistance application and Patient Profile Questionnaire. Exception: when there is Presumptive Financial Assistance Eligibility or patient resides in hospital's primary service area and is ED patient. (see below)
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior-year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets *in excess of \$5,000 which would be available to satisfy their JHHS affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the hospital.
8. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of the day when the application was satisfactorily completed and submitted. The Manager or designated responsible party will issue the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial

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Assistance from another affiliate.

11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.
12. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
 - Active Medical Assistance pharmacy coverage
 - QMB coverage/ SLMB coverage
 - PAC coverage
 - Homelessness
 - Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
 - Maryland Public Health System Emergency Petition patients
 - Participation in Women, Infants and Children Programs (WIC)
 - Food Stamp eligibility
 - Eligibility for other state or local assistance programs
 - Patient is deceased with no known estate
 - The Access Partnership Program at Hopkins
13. Patients who present to the Emergency Departments but are not admitted as inpatients and who reside in the hospitals' primary service area need not complete a Financial Assistance Application but will be granted financial assistance based upon the following criteria:
 1. Reside in primary service area (address has been verified)
 2. Not have any health insurance coverage
 3. Not enrolled in Medical Assistance for date of service
 4. Indicate an inability to pay for their care

Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

14. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

*Liquid Assets are defined as cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, pension benefits, accounts receivable or other property immediately convertible to cash.

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APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The JHM Financial Assistance Program
 - Other forms of assistance available through JHM affiliates
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$5,000)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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Definitions


Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash.
Living Expenses	Per-person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e., drugs, co-pays, deductibles and durable medical equipment.)
Take-Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports.

Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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**TABLE FOR DETERMINATION OF
FINANCIAL ASSISTANCE ALLOWANCES**

Effective 2/2/09

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	\$ 16,245	\$ 19,494	\$ 21,119	\$ 24,368	\$ 25,992	\$ 29,241
2	\$ 21,855	\$ 26,226	\$ 28,412	\$ 32,783	\$ 34,968	\$ 39,339
3	\$ 27,465	\$ 32,958	\$ 35,705	\$ 41,198	\$ 43,944	\$ 49,437
4	\$ 33,075	\$ 39,690	\$ 42,998	\$ 49,613	\$ 52,920	\$ 59,535
5	\$ 38,685	\$ 46,422	\$ 50,291	\$ 58,028	\$ 61,896	\$ 69,633
6	\$ 44,295	\$ 53,154	\$ 57,584	\$ 66,443	\$ 70,872	\$ 79,731
7	\$ 49,905	\$ 59,886	\$ 64,877	\$ 74,858	\$ 79,848	\$ 89,829
8*	\$ 55,515	\$ 66,618	\$ 72,170	\$ 83,273	\$ 88,824	\$ 99,927
Allowance to Give:						
	100%	80%	70%	50%	40%	20%

*150% of Poverty Guidelines

EXAMPLE: Annual Family Income \$50,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$33,075
 Upper Limits of Income for Allowance Range \$52,920 (40% range)
 (\$50,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

*For family units with more than eight (8) members, add \$5,610 for each additional member.

Exhibit A

Johns Hopkins Hospital
 5300 Alpha Commons/Suite 300
 Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
 First Middle Last

Social Security Number _____ - ____ - ____
 US Citizen: Yes No

Marital Status: Single Married Separated
 Permanent Resident: Yes No

Home Address _____

Phone _____

 City State Zip code

Country _____

Employer Name _____

Phone _____

Work Address _____

 City State Zip code

Household members:

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

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Exhibit A***I. Family Income***

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Exhibit A

Johns Hopkins Bayview Medical Center
 5300 Alpha Commons/Suite 300
 Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
 First Middle Last

Social Security Number _____ - ____ - ____
 US Citizen: Yes No

Marital Status: Single Married Separated
 Permanent Resident: Yes No

Home Address _____ Phone _____

City _____ State _____ Zip code _____ Country _____

Employer Name _____ Phone _____

Work Address _____

City _____ State _____ Zip code _____

Household members:

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

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

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

Exhibit A***I. Family Income***

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

Family Size:

Individual: \$2,500.00

Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
If not a Maryland resident, in what state does patient reside? _____
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:

Medical Assistance Pharmacy Only	Yes or No
QMB coverage/ SLMB coverage	Yes or No
PAC coverage	Yes or No
13. Is patient employed? Yes or No
If no, date became unemployed. _____
Eligible for COBRA health insurance coverage? Yes or No

Appendix 3

Mission, Vision, and Value Statement Description

Appendix 3

The mission of the Hospital is to improve the health of the community and the world. The hospital Board reviewed and approved the current mission, vision, and values in September 2007. The review cycle is every three years.

Appendix 4

Mission, Vision, and Value Statement



Appendix 4

Statement of Mission, Vision, and Values

The Johns Hopkins Hospital Mission

The mission of The Johns Hopkins Hospital is to improve the health of the community and the world by setting the standard of excellence in patient care. Diverse and inclusive, The Johns Hopkins Hospital in collaboration with the faculty of The Johns Hopkins University supports medical education and research, and provides innovative patient-centered care to prevent, diagnose and treat human illness.

The Johns Hopkins Hospital Vision

The vision of The Johns Hopkins Hospital is to be the world's preeminent health care institution.

The Johns Hopkins Hospital Values

- Excellence & Discovery
- Leadership & Integrity
- Diversity & Inclusion
- Respect & Collegiality

James Lawrence Kernan Hospital Community Benefits Narrative FY 2009

General Statement

The James Lawrence Kernan Hospital is the largest inpatient rehabilitation hospital in the state of Maryland. Known also as Kernan Orthopaedics and Rehabilitation, the hospital is a committed provider of a full array of rehabilitation programs and specialty surgery- primarily orthopaedics- for over 110 years.

Located on 85 acres on the border of southwest Baltimore City and Baltimore County, Kernan Hospital is dedicated to reaching out to the community and providing personalized care to patients. Kernan continues to be committed to excellence in the areas of patient care and medical education through training programs provided for orthopaedic, dental, anesthesia and rehabilitation physician residents, nursing and physical and occupational therapy students. Kernan has kept pace with the changing environment in healthcare by blending a multidisciplinary staff of specialists to meet a variety of patient needs.

Approximately 15 percent of Kernan's patients are admitted to the hospital for elective procedures. Patients requiring rehabilitative care comprise the other 85 percent of admissions and are patients who are transferred to Kernan from other hospitals throughout the state of Maryland.

The following statistics apply to Kernan Hospital for FY 2009:

Number of licensed beds: 138

In-patient Admissions: 3,316

Surgeries: 5,454

Outpatient Visits: 79,359

As part of the continuum of care for patients whose acute care treatment may begin at The University of Maryland Medical Center, R. Adams Cowley Shock Trauma Center, or other acute care hospitals throughout Maryland, Kernan's outreach, community and professional education initiatives, as well as other community involvements are driven by the diagnostic categories that Kernan serves, and the need to invest in the development of future professionals to care for individuals who require the unique blend of services available at Kernan.

Kernan provides specialized rehabilitation services within its four 32-bed units, dedicated to spinal cord injured, traumatic brain injured, stroke and comprehensive medical rehabilitation. Each unit is staffed by a multi disciplinary team lead by a rehabilitation physician collaborating in quality care delivery with the disciplines of nursing, physical therapy, occupational therapy, speech therapy, therapeutic recreational, case management and dietary, as well as consulting physician services such as ENT and urology. In addition, orthopaedic services such as total joint replacement-including reverse shoulder replacement and sports medicine procedures-are provided. Over the past 10 years, Kernan has provided inpatient services to over 20,000 patients.

The hospital also provides a complete dental practice, including nine treatment areas for general and pediatric dentistry. In addition to the reception and business areas, the suite also includes areas for disinfection, sterilization, X-ray and laboratory, and facilities for comprehensive dental treatment under general anesthesia.

A special mission of the Kernan Dental Service is to serve children and adults who have limited access to oral health care in the community. This population includes mentally and/or physically disabled individuals, as well as many children in the Maryland Medicaid Program.

Mentally disabled adults experience a range of oral health problems greater than that seen in the general population. Their disabilities can make even routine care difficult, sometimes requiring the use of general anesthesia. The general dentists at Kernan have taken up the challenge of treating this special group of people. Staff visits area schools to instruct students on oral care, as well as participate in community health fairs.

The University of Maryland Medical System Community Health Outreach and Advocacy Strategic Plan developed in FY 2006 is one determinant of Kernan's community outreach initiatives. Other factors that determine these initiatives include an integration of evidence-based research and data obtained through relationships with:

- Brain Injury Association of Maryland
- Maryland Stroke Alliance
- The National Center for Injury Prevention & Control
- USAMS
- Maryland Hospital Association
- National Caregivers Association
- Arthritis Foundation

and other disability specific organizations that advocate, support and empower our patients and families as they adjust to their disabilities.

Community Benefits Evaluation

The community outreach initiatives involve partnerships with both local education and community groups as well as organizations with specific ties to disabilities treated at Kernan. These groups include

Community Groups

Franklintown Community Association
Greater Catonsville Chamber of Commerce
Security-Woodlawn Business Association
Baltimore County Chamber of Commerce
Rotary Club of Woodlawn-Westview
Gwynns Falls Trail Council

Schools

Baltimore City Schools
 Dickey Hill Elementary and Middle schools
Baltimore County Schools
 Randallstown High School
 Milford Mill High School
 Hereford High School
Howard County Schools
 Howard High School
 Mt. Hebron High School

Corporate/Non-Profit

Baltimore Municipal Golf Corporation
Baltimore City Department of Parks & Recreation – Therapeutic Division
Howard County Youth Programs
The Brain Injury Association of Maryland
Arthritis Foundation of Maryland
Towson YMCA
Baltimore Adaptive Recreation and Sports
Multiple Sclerosis Society of Maryland
Boy Scouts of America-Maryland

Kernan's leadership consults with community leaders on an ongoing basis to determine how best to meet the needs of their constituents through attendance at monthly meetings and actively participating on board and commissions within these organizations, plus sponsoring of community events.

Community Benefits Implementation

The community outreach initiatives have designated staff members assigned to assist and monitor the community benefits activities. A staff member is assigned to work within the Community Outreach Advocacy team, a part of the University of Maryland Medical System. The community groups and hospital leadership are kept abreast of the initiatives and their progress towards goal achievement.

James Lawrence Kernan Hospital

Kernan provides education, serves as an advocate and supports the disability populations within its continuum of care. During FY 2009, Kernan provided and facilitated monthly support groups for brain injury, stroke, spinal cord injury, amputee, and caregivers' programs.

In addition to support groups, physical space was provided within the hospital for:

- the Brain Injury Association of Maryland
- the MS Day Program funded by US Against MS
- Women Embracing Abilities Now, a mentoring program for women with disabilities
- monthly meeting space for the Franklinton Community Association

Responding to the need to healthcare education and career awareness, opportunities were brought to students within the Kernan community as well. Dental education was provided to Dickey Hill Elementary School students as well as students attending the St. Michael's School health fair. High school students in Howard County at Hammond High School, Mt. Hebron High School, and Folly Quarter Middle School and Baltimore County students from Randallstown, Milford Mill and Hereford high schools, as well as Baltimore City partner school Dickey Hill Elementary/Middle School learned about health care careers through activities of Kernan staff at those schools. Additionally, health care dental screenings and backpack safety lesson are two events held annually at Dickey Hill Elementary and Middle School.

Clinical education and mentoring of future health care professionals was provided to numerous college and university students in the fields of occupational therapy, physical therapy, speech language pathology, dental, nursing and medicine. Athletic trainers and medical residents were also provided to area high schools, and provided pre-season sports physicals.

Community integration and adaptive leisure opportunities were provided through collaborative initiatives with Baltimore Municipal Golf Corporation and Baltimore City Parks and Recreation-Therapeutic Recreation Division.

Community Benefits Evaluations FY 2009

Many of the individual initiatives have tracked outcomes(s) through satisfaction and participation questionnaires. College students who were provided clinical experience for workforce development completed structured evaluations of their experiences. The community fairs and health screenings yielded spontaneous input and suggestions from those in attendance. Due to constant feedback from support group attendees Kernan staff are able to develop and implement program content that is the most beneficial to the end-user--the patient.

Two initiatives were identified because of community input – Backpack Awareness, and Total Joint Education.

Because of the relationship with Dickey Hill Elementary and Middle, Kernan utilized its physical therapy experts to create a fun, interactive method of teaching children the best way to carry books, school supplies, etc. –without overloading and causing bodily injury.

The Total Joint Education seminars and classes were created with input from people who visited Kernan physical therapists and orthopaedic nurses during community events. Individuals expressed their ideas about activities and information that would make their stay and recovery more meaningful. That information was packaged as part of the Total Joint classes held at Kernan, and used as speakers visit area senior centers to talk about arthritis and joint replacement options.

Gap Coverage

The James Lawrence Kernan Hospital does not have an emergency department. It is classified as a Level IV emergency service facility, therefore, the hospital offers reasonable care in determining if an emergency exists, renders life saving first aid and makes appropriate referral to an acute care facility capable of providing continued emergency services.

Visitors and outpatients who suffer cardiopulmonary arrest will have emergent care initiated by the code blue team and then will be transported to an emergency room via 911.

All inpatients requiring treatment by the code blue team will be transported, with monitoring, to the Intensive Care Unit at Kernan at the discretion of the team leader. In consultation, the intensivist and service attending will make the determination regarding patient transport to a tertiary care facility.

Kernan has a rapid response team that will respond to calls regarding visitors/patients who need emergent care or rapid management outside of the critical care setting. The rapid response team consists of a respiratory therapist, registered nurse, intensivist (day shift only) and hospitalist. Patient family members are educated about the services that the rapid response team offers, and how to contact them if family members feel that the patient requires that service.

Appendix 1

Charity Care policy of The James Lawrence Kernan Hospital.

Kernan Orthopaedics and Rehabilitation Hospital, as a part of the University of Maryland Medical System, provides healthcare services to those in need regardless of an individual's ability to pay. Care may be provided without charge, or at a reduced charge, to those who do not have insurance, Medicaid/Medical Assistance coverage, and are without the means to pay. An individual's eligibility to receive care without charge, at a reduced charge, or to pay for their care over time is determined on a case by case basis.

Within two days following a patient's request for charity care services, application for medical assistance, or both, the hospital makes a determination of probable eligibility.

A large percentage of Kernan's patients are transferred from the Shock Trauma Center or the University of Maryland Hospital. Those who do not have the ability to pay are never turned away and are helped to find resources to cover the costs of their hospital stay and medications with the assistance of Kernan's case managers. For patients who require financial assistance, Kernan Hospital has endowment funds available to assist people without resources who may need medical supplies or medications. This assistance is available upon request and is reviewed on a case-by-case basis.

Information regarding the charity care policy at Kernan is posted within the hospital in clinic areas and business areas where eligible patients are likely to be present. Patients also receive individualized help in obtaining services and care should they not have the ability to pay. Information regarding Kernan's charity care policy is provided at the time of preadmission or admission to each person who seeks services at the hospital. Kernan Hospital makes every effort that information is provided in languages that is understood by the target population of patients utilizing hospital services.

Appendix 2

UNIVERSITY OF MARYLAND MEDICAL CENTER JAMES LAWRENCE KERNAN HOSPITAL UNIVERSITY SPECIALTY HOSPITAL

FINANCE POLICY AND PROCEDURE MANUAL

Effective Date: September 2008

Revision: December 2008

SUBJECT: FINANCIAL CLEARANCE PROGRAM

APPROVALS:

- | |
|---|
| <ul style="list-style-type: none">• SVP & Chief Financial Officer• |
|---|

POLICY STATEMENT

This policy outlines the principles of the Financial Clearance Program, also formerly known as the Financial Assistance Program. The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their prospective or outstanding hospital bill.

SCOPE

The Financial Clearance Program may cover all medically necessary and appropriate hospital-based services provided by the Hospital (which for this policy includes the University of Maryland Medical Center, University Specialty Hospital, and Kernan Hospital) when ordered by a physician on the Hospital's medical staff.

The Financial Clearance Program does not cover the following:

- Services provided by healthcare providers not affiliated with the Hospital (e.g., durable medical equipment, home health services).
- Insurance co-payments for need-based programs such as Medicaid.
- Unpaid balances resulting from cosmetic or other non-medically necessary services.
- Patient convenience items.
- Patient meals and lodging.

The Patient Financial Services (PFS) staff administers the Financial Clearance Program and evaluates each application in a fair and equitable manner. If PFS staff is unable to review and financially clear a non-emergent/urgent service *before* it has been scheduled to be provided, such service may be subject to rescheduling, after consultation with Hospital Management and the patient's physician. The Hospital retains the right in its sole discretion to determine a patient's ability to pay.

All patients presenting for emergency services will be treated regardless of their ability to pay.

PROCEDURE

1.1 The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their outstanding hospital bill. In order to be eligible, patients must complete an application and provide all required documentation.

1.2 Individuals are ineligible for the Financial Clearance Program if they:

- 1.2.1 Refuse to provide requested documentation or provide incomplete information.
- 1.2.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Hospital due to insurance plan restrictions/limits.
- 1.2.3 Fail to pay co-payments as required by the Financial Clearance Program.
- 1.2.4 Fail to keep current on existing payment arrangements with the Hospital or one of its affiliate Hospitals.
- 1.2.5 Fail to make appropriate arrangements on past payment obligations owed to the Hospital or one of its affiliate Hospitals (including those patients who were referred to an outside collection agency for a previous debt).
- 1.2.6 Refuse to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.

1.3 Before scheduling hospital based, non-emergent/urgent services for individuals indicating an inability to pay, staff from the faculty practice plans will contact the Hospital's Financial Counseling team to inform them that a patient is being referred for Financial Clearance.

- 1.3.1 Patients must have a referring/attending physician on staff at the Hospital before they may be evaluated for Financial Clearance eligibility.
- 1.3.2 Patients can call Financial Counseling staff directly at (410) 821-4140. Hours of operation are Monday – Friday from 8:00 a.m. to 9:00 p.m.

- 1.3.4 The Financial Counselor will work with the patient to determine if he/she qualifies for Financial Clearance. A determination of probable eligibility will be made within two business days following a patient's initial completed request for Financial Clearance services, application for Medical Assistance, or both.
- 1.3.5 Notice of the availability of Financial Clearance/Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the Hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.

Individual notice of the availability of Financial Clearance/Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the Hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.

- 1.3.6 The Hospital will publish notice of the availability of Financial Clearance/Financial Assistance annually in the Baltimore Sun Paper.
- 1.3.7 If the patient does qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff who may then schedule the patient for the appropriate Hospital-based service.
- 1.3.8 If the patient does not qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff of the determination and the non-emergent/urgent Hospital-based services will not be scheduled.
- 1.3.9 A decision that the patient may not be scheduled for Hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Physician Leader/Clinical Chair. The Financial Clearance Executive Committee is comprised of the Medical Center Chief Financial Officer and Chief Medical Officer or their designees.
- 1.4 If there is a change in the patient's financial circumstances, an updated or new application must be completed.

2.0 GUIDELINES

2.1 For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving these types of services.

2.2 For scheduled/elective appointments or admissions, all applications to the Financial Clearance Program must be evaluated and approved prior to the patient's date of service.

2.3 The Hospital reserves the right to request and review all pertinent information, including a review of an applicant's credit report history, for purposes of processing the application.

2.4 All applicants will be screened for other programs before screening for the Financial Clearance Program can begin. The other programs are as follows (in order of screening):

2.4.1 Maryland Medicaid—A denial letter may be required, if appropriate.

2.4.2 Other needs based assistance programs.

2.5 Applicants or family members are not eligible for the Financial Clearance Program if they qualify for Medicaid.

2.6 Unemployed applicants who have been unemployed for more than six (6) months and who have no custodial dependents under the age of 12 must provide proof of disability, as evidenced by a physician's certification, prior to qualifying for the Plan. Exceptions to this rule may be considered in accordance with Section 2.19 below.

2.7 Patients who falsify the Financial Clearance Program application or related documentation will be excluded from the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

2.8 One hundred percent Financial Clearance may be granted to uninsured patients whose sources of income is less than two times the federal poverty income level and who have less than \$10,000 in total assets. Financial Clearance will be granted on a sliding scale to uninsured patients with incomes more than two times the federal poverty income level.

2.9 Cost of care will be included in the determination of patient's eligibility for Financial Clearance.

2.10 The amount of uninsured medical costs will be considered in determining a patient's eligibility for the Financial Clearance Program, (**e.g.**, a patient whose income is \$40,000 a year but whose child recently incurred \$200,000 in uninsured medical costs).

2.11 The Financial Clearance Program decisions are valid for a six-month period. In order to continue in the Program, each patient must reapply before the end of each six month period. In addition, patients who have been approved for the Program must inform the Hospital of any changes in income, assets, expenses, or family status within 30 days of such change(s).

2.12 The patient must fulfill all co-payment obligations. Co-payments are due at the time of service. If a patient fails to pay the required co-payment at the time of service, he/she will no longer qualify for the Financial Clearance Program.

2.13 The Financial Clearance Program will not cover co-insurance or deductibles for patients who have insurance, including Medicare.

2.14 Patients who have access to other medical care (**e.g.**, primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Clearance Program.

2.15 Patients whose insurance program or policy denies coverage for services at the Hospital by their insurance company (**e.g.**, HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Clearance Program.

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

2.17 The Financial Clearance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

2.18 Where there is a compelling educational and/or humanitarian benefit, School of Medicine faculty or Hospital faculty may request the Financial Clearance Executive Committee to consider exceptions to the Financial Clearance Program guidelines.

2.18.1 Faculty/Physicians requesting Financial Clearance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.

2.18.2 The Chief Medical Officer will notify the attending physician and the Financial Counseling staff of the Financial Clearance Executive Committee determination.

Appendix 3

Mission, Vision and Value Statement for the James Lawrence Kernan Hospital

The staff at Kernan Orthopaedics and Rehabilitation is committed to working with patients and family members to meet their health care needs. Our dedicated staff serves the community with the goal to provide the same care and attention we would want for our families and ourselves.

The hospital's mission is to deliver innovative, high-quality, cost-effective rehabilitation and surgical services to the community and region.

The vision of the hospital is to be widely recognized as an integral component of the University of Maryland Medical System in its role as a regional hospital specializing in rehabilitation and orthopaedic services.

Core values include providing quality and compassionate care, excellent service, and respect for patients, families and employees. Additionally, providing patient safety, quality research and education, as well as cost effective health care are also part of the core values of Kernan Hospital.

Appendix 4

Copy of the Mission and Vision Statement of Kernan Hospital

Following is a copy of Kernan Hospital's mission and vision statement.



MISSION

Kernan Orthopaedics and Rehabilitation delivers innovative high quality, cost effective rehabilitation and surgical services to the community and region. We provide:

- An interdisciplinary continuum of care including inpatient and outpatient surgery, rehabilitation and additional services as required.
- A proactive environment for patient safety, implementing improvements as patient safety risks are identified
- A site for public and professional health care education and research.

VISION

Kernan Orthopaedics and Rehabilitation's vision is to be widely recognized as an integral component of the University of Maryland Medical System in its role as:

- A regional hospital specializing in the provision of acute, chronic and outpatient rehabilitation services.
- A regional hospital specializing in the provision of a full array of orthopaedic services for adults and children.
- A high quality provider of specialized medical/surgical programs.

VALUES

Quality and Compassionate Care • Excellence in Service
• Respect for the Individual • Patient Safety
Quality in Research and Education • Cost Effectiveness

**Community Benefits Reporting
Fiscal Year 2009**

**Laurel Regional Hospital
7300 Van Dusen Road
Laurel, MD 20707
301-725-4300
410-792-2270**

Introduction:

Laurel Regional Hospital has been providing high quality, efficient healthcare services to residents in Prince George's, Anne Arundel, Howard, and Montgomery Counties since 1978. Though the hospital has grown considerably in the last few decades, its commitment to the community has never changed.

Today Laurel Regional Hospital is still a community hospital with 124 beds and 624 employees serving residents of the Baltimore-Washington region. Laurel Regional Hospital is conveniently located off of I-95, Route 1 and the Baltimore- Washington Parkway.

Laurel Regional Hospital offers a comprehensive range of inpatient and outpatient medical and surgical services including:

- Behavioral Health
- Emergency Services
- Maternal and Child Health
- Physical Medicine
- Sleep Disorders
- Wound Care
- Cardiopulmonary Services
- Diagnostic Services

Laurel reaches out to the community with screenings and speakers who are educated on a wide range of topics. The hospital also offers CPR, ACLS, and smoking cessation classes. Laurel Regional Hospital is proud to partner with outreach groups such as Alcoholics Anonymous, Narcotics Anonymous, and a Parkinson's Support group.

Laurel Regional Hospital is also backed by two support organizations, the Auxiliary and Foundation help raise money to fund capital needs.

Evaluation Framework:

Laurel Regional Hospital has not completed a formal evaluation of its community benefits programs. We do, however, informally evaluate some of the programs that we provide to the community. During programs such as our various seminars we have participants fill out evaluation sheets that track general information. These evaluations ask age, demographic information, how they heard about the program, the perceived value of the program and their opinion of the hospital. We also use this tool to gauge what the community would like to see done in the future.

- Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

At this time Laurel Regional Hospital does not have a community benefit plan or include it as part of its strategic plan. We are hoping that our finances will improve and we will be able to add this in the future.

2. Were hospital staff and leadership involved in developing the plan?

N/A

- Community Needs Assessment

3. Does the hospital's plan target specific areas of community need?

N/A

4. Did the local health department/s provide current needs assessment information that was used by the hospital? Were other information sources used to identify community benefits needs? Please provide a description of these sources.

Due to lack of staff and funds, a needs assessment has not been conducted by Laurel Regional Hospital to identify community needs. Though Laurel Regional Hospital is physically located in Prince George's County, our services area goes well into Anne Arundel, Howard, and Montgomery Counties which makes data collected by any one health department difficult to compile for our use.

- Community Benefits Initiatives

5. Does the hospital identify its Community Based Initiatives?

At the present time we do not but we are hoping to in the future.

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

N/A

7. Were the initiatives performance-based and did they involve process and/or outcome measures? N/A

- Community Collaboration

8. Did the hospital involve other community participants in planning and/or implementing its community benefits activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?

We held a community health fair in both 2008 and 2009 in which we collaborated with several community organizations to provide health/wellness information and screenings. The community was involved in identifying the specific type of screenings and information to be offered to community members.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

Throughout the year we have collaborated with a number of associations and foundations to both plan and implement some of our activities. For example, we work with the American Red Cross to hold blood drives at the hospital 3 times a year.

- Community Benefits Implementation

10. Does the hospital monitor how its activities fulfill the goals identified in the plan such as through a regular progress reporting process, or by having a staff person assigned to monitor the plan?

At the present time we do not. We hope to in the future.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

The community is kept informed as to the progress of the community benefits program. The leadership is kept informed and is interested in the community benefits program.

Gaps in the availability of specialist providers to serve the uninsured in the hospital:

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 by physicians for compensation for on call coverage.

Mission, Vision, Values and Service Priorities:

Mission

Our mission is to provide high quality, efficient healthcare services to preserve, restore and improve the health status of our community.

Vision

To be recognized as a premier health care system.

Objectives:

- Retaining and attracting first-class physicians, nurses and other team members;
- Providing state-of-the-art facilities and leading edge diagnostic and treatment equipment; and
- Assuring access to high quality healthcare services for all patients.

Values

Our values consistently show that **Laurel CARES**. These values include:

- Compassion
- Accountability
- Respect
- Excellence
- Service

Maryland General Hospital Community Benefits Narrative FY 2009

1.	Licensed Bed Designation:	191
	Rehabilitation Beds:	33
	Bassinets:	<u>17</u>
		241

Inpatient admissions, FY 2009: 12,433

2. Maryland General Hospital is a 241 bed community teaching hospital with a network of services providing care to 110,000 patients each year. In addition, MGH was one of the first hospitals in Baltimore to establish an outreach program offering education, prevention and screening, serving individuals who face significant barriers in obtaining high quality and affordable care. 95% of all admissions to Maryland General Hospital are from Baltimore City, with 70% originating from the primary service area of West Baltimore. MGH serves an urban population and the highest percentage of Medicaid patients of all hospitals in Maryland. Ninety Percent (90%) of MGH's patients are Medicaid, Medicare, or Self pay.

As previously mentioned, Maryland General Hospital serves a community with a disproportionate share of federally funded insurance recipients. For Fiscal 2009, Maryland General Hospital had the highest percentage of Inpatients with Medicaid as the primary insurance (47.8%). Maryland General also has the highest combined Medicare, Medicaid, and Self Pay percentage of inpatients at (90.9%) for the same time period. The Hospital serves the second highest percentage of African American patients in the state as a percentage of total patients at 81.5%. Lastly, Maryland General has the fifth (5th) highest percentage of inpatients whose level of severity is either "Major" or "Extreme", according to the APR Severity Index scale and this severity level continues to increase.

Maryland General Hospital is located in an area of Baltimore City which is defined as both a Medically Underserved Area and a Health Professional Shortage Area by the U.S. Department of Health and Human Services.

- A. Maryland General Hospital is assigned a score of 38.6 for Medically Underserved Areas for the area containing the specific census tracts of our catchment zone. Any score of 62.0 or below qualifies for designation as an MUA. The lower the score, the greater the need.
- B. Maryland General Hospital is assigned a score of 22 for Health Professional Shortage Areas for the West/Central Baltimore City zone. Any score below 25 qualifies for designation as a HPSA. The higher the score, the greater the priority.

3. Maryland General Hospital utilizes consultants and internal committees to identify the health needs of our community. WB&A Market Research conducted multiple focus groups in the Spring of 2009. Determinations are made about current health profiles, health statuses, use of

health care in the area and level of concern regarding what services are generally needed for themselves and their families. In addition, the participants were asked if there are any health services that are not currently available that need to be offered.

Other examples of MGH assessing community health needs:

- Provide healthcare to the Mt. Royal Elementary and Middle schools
- Provide health and medical education to Sollers Point High School
- Our Board of Directors, which is made up of community members, meets every other month and also has an annual Board retreat
- Department of Health and Mental Hygiene
 - o Conducted a needs assessment in the summer of 2008
 - o MGH provided screenings to over 1,300 DHMH employees

Other data used include Baltimore City Health Status reports, The University of Maryland Discharge Abstract database and discussions with local community and religious leaders.

4. The major community health needs identified were access to primary care services and affordable health care. These findings, and others suggest the need for outreach programs for those who cannot afford health care and an evaluation of primary care services in the area:

- a. Specialty & Primary Care Services
- b. Health Screenings
- c. Transportation
- d. Patient Financial Counseling

5. MGH's administration and community outreach staff evaluates and oversees which needs will be addressed through community benefit activities throughout the year.

6. The Community Health Education Center (CHEC) assesses the health education and health screening needs of the community by responding to specific requests by organizations and community leaders. Services offered are in response to the needs assessments performed and evaluated by management. In FY 2009, CHEC attended nearly 100 events in Baltimore City at the request of these leaders. In total, 14,994 people participated in this free program and 23,538 tests were performed. In addition, CHEC has a facility at Maryland General Hospital where access is provided to health information and screening services from 8am to 8pm, Monday through Friday.

7. The effectiveness of the program is measured informally by the number of patients identified as needing additional care. The positive impact the program has had on the community is undeniable. During fiscal year 2009, CHEC identified 1,804 who required follow-up on their blood pressure, 380 who required follow-up with their cholesterol level, 147 who needed to follow-up on their blood sugars, 488 who were reactive on the PPD test for tuberculosis, and 2,066 who had a positive pregnancy test.

We intend to continue and grow our CHEC and other outreach screening programs to meet the needs of our neighbors and the greater community.

8. In January 1999, Maryland General Hospital affiliated with the University of Maryland System to form one of the largest health systems in the Baltimore metropolitan area. This affiliation brought together the world-class research and specialized medical care of the University of Maryland Medical System with the excellent community-based physicians and services of Maryland General Health Systems. Arrangements for specialized care not provided by Maryland General Hospital are available within the University system located 2 miles south of our campus.

APPENDIX 1, Financial Assistance Policy

APPENDIX 2, Charity Policy Description

APPENDIX 3, MGH Mission, Vision, and Value Statement

APPENDIX 4, MGH Mission Statement

ADMINISTRATIVE POLICY

Number: 2041

Last Review Date: 01/09/08

Title: *Financial Assistance*

Page 1 of 4

POLICY:

It is the policy of Maryland General Hospital to provide quality medically necessary healthcare to our patients and financial assistance for patients who live in our community who are uninsured or underinsured

PURPOSE

- A. To establish the income scale for the means test for financial assistance.
- B. To provide definitions for the five main determinates of eligibility: income, family size, and member of the community, liquid assets, and valid social security card.
- C. To establish the general operational guidelines for the administration of the program.
- D. To establish the patient notification requirements as set forth in the Maryland State Health Plan.

ACTIONS

- A. Income and Family Size Scale: Maryland General Hospital will use a sliding scale based on the Federal Poverty Income Guidelines, which are published in the Federal Register each year. Patients below these guidelines who meet the qualifications set forth in this policy will automatically be eligible for financial assistance. Patients above these guidelines may be eligible for partial financial assistance based on income and family size.
 1. The current annual income scale is set forth below:

Number in Family or Household	100%	75%	50%	25%	0% Full Pay
1	0 - 15,600	15,600 - 17,264	17,264 - 18,928	18,928 - 20,800	20,800+
2	0 - 21,000	21,000 - 23,240	23,420 - 25,480	25,480 - 28,000	28,000+
3	0 - 26,400	26,400 - 29,216	29,216 - 32,032	32,032 - 35,200	35,200+
4	0 - 31,800	31,800 - 35,192	35,192 - 38,584	35,584 - 42,400	42,400+
5	0 - 37,200	37,200 - 41,168	41,168 - 45,136	45,136 - 49,600	49,600+
6	0 - 42,600	42,600 - 47,144	47,144 - 51,168	51,168 - 56,800	56,800+
7	0 - 48,000	48,000 - 53,120	53,120 - 58,240	58,240 - 64,000	64,000+
8	0 - 53,400	53,400 - 59,096	59,096 - 64,792	64,792 - 71,200	71,200+

ADMINISTRATIVE POLICY

2. The annual income brackets will be changed yearly when the Federal Poverty Income Guidelines are published.
3. Annually once the Federal Poverty Income Guidelines are published and Maryland General Hospital has revised and approved the new Financial Assistance guidelines, Maryland General Hospital will post a written notice of the availability of Financial Assistance at Maryland General Hospital in a public forum, such as a local newspaper.

B. Means Test Definitions: The determination of eligibility is based on family size and income. For the administration of this policy, the following definitions are utilized:

1. Family. A family is a group of two or more persons related by birth, marriage, or adoption who reside together; all such related persons are considered members of one family.
2. Income. Income refers to total annual cash receipts before taxes for all sources. Income includes regular payments from employment, social security, railroad retirement, unemployment compensation, workers' compensation, veteran benefits, public assistance, alimony, child support, and other regularly received payment from investments or trusts. The income to be utilized for non-farm and farm self-employment is the net receipts from the business.
 - a. To determine eligibility, income data for part of a year may be annualized by multiplying by four the amount of income received during the most recent three months.
 - b. Individuals requesting charity may be required to provide proof of income. Examples of proof of income are prior year income tax submissions, W-2s, recent pay stubs, written eligibility determination from Maryland Medical Assistance, etc.
3. Member of the Community. A patient must reside in Maryland General Hospital's Primary Service Area (PSA) to be eligible for the financial assistance program.
4. Valid Social Security Card. There are three types of cards that are issued by Social Security. Only one of these three types of Social Security cards will be customary to qualify for financial assistance.
 - a. The first type of card shows name and Social Security number and allows work without restriction. This card is issued to U.S. citizens and people lawfully admitted to the United States with permanent DHS work authorization. This type of card is required to apply for financial assistance.
 - b. The second type of card shows name and number with "VALID FOR WORK ONLY WITH DHS AUTHORIZATION" on the card. This type of card is issued to people lawfully admitted to the United States on a temporary basis who have DHS authorization to work. This type of card **cannot** be utilized to apply for financial assistance.
 - c. The third type of card shows name and number with NOT VALID FOR EMPLOYMENT on the card. This card is issued to people from other countries

ADMINISTRATIVE POLICY

admitted to the United States without work authorization from DHS, but with a valid non-work reason for needing a Social Security number and to people who need a number because of a federal law requiring a Social Security to get a benefit or service. This type of card **cannot** be utilized to apply for financial assistance.

C. Guidelines for Program Administration

1. An application for financial assistance must be completed prior to services being rendered to the patient. However, an application may be completed by the patient after services were rendered only if the account is active and not in bad debt. Applications may be taken in person or by telephone interview.
2. Hospital will evaluate all applicant assets. Applicants with liquid assets (cash and cash equivalents, cash, savings, checking accounts, certificates of deposit, stocks, bonds, IRA, trust funds and equity in any real estate that is not the primary residence) in excess of the 100 % of the current year's Federal Poverty Income Guidelines for 1 will be ineligible for financial assistance. The hospital will not count the house, the car or the applicant's furniture as assets during the financial assistance process.
3. Determination of eligibility will be made within five business days of receipt of the completed Financial Assistance Application. Subsequently a determination letter will be mailed to the patient explaining level of financial assistance they qualified for.
4. If a patient is approved for financial assistance Patient Access will register the patient with one of the following insurance plans:
 - A. CHAR100%: all the charges will be covered:
 - B. CHAR75% 75% of the charges will be covered:
 - C. CHAR50% 50% of the charges will be covered:
 - D. CHAR25% 25% of the charges will be covered.The financial assistance will expire six months from the date of approval and the patient will have to reapply for financial assistance at that time.
5. Financial assistance will cover all hospital care except for the services of a doctor not employed directly by the hospital.
6. The hospital will exhaust all possible sources of payment before the account balance is eligible for financial assistance. Financial assistance should always be the payer of last resort.
7. Copies of the Financial Assistance Application, which indicate the determination, will be filed with the patient's financial record. A separate log of all applications will be maintained in order to provide for reconciliation and documentation of the financial assistance program

ADMINISTRATIVE POLICY

D. Patient Notification Requirements

1. Notices are posted in the Admissions Lobby, Business Office, Emergency Room, ENT and General Clinic's advising patients that financial assistance is available for those unable to pay.
2. Individual notices are available to each person who seeks services in the facility. These notices are available in the Eligibility Services area of the Patient Accounting Department

RESPONSIBILITY

- A. The Assistant Director of Admissions will ensure that the Patient Notification Requirements of this policy are carried out.
- B. The Director of Patient Financial Services or his/her designee will ensure that documentation is maintained of eligibility determine, along with logs of applications acted upon, and patients screened for potential financial assistance.
- C. The Senior Vice president of Finance will ensure that the provisions of this policy are implemented and maintained administratively.

Sylvia Smith Johnson
President and Chief Executive Officer

Original Implementation Date:

Originating Department:

Revision/ Review Dates:

Maryland General Hospital

Charity Policy Description

FY2009

Appendix 2

1. MGH posts notification of the Financial Assistance policy, and financial assistance contact information at all patient access points.
2. MGH provides a summary of the Financial Assistance policy and financial assistance contact information within the Patient Handbook which is provided to inpatients or their families as part of the intake process;
3. MGH provides a summary of the Financial Assistance Policy, and financial assistance contact information to outpatients within the brochure “Important Information about Your Hospital Bills”.
4. MGH provides a summary of the Financial Assistance Policy, and a Financial Assistance application to outpatients registered with a “Self Pay” insurance plan during registration.
5. MGH contacts / meets with, interviews and completes a Financial Assessment of all “Self Pay” inpatients within 48 hrs of admission to determine / discusses with the patients or their families the availability of various government programs, such as Medicaid and assists patients in qualifying for such programs such as eligibility for Medical Assistance or Financial Assistance. where applicable.
6. MGH publishes annually the availability of Financial Assistance at MGH along with a summary of the Financial Assistance Policy, and financial assistance contact information.

Appendix 3



**827 Linden Avenue
Baltimore, Maryland 21201**

Mission, Vision and Values elaborated:

Our mission is to improve the health care of our community through superior compassionate care and medical education in partnership with our physicians and employees.

We intent to accomplish this by enhancing quality patient care and safety through exceptional customer service;

Secure our financial position to enable investment in key clinical programs and facilities;

Deploy technology to achieve maximum return on investment;

Recruit and maintain a skilled, productive, stable and service focused workforce;

Building a partnership with West Baltimore neighborhoods to provide comprehensive community health and education programs.

Appendix 4



**827 Linden Avenue
Baltimore, Maryland 21201**

Mission, Vision and Values Statement:

Our Mission: To provide superior, accessible healthcare in Central Maryland, at a reasonable cost.

Our Vision: To be an integrated system of care, positioned as a provider of choice for healthcare consumers and payors in Central Maryland.

Our Values: To provide a comprehensive array of high-quality healthcare services with a commitment to excellence and compassion.

Edward W. McCready Memorial Hospital
Community Benefits Narrative
Fiscal Year 2009

Edward W. McCready Memorial Hospital is located in Crisfield, Maryland in Somerset County. During fiscal year 2009, the facility was licensed for 8 medical/surgical acute beds and had 668 inpatient admissions. The majority of the patients seen at McCready live in Somerset County, but we also serve Worcester and Wicomico counties in Maryland and the Eastern Shore of Virginia. Due to the low number of medical services available in the area, Somerset County is designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, as a medically underserved area. We are the closest and most convenient medical facility available to those living in the remote crabbing/fishing communities of Smith and Tangier Islands in the Chesapeake Bay and we are the only facility having boat access for these residents. Economically, Somerset County is a very depressed county. In 2004, the U.S. Census Bureau indicated that 19.7% of Somerset County's population fell below poverty level; higher than any other county in the state of Maryland and higher than the state average of 9.2%. According to the Maryland Department of Business and Economic Development, the median Somerset County income in 2007 was \$33,700 with the per capita income in 2006 equaling \$22,656. The unemployment rate in Somerset County was 5.4% in 2007, much higher than the statewide rate of 3.6%, according to the Maryland Department of Labor, Licensing and Regulation.

Community needs are assessed in a variety of ways. Hospital staff meets with local schools and health departments regularly to discuss health care needs in the local community. In 2005, McCready was involved with a consortium of health care providers in the area which included all three hospitals, all local health departments, as well as area schools and other agencies. The team developed a tri-county survey that was sent to Lower Shore residents. The results of this survey were used to identify health care needs in the tri-county area (Wicomico, Worcester and Somerset Counties) and programs were developed in response to that survey. Major health care needs in the area identified the following medical conditions to be the most prevalent in the community: diabetes, heart disease, lung disease, cancer, obesity and metabolic syndrome. Currently, a new survey process is underway with the same stakeholders participating to address any potentially new areas for concern in the community.

As a result of the survey, hospital staff and the local health department worked on developing programs to identify the top areas for concern with residents in Somerset County. In cooperation with the Tri-County Diabetes Alliance and the local health department, McCready developed a free diabetes education program for area residents. The program is monitored by a registered nurse and offers nutrition counseling, testing supplies, as well as help with monitoring and tracking blood sugar. Until recently, the program was completely free to those at risk or burdened with diabetes. In addition, McCready developed a discounted community exercise program for residents in need of monitoring during physical activity. The program is monitored by a licensed ER tech and is geared towards those residents with risk factors or diseases identified as major community needs (heart disease, obesity and metabolic syndrome). Another program was developed, in conjunction with the local health department, to identify medically indigent women in the community and provide them with free preventative women's health

services. The program provides free mammograms, screening visits with a physician or mid-level provider and cancer removal surgery, if necessary. The program is partially funded through a grant received by the health department. In March 2010, a committee will meet to discuss the effectiveness of the current community benefit programs, identify areas for improvement and develop new ideas based upon community needs.

Because there are no private physician practices in Crisfield, Marion, Westover, Rumbly, Fairmount and other small towns along Route 413 (the highway from Route 13 to Crisfield on Tangier Sound), McCready Hospital operates an outpatient center which employs two family medicine/internal medicine primary care physicians, a general surgeon and a family medicine physician assistant. McCready also employs its own anesthesiologist, radiologist and, most recently, pulmonologist. With these physicians and specialty visiting physicians, the hospital is able to provide care for only the basic healthcare needs of local residents. The nearest private general and specialty practices are about 25 miles away by car so McCready “lends” office space to “visiting” physicians who come one to four times a month to see patients here in Crisfield. They include a podiatrist and three cardiologists. McCready’s emergency room is staffed with emergency physicians via a contract with the Emergency Service Associates group. However, major trauma cases and cases requiring more specialized surgery, diagnostic and medical care must be transported elsewhere. McCready’s patient population has a tragically high incidence of heart disease, lung disease, diabetes, cancer, obesity and metabolic syndrome – all chronic conditions that would benefit from specialist physician practices. However, the nearest are in Salisbury – 45 minutes away. The service area’s high unemployment rate, a large elderly population and one of the highest poverty levels in the state contribute to the incidence of these potentially serious and often fatal conditions.

Edward W. McCready Memorial Hospital
Appendix 1

McCready Memorial Hospital posts its financial assistance/charity care policy along with necessary contact information in all patient care/registration areas. Upon admission, each patient also receives the same information about the program. Patients whom are uninsured or underinsured receive assistance with determining eligibility for governmental programs or the hospital's financial assistance program through one-on-one financial counseling, including assistance in filling out all necessary paperwork. In addition, self-pay patients whose balances remain unpaid after three consecutive billing cycles receive a financial assistance application with instructions and contact information in their final statement before being sent to collections. Every effort is made to try to identify and assist patients in getting the financial assistance they need.

**Edward W. McCready Memorial Hospital
Appendix 2**

**McCready Foundation, Inc.
Administrative Policy and Procedure**

SUBJECT: Financial Assistance

**FILE: Index Tab
Organizational Ethics**

APPROVED BY: _____
Charles F. Pinkerman, CEO

Page:

**Effective Date: 9/2005
Revised: 5/2006, 3/2007, 3/2008,
7/2009**

I. Policy

McCready Foundation is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, McCready Foundation strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with McCready Foundation's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow McCready Foundation to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity.

II. Definitions

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, 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.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- a. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement

- income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- b. Non-cash benefits (such as food stamps and housing subsidies) do not count;
- c. Determined on a before-tax basis;
- d. Excludes capital gains or losses; and
- e. If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

III. Procedures

A. Services Eligible Under this Policy.

For purposes of this policy, “charity” refers to healthcare services provided without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis at McCready Foundation’s discretion.

B. Eligibility for Charity.

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. McCready Foundation shall determine whether or not patients are eligible to receive charity for deductibles, co-insurance, or co-payment responsibilities.

C. Determination of Financial Need.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
 - a. Include an application process, in which the patient or the patient’s guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
 - b. Include the use of external publicly available data sources that provide information on a patient’s or a patient’s guarantor’s ability to pay (such as credit scoring);
 - c. Include reasonable efforts by McCready Foundation to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
 - d. Take into account the patient’s available assets, and all other financial resources available to the patient; and
 - e. Include a review of the patient’s outstanding accounts receivable for prior services rendered and the patient’s payment history.
2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle.

The need for payment assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. McCready Foundation's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and McCready Foundation shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D. Presumptive Financial Assistance Eligibility.

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, McCready Foundation could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address; and
8. Patient is deceased with no known estate.

E. Patient Charity Guidelines.

Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination, as follows:

1. Patients whose family income is at or below 150% of the FPL are eligible to receive free care;
2. Patients whose family income is above 150% but not more than 262.50% of the FPL are eligible to receive services at a sliding fee schedule according to the following guidelines:

Family Size	100%	75%	50%	25%	Full Pay
1	16,245	20,306	24,368	28,429	28,430
2	21,855	27,319	32,783	38,246	38,247
3	27,465	34,331	41,198	48,064	48,065
4	33,075	41,344	49,613	57,881	57,882
5	38,685	48,356	58,028	67,699	67,700
6	44,295	55,369	66,443	77,516	77,517
7	49,905	62,381	74,858	87,334	87,335
8	55,515	69,394	83,273	97,151	97,152

3. Patients whose family income exceeds 262.50% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of McCready Foundation.

F. Communication of the Charity Program to Patients and the Public.

Notification about charity available from McCready Foundation, which shall include a contact number, shall be disseminated by McCready Foundation by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as McCready Foundation may elect. Information shall also be included on facility websites and in the Conditions of Admission form. Such information shall be provided in the primary languages spoken by the population serviced by McCready Foundation. Referral of patients for charity may be made by any member of the McCready Foundation staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

G. Relationship to Collection Policies.

McCready Foundation management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from McCready Foundation, and a patient's good faith effort to comply with his or her payment agreements with McCready Foundation. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, McCready Foundation may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, will not send unpaid bills to outside collection agencies, and will cease all collection efforts.

H. Regulatory Requirements.

In implementing this Policy, McCready Foundation management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

Edward W. McCready Memorial Hospital

Appendix 3

McCready embodies the description “community” hospital in every sense of the word. We are located in the heart of a rural, somewhat isolated area where high-paying jobs are scarce and per-capita income is modest at best.

Nevertheless, each day our health-care team strives to provide appropriate care to those in need of hospital services, regardless of a person’s ability to pay. The McCready staff also strives to identify and address community needs on an ongoing basis.

Everything we do – providing acute, emergency, health-maintenance and elder care – is specifically geared with our hard-working neighbors always in mind. They and their families have counted on us for eight decades.

We concentrate on the delivery of basic health care, and most of our resources are dedicated to that cause. It has enabled us to be comfortable embracing our mission statement: “building a healthy community, one person at a time.” It is a true reflection of our vision and values.

**Edward W. McCready Memorial Hospital
Appendix 4**

Our Mission:

"We are working to build a healthy community, one person at a time."

Our Vision:

McCready Foundation is a community organization providing high-quality, coordinated health care services; focusing on prevention, diagnosis, treatment, rehabilitation and long-term care.

Our Values:

We maintain the highest standards in providing effective, efficient and compassionate services either directly or through coordinated efforts with other local and regional healthcare providers.

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Mercy Medical Center has 243 licensed beds and had 18,214 inpatient admissions for the fiscal year ending June 30, 2009.

2. Describe the community your organization serves.

Located in the heart of downtown Baltimore, Mercy Medical Center is sponsored by the Sisters of Mercy and has maintained a special commitment to the poor and underserved since its founding in 1874. In welcoming patients, visitors, and employees from a variety of backgrounds, Mercy strives to meet the health care needs of the Baltimore community's most vulnerable and underserved populations.

According to United States Census Data, in 2005, 608,481 individuals resided in Baltimore City with approximately 65% categorized as Black or African American and 30% as White. The population of residents who are age 55 and above is 22%. The median household income is \$32,456 with nearly 19% of families living below the poverty level.

While this data describes Baltimore City overall, the ZIP code 21202 served by Mercy Medical Center has a Median Family Income of \$22,191 with 35% of families living below the poverty level with 22% speaking a language other than English at home.

Approximately 59% of the patients served by Mercy Medical Center are members of a racial or ethnic minority; 66% percent are women; and 51% receive Medicaid or Medicare.

3. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done. In seeking information about community health needs, did you consult with the local health department?

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

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

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

In response to questions 3-6, we offer the following information.

In 2008 Mercy staff participated in a series of discussions with the Baltimore City Health Department to share information, discuss priorities and consider collaboration on community health efforts. As a follow-up to those discussions, the Baltimore City Health Department, in collaboration with the Johns Hopkins Bloomberg School of Public Health, developed and published Neighborhood Profiles, identifying mortality rates by disease and other key health indicators.

This information has been discussed by several key Board and Management committees, including the Mission and Corporate Ethics Committee and the Mission Integration Committee. The Board of Trustees of Mercy Medical Center conducts a comprehensive strategic planning process that includes a review of community health needs identified by the Baltimore City Health Department as well as statistical information compiled by consulting firms. We continue to evaluate how best to use this data to target our resources to best serving our community's needs.

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

Mercy Supportive Housing Program

The Mercy Supportive Housing Program (MSHP), which assists families at risk of losing their homes, provided eviction prevention and resident advocacy services to over 400 low-income residents of Baltimore City in fiscal last year.

The program strives to help families increase residential stability, increase skill level and income, and increase self-determination. Those served by the program benefit from services such as: eviction prevention grants, tenant/landlord education, eviction prevention counseling, transportation assistance, court advocacy, and life skills training. It is necessary to address the underlying issues that cause the crisis to prevent the crisis from reoccurring. Many, if not most, of the families that come through the program live in unstable environments.

Mercy Forensic Nurse Examiner Program (*formerly Sexual Assault Forensic Examiner Program*)

The Forensic Nurse Examiner Program (FNE Program) provides 24/7 care to patients who are victims of sexual, domestic, child, elder, vulnerable population, and institutional violence. Forensic Nurses provide comprehensive forensic medical interviews, medical assessments, and evidence collection, and assure crisis intervention to an ever increasing volume of underserved patients. Since 1994, the program has treated over 5,000 victims, the majority of whom are poor and uninsured. Through the FNE Program, Mercy conducted 453 examinations to assist law enforcement with prosecution in fiscal year 2009. The FNE Program at Mercy is the designated site for forensic patients in Baltimore City and is the only comprehensive program of its kind in Maryland.

The Mercy FNE Program has undertaken a major campaign to educate policy makers, law enforcement, attorneys, judges, health care professionals, and college students and counselors about the importance of referring sexual assault victims to the Mercy FNE program. This community education effort directly influenced the increased number of FNE Program patients.

The Mercy FNE Program connects with and complements community programs that serve our patient population. Together, we provide a coordinated community response with the goals of helping these individuals to live in healthy, safe environments and improving the quality of their lives.

Family Violence Response Program

The Family Violence Response Program provides services to Mercy's patients and employees who are victims of violence, abuse and neglect, including child abuse, intimate partner violence, sexual abuse/assault, and elder/vulnerable adult abuse. Many of these individuals are impoverished and initially seen in Mercy's emergency department which cannot turn away patients based on their ability to pay. The Family Violence Response Program provided crisis intervention services to 482 victims of abuse and 174 affected family members in fiscal year 2009.

The program provides education about family violence and its health effects to the Mercy staff. Fifteen staff trainings were provided at Mercy during fiscal year 2009.

Mercy Children's Health Outreach Project (MCHOP)

The Mercy Children's Health Outreach Project (MCHOP) provides health care and related services to homeless children and their families. A team of pediatric nurse practitioners and a social worker partner with local shelters to identify and assist homeless children and their parents. The objective is to help them achieve and maintain a level of health that permits the greatest possible level of self-sufficiency. Services to children in the shelters include: interdisciplinary health assessments, acute care treatments, preventative health services, and coordination of referrals for substance abuse, mental health care, and primary and specialty care. MCHOP served over 500 women and children in fiscal year 2009. During the past year, MCHOP launched an Electronic Health Records (EHR) Program to convert medical recordkeeping from paper to electronic. The EHR system is helping to increase the efficiency and effectiveness of the health care services that MCHOP provides to homeless children and their families in Baltimore City by enabling rapid retrieval of data, improving continuity of care, and enhancing confidentiality.

Pharmacy Charity Care

Mercy Medical Center provides medications to Mercy patients who are uninsured or underinsured, such as the homeless and individuals awaiting Medical Assistance. Individuals

who visit the Emergency Department, undergo surgery, or receive inpatient care frequently must continue with medications at home.

The Pharmacy Charity Care Fund at Mercy pays for 650 to 700 prescriptions each month, for a total of 8,000 or more prescriptions annually. Patients who are helped by the Fund typically receive two or three prescriptions. The Pharmacy Charity Care Fund expends \$120,000 or more each year, serving 3,000 to 3,500 patients.

Through the Pharmacy Charity Care program, we provide prescriptions to as many patients as possible who are in need of assistance. Mercy's social workers, case managers, and financial counselors carefully assess each patient's situation for eligibility. The process includes verifying that the patient does not have insurance coverage or other resources that could cover the cost of medications, and obtaining a statement of the patient's needs. By providing medications for conditions such as HIV, cancer, diabetes and cardio-vascular disease, Mercy is helping to prevent greater financial burden on our community's health care system should such conditions be left untreated. Our goal is to provide education and sufficient funds for medications so that individuals can take care of themselves.

Charity Transportation

The poor – and the elderly in particular – frequently lack the financial resources to pay for transportation to and from Mercy. Charity Transportation for such expenses as bus tokens, cab fares, and ambulances totaled approximately \$200,000 in fiscal year 2009. In keeping with the priority of providing an array of services to the elderly, Mercy pays for small medical equipment items such as walkers, canes, and cushions.

Other:

In providing over \$40 million in charity care for the fiscal year ending June 30, 2009, Mercy devoted approximately 12.8% of its operating budget to benefit the poor and underserved. This compared to a Maryland State average of 7.2%.

The most significant service provided to low-income, underserved, and uninsured populations is the care provided by Mercy physicians. For the fiscal year ending June 30, 2009, Mercy physicians provided \$1.6 million in uncompensated care.

More babies are born at Mercy than at any other hospital in Baltimore City – 2,845 for the fiscal year ending June 30, 2009. Three out of every five mothers giving birth at Mercy are from the Medicaid population. On February 1, 2009, Mercy added a physician group serving low-income expectant mothers that is expected to increase annual births by over 300.

Mercy also provides specialized care for extremely low birth weight infants through its Neonatal Intensive Care Unit serving nearly 400 babies each year.

Mercy offers the only hospital-based Dental Department in the State of Maryland and recently added a Pediatric Dentist to help meet the specialized needs of low-income children who very often do not have access to regular dental care.

The Emergency Services Department witnessed 59,667 visits during the fiscal year ending June 30, 2009. Mercy serves low-income neighborhoods in East and South Baltimore where United States Census Data indicates that approximately one out of every three households are characterized as living below the poverty level and one out of two households have incomes under \$25,000. The Emergency Services Department also serves as an informal overnight shelter for homeless women, particularly during the winter months.

Mercy is a founding partner of Health Care for the Homeless, a direct services and advocacy group established in 1984, that now serves 6,000 homeless individuals each year.

Mercy hosts two of the four clinic sites for Family Health Centers of Baltimore, a federally-qualified health center serving Baltimore's poor and uninsured.

The Mercy Children's Health Outreach Program (MCHOP) provides and coordinates health care and related services to homeless children and their families. More than 500 children and their mothers are served each year.

Mercy's Sexual Assault Forensic Examiner (SAFE) Program performs all forensic evidence examinations for Baltimore City and has treated more than 4,000 victims of sexual assault since the program was established in 1994. Approximately 80% of victims are African-American.

Since 1999, the Mercy Supportive Housing Program has provided eviction prevention and resident advocacy services to more than 600 at-risk individuals and families.

Through its Pharmacy Charity Care Program, Mercy provides of \$300,000 annually to patients who are uninsured or underinsured, such as the homeless and individuals awaiting Medical Assistance.

Each year, Mercy provides over \$200,000 in Transportation Assistance to patients for taxis and buses. A significant portion of these funds are dedicated to low-income individuals who must make regular trips to Mercy for cancer treatments.

Restricted philanthropic support from the community makes it possible for Mercy to provide special support to low-income individuals. Financial resources are made available to low-income patients diagnosed with Lymphodema and to insured patients in the cases where insurance will not cover the cost of bandages. An endowment of \$500,000 and annual philanthropic support for individuals enables Mercy to provide mammograms to low-income women. And, financial support from a major corporation made it possible for Mercy to help elementary school nurses better recognize the early signs of juvenile diabetes.

In addition to the supported described above, Mercy also extends itself into the Baltimore community by offering employment opportunities. Approximately 40% of Mercy Medical

Center's 3,276 employees live in Baltimore City. As one of the largest private employers in Baltimore City, Mercy provides employment opportunities for many non-skilled individuals with limited educational backgrounds. Mercy provides on-site Graduate Equivalent Degree (GED) programs, English proficiency, a clinical nurse ladder, and an on-site Bachelor of Nursing degree program with The College of Notre Dame of Maryland.

Mercy also gives witness to its mission to serve the poor and underserved through leadership and advocacy. Sister Helen Amos, RSM, Executive Chair of the Board of Trustees since 1999, and President and CEO from 1992 to 1999, was Chair of the Board of The Downtown Partnership of Baltimore and the Downtown Management Authority from 2005 to 2008. During this period, issues facing the poor, particularly the homeless, represented a significant portion of the agenda of this business group. In 2006, Sister Helen was named Co-Chair of the blue-ribbon Leadership Council organized by the Baltimore Mayor to create a plan to end homelessness in Baltimore within 10 years. She now chair of the implementation phase of this important community initiative.

Thomas R. Mullen, President and CEO since 1999, and Executive Vice President and Chief Financial Officer from 1991 to 1999, is former Treasurer of the Maryland Hospital Association which supports and advocates for health care access for the uninsured. In addition, Mr. Mullen serves on the Board of Directors of the Maryland Catholic Conference, the public policy arm of the Roman Catholic Bishops serving Maryland. The Maryland Catholic Conference pursues public policy that expands Medicaid eligibility and creates new opportunities for individuals and families in poverty.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

As a major provider of medical services to patients throughout the City of Baltimore (and even regionally), Mercy serves a vital safety net for the medically underserved. This safety net is most severely tested in provision of services to Emergency Department (ED) patients.

- **Emergency Department:** 24% of patients accessing Mercy's ED are uninsured and another 28% are underinsured.
- **Psychiatric Evaluation and Emergency Treatment:** Mercy provides for professional services to evaluate patients presenting to the Emergency Department with psychiatric complaints, 90% of whom are uninsured or underinsured.
- **Orthopedics:** This specialty is especially problematic in terms of Emergency Department coverage. At present Mercy has four orthopedic surgeons who have accepted the responsibility for providing coverage in Mercy's ED, an area where a significant number of uninsured patients seek care.
 - In addition, Mercy supports a weekly Orthopedic Clinic which serves as the site providing follow-up care to patients initially seen in the Emergency Department and other outpatient sites. 99% of the patients are either uninsured or

underinsured. Although originally designed to manage the follow-up needs of Mercy's ED, follow up orthopedic services are so limited in the city for patients with inadequate insurance that many patients are referred for free care from other, non-Mercy settings throughout Baltimore City.

- **Otolaryngology:** This specialty is also problematic in terms of Emergency Department coverage. Mercy currently has two active otolaryngologists on staff. Patients who present with the most urgent problems have higher rates of inadequate insurance coverage (un-insured or underinsured, e.g., Medicaid).
- **Dentistry & Oral Surgery:** Mercy provides as one of the few, if not the only, community hospital based Dentistry & Oral Surgery Program in the City of Baltimore. The Program provides services for adults (which are not covered under the State's Medicaid Program) and pediatric patients seen in the Emergency Department and local community health centers.
- **Substance Abuse and Medical Detoxification:** Mercy is the only inpatient detoxification provider in Baltimore City. Over 90% of patients are under or uninsured. Mercy provides all of the professional reimbursement for these inpatient services. A number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Otolaryngology, Gastroenterology).
- **General Surgery:** Mercy believes that we provide higher levels of uncompensated care to patients in this discipline than any other community hospital in the City of Baltimore. This is partly attributed to our relationship with Healthcare for the Homeless (where Mercy became one of the founding members).
- **Dermatology:** Mercy supports the only community hospital based Dermatology practice in the central city, which acts as a referral center for dermatologic disease from numerous urban clinics and settings. (Dermatologic disease is often present in advanced HIV disease.)
- **Mammography/Women's Imaging:** Mercy provides the largest hospital-based mammography service to the residents of Baltimore City. In FY 2008, the Center for Women's Imaging provided over 12,000 imaging exams, 25% of which were provided to patients without insurance or to the underinsured. Due in large part to a shortage in mammographers, Mercy is currently experiencing long wait time delays in patients seeking mammography services.
- **Gastroenterology:** Coverage in this specialty remains problematic primarily for inpatients because of Mercy's payor mix. (Emergent gastroenterologic problems involve higher proportions of inadequately insured patients.)

9. If you list Physician Subsidies in your data, please provide detail.

Included in our data, classified as Mission Driven Health Services, are the following physician subsidies:

Emergency Room Physician Services. The Emergency Services Department witnessed 59,667 visits during the fiscal year ending June 30, 2009. Mercy serves low-income neighborhoods in East and South Baltimore where United States Census Data indicates that approximately one out of every three households are characterized as living below the poverty level and one out of two households have incomes under \$25,000. The Emergency Services Department also serves as an informal overnight shelter for homeless women, particularly during the winter months.

Physician Charity Care. Mercy Health Services, parent of Mercy Medical Center, includes a primary care and specialty physician not-for-profit organizations. Patients who have been identified as eligible for charity care under the Mercy Medical Center Charity Care policy (see below), also are eligible for free or reduced physician care.

OB Coverage. To be prepared for uninsured patients who are not under a physician's care, Mercy compensates OB attending physicians to be on-call and available to provide the needed services.

Antenatal Physician Subsidy. Recognizing the importance of good pre-natal care, Mercy financially supports an OB physician group that provides this service to uninsured and underinsured patients, many of whom are high risk pregnancies.

Psychiatric Care Coverage. To be prepared for patients who present to our Emergency Room with a psychiatric issue, Mercy compensates Psychiatric specialists to be on-call and available to provide the needed services.

Describe your charity policy. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy.

Mercy attempts to be very proactive in communicating its charity care policy and financial assistance contact information to patients. The charity care policy and financial assistance contact information is posted in all admissions areas, including the emergency room. A copy of the policy and financial assistance contact information is also provided to patients or their families during the pre-admission, pre-surgery and admissions process.

Mercy utilizes a third party, as well as in-house financial counseling staff, to contact and support patients in understanding and completing the financial assistance requirements. They also discuss with patients or their families the availability of various government benefits and assist patients with qualifications for such programs.

Even after the patient is discharged, each billing statement contains an overview of Mercy's Financial Assistance Policy, a patient's rights and obligations, and contact numbers for financial assistance, financial counseling, and Maryland Medicaid. Follow-up phone calls by hospital billing/collection staff made to patients with unpaid balances also stress the availability of financial assistance and charity care availability.

MERCY MEDICAL CENTER
POLICY AND PROCEDURE

FINANCIAL SERVICES

FINANCIAL ASSISTANCE POLICY

POLICY #: 602-176-93

ISSUE/REISSUE DATE: 09/07

Mercy Medical Center provides and promotes health services for the people of Baltimore of every creed, race, economic, and social condition. In the spirit of the Sisters of Mercy who are its sponsors, Mercy continues a special commitment to the underserved and the uninsured.

Consistent with this mission, it has been the policy of Mercy Medical Center to accept, within the limits of its financial resources, all patients who require its services, without regard to their ability to pay for such services. Emergency care will be rendered to all patients without regard to the limitation of financial resources. This policy, however, does not preclude an attempt to review:

- a. The patient's ability to pay;
- b. The availability of insurance benefits;
- c. The eligibility of Medical Assistance for the patient;

FINANCIAL ASSISTANCE

Financial Assistance will be provided at no charge or at a reduced charge to patients who are unable to pay based on a sliding scale that will be applied for incomes up to approximately 400% above the HHS poverty guidelines. The poverty guidelines are issued each year by the DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS).

In order to qualify for financial assistance, one of the following conditions must be met:

1. Patient's income level is at or two times below HHS poverty guidelines and patient has less than \$10,000 in net assets to qualify for full financial assistance.
2. Patient's income level is at or above the parameters of the sliding scale, and their financial profile indicates that expenses related to the necessities of life (food, housing, utilities, etc.) exceed income.
3. Patient is homeless.
4. Patient is deceased, with no person designated as director of financial affairs, or no estate number on file at the applicable Registrars of Wills Department.

5. Patient has a remaining balance after Medical Assistance.

In addition, the following conditions must be met and it will then be determined if the patient qualifies for full or partial assistance:

a. Fixed income such as Social Security, Retirement or Disability with no additional income sources available.

b. Medical expenses which exceed 50% of net monthly income.

In determining eligibility, the size of the patient's bill relative to the patient's ability to pay will be considered. Financial assistance will be granted for necessary hospital services and it will be provided to those who properly document eligibility and cooperate with Mercy Medical Center's financial assistance application process.

Within two business days following a patient's initial request for Financial Assistance services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

Notice of the availability of Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Individual notice of the availability of Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Mercy Medical Center will make an effort to provide the Financial Assistance application, policies, procedures, and information available in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Developed by: Edna Jacurak
Betty Bopst

APPROVED BY:


John Topper, SVP, CFO


Mary Crandall, Director

Describe the hospital's missions, vision, and values statement.

Rooted in God's love for all people, and sponsored by the Sisters of Mercy, Mercy Health Services is dedicated to carry forward the 134 - year tradition of the Sister's healing ministry in Baltimore. Grounded in a vision of God's healing love for all people, we are committed to providing healthcare for persons of every creed, color and economic and social condition in Baltimore City, Central Maryland and beyond. In the tradition of Catholic healthcare and of the Sisters of Mercy, we continue our special commitment to poor and underserved persons. Mercy Health Services is driven by its mission to serve and will remain steadfast in its commitment to uphold its highest standards for care, its commitment to the poor and its commitment to Baltimore. We are here to provide excellent healthcare, with compassion and respect, to all who come to us for help.



Mercy Health Services Mission Statement

Rooted in God's healing love for all people, and sponsored by the Sisters of Mercy, MERCY HEALTH SERVICES provides healthcare for persons of every creed, color, and economic and social condition in Baltimore City, Central Maryland and beyond. In the tradition of Catholic healthcare and of the Sisters of Mercy, we continue our special commitment to poor and underserved persons.

We strive to provide excellent clinical services across the life span within a community of compassionate care. We create an environment where individuals can take primary responsibility for their own healthcare and where all are served with courtesy and respect. Concern for spiritual and personal well-being is reflected in every aspect of our service.

We commit ourselves to provide safe patient care, and continuously to improve the quality and effectiveness of our work.

Through our university affiliations and relationships with other organizations, we participate in the education of physicians and other healthcare professionals. We support the educational and professional development of all of our employees.

We hold ourselves accountable to the highest standards of clinical and corporate ethics.

We operate in a financially responsible manner, committing all of our human and material resources to further our mission.

We engage in advocacy for public health policies that have as their goal accessible and sustainable healthcare.

MERCY HEALTH SERVICES PHILOSOPHY AND CORE VALUES

We believe that all people are created in the image of a loving God, and thus we strive to reflect that love in our lives. As social beings, people seek interaction with one another and are most fulfilled when others acknowledge them and their actions. Mercy Health Services holds individuals, their families and our community in the highest esteem – offering respect to all and maintaining the dignity of all.

In the healthcare ministry, we come face to face with the mysteries of life, illness, birth, death and resurrection. We believe that every moment in a person's journey to God is sacred.

Guided by both our PHILOSOPHY and MISSION, we in the Mercy Health Services community commit ourselves to the following CORE VALUES:

RESPECT FOR THE DIGNITY OF EACH PERSON

Every human life has worth. We celebrate the inherent value of each person and respond to the needs of the whole person in health, sickness and dying. We honor the God-given gifts of each individual and help to develop them.

HOSPITALITY

From many religious traditions and walks of life, we welcome one another as children of the same God, whose mercy we know through the warmth, courtesy and generosity of others. A climate of hospitality supports healing of body, mind and spirit.

MERCY/JUSTICE

Compassionate love shapes relationships based on integrity, equality and fairness. We advocate strongly on behalf of persons who are poor or vulnerable. We work toward changes necessary to create more just healthcare and other social systems.

EXCELLENCE

Because God's people deserve our best efforts, excellence holds us to the highest professional standards of care, as well as to the courtesy, respect, and compassion with which that care is rendered.

EMPOWERMENT

A healthy community empowers those who serve and those who are served. It enables people to act both on their own behalf and on behalf of others. The ability of persons to shape decisions affecting their own lives is a right, its exercise a responsibility.

STEWARDSHIP

Given to us in trust, our world is sacred and deserves respectful care. Utilizing our human, financial and material resources creatively and wisely responds to that trust. Planning responsibly will permit us to address both present and future needs.

PRAYER

From the beginning to the end of life, we belong to God. Prayer is our response to God's faithful presence in every moment of our lives. Only through God's mercy can we be a people of Mercy.



Montgomery General Hospital (MGH)
Community Benefits FY2009 Narrative Report

Serving the greater Baltimore and Washington, D.C. metro areas, Montgomery General Hospital (MGH) is a 165 bed, not-for-profit community hospital. It also is the newest member of the MedStar Health network. Founded in 1920 by Jacob Wheeler Bird, M.D., the original hospital had 28 beds and was the first acute care facility in Montgomery County. Nearly nine decades later, MGH remains committed to improving the health and welfare of the communities it serves and is dedicated to providing high quality care.

While the provision of high quality care is an imperative, the hospital has also devoted itself to prevention. Throughout the year many MGH medical staff take part in projects that not only improve the community but enhance the lives of residents. Staff takes great pride in its outreach efforts and collaboration with community organizations.

In FY2009, of the 11,189 inpatient admissions, 75% of MGH patients traveled from within MGH's total service area (as listed below). All of MGH's primary and secondary service area zip codes fall within Montgomery County, MD.

MGH's Total Service Area

Zip Code	City
20833	Brookeville
20879	Gaithersburg
20882	Gaithersburg
20832	Olney
20853	Rockville
20860	Sandy Spring
20904	Silver Spring
20906	Silver Spring
20905	Silver Spring
20861	Ashton
20862	Brinklow
20866	Burtonsville
20872	Damascus
20855	Derwood
20877	Gaithersburg
20878	Gaithersburg
20874	Germantown
20876	Germantown
20850	Rockville
20851	Rockville
20902	Silver Spring
20868	Spencerville

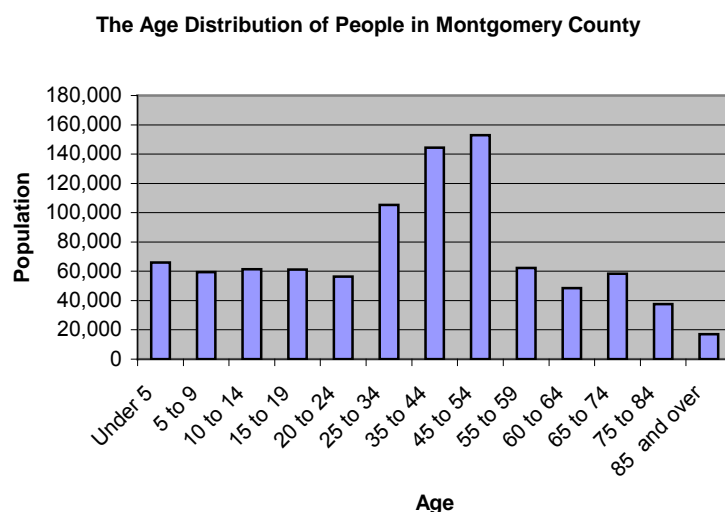
income that the same family would need to meet its basic needs. In 2004, the Self-Sufficiency Standard for the county was \$51,086.⁷

In addition to individuals living at or below the Federal Poverty Level, it is also estimated that 42,565 Montgomery county families had incomes between \$15,000 and \$49,999 in 2003, according to the American Community Survey⁸. With an average family size of 3.19 in Montgomery County, these statistics indicate that a large number of families in the county are low income, if not below the poverty level.

Although, the population of Montgomery County as a whole is financially stable as compared to many other counties in the United States, there are still community members in need. Of MGH's inpatient population in FY09, 17% of them are made up of Medicaid and Self Pay patients.

Demographics

Montgomery County has experienced continuous growth over the years. As of 2008, 950,680 people live in Montgomery County.⁹ Since 2000, Montgomery County has experienced a population increase of 8.9 percent according to the U.S. Census Bureau. The most recent estimate puts the average age in the county at 38.7. More than half of the population is female.



Source: U.S. Census Bureau, 2005-2007 American Community Survey

Persons under the age of 5 make up 6.9 percent of the population. Persons under 18 make up 24.1 percent and persons 65 and older account for 12.5 percent of the population.¹⁰

Montgomery County is racially diverse and very rich with culture. The county's racial breakdown is 61.2 percent caucasian, 16.2 percent black or African American, and 13 percent Asian. Including all races, 14 percent of the population is of Hispanic origin. Lastly, 29.4 percent of county residents are foreign-born.¹¹

⁷ Self-Sufficiency Standard for Montgomery County, MD, 2002/2003, Department of Health and Human Services, Community Action Agency.

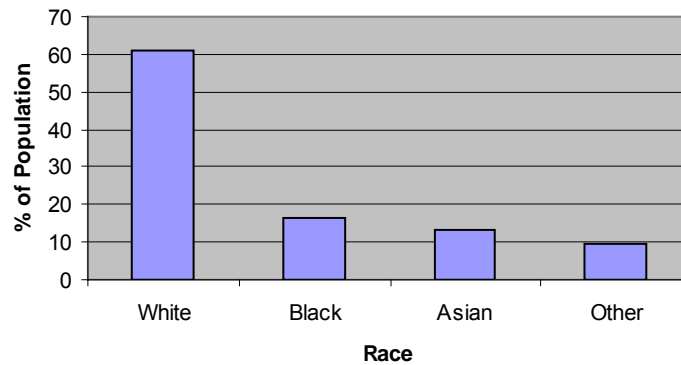
⁸ U.S. Census Bureau, American Community Survey, 2003.

⁹ U.S. Census Bureau, <http://quickfacts.census.gov/qfd/states/24/24031.html>

¹⁰ U.S. Census Bureau, 2005-2007 American Community Survey

¹¹ *ibid*

The Racial Distribution of People in Montgomery County

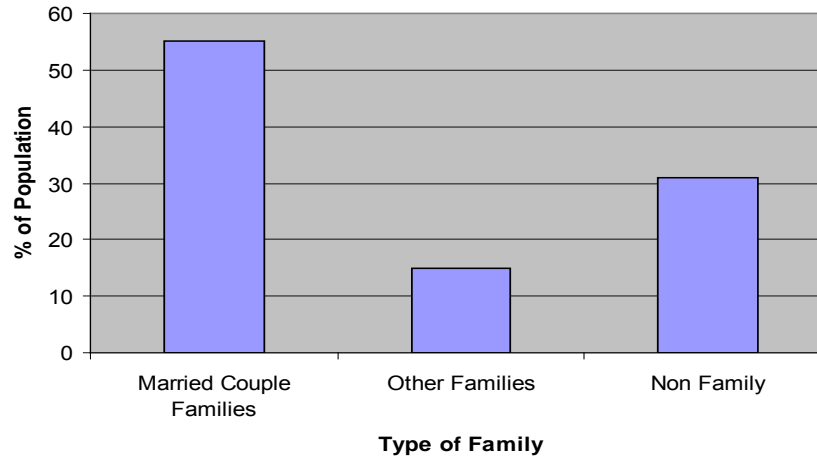


Source: U.S. Census Bureau, 2005-2007 American Community Survey

Social Characteristics

In 2007 there were 343,000 households in Montgomery County. Of the 343,000 households, 69 percent were families. That includes both married-couple families (55 percent) and other families (15 percent). Nonfamily households made up 31 percent of all households in the County. Most of the nonfamily households were people living alone, but some were composed of people living in households in which no one was related to the householder.¹²

Households in Montgomery County



Source: U.S. Census Bureau, 2005-2007 American Community Survey

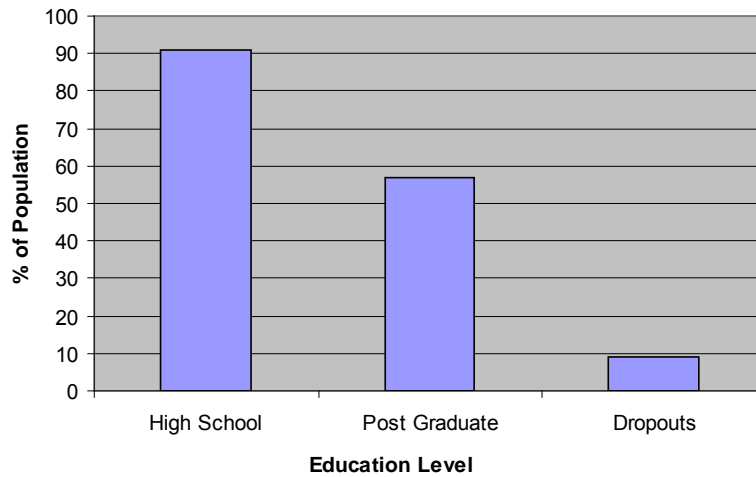
Education

In Montgomery County, 91 percent of people 25 years and over have at least graduated from high school and 57 percent have a bachelor's degree or higher. Nine percent were dropouts, meaning they were not enrolled in school and had not graduated from high school.¹³

¹² *ibid*

¹³ *ibid*

Educational Attainment of People in Montgomery County

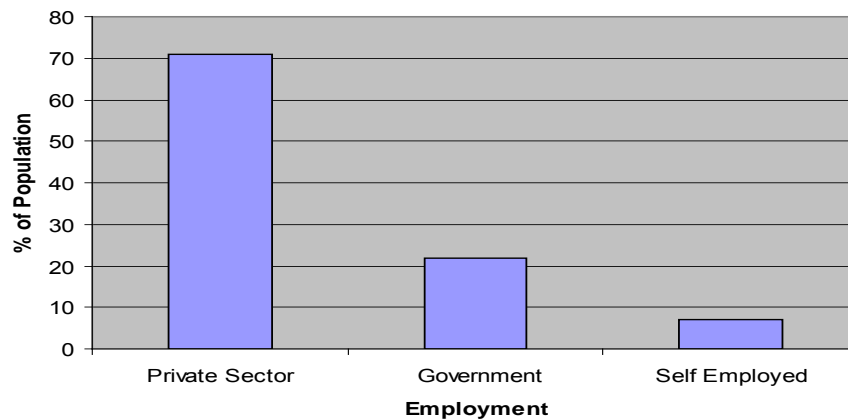


Source: U.S. Census Bureau, 2005-2007 American Community Survey

Employment

The private sector accounts for approximately 71 percent of employment in the county followed by the government, which employs roughly 22 percent. The remaining 7 percent are self-employed.¹⁴

Employment of People in Montgomery County



Source: U.S. Census Bureau, 2005-2007 American Community Survey

Identification of Community Needs:

Community Health Improvement Process, part of the Montgomery County Department of Health and Human Services, recognized the need to conduct a comprehensive needs assessment. Montgomery General Hospital, along with other Montgomery County hospitals, is participating in this collaborative community driven effort. Results are expected to be available in FY2011.

¹⁴ ibid

In the interim, MGH's Director of Marketing & Strategic Planning along with the Community Outreach Coordinator have identified community needs based on the Montgomery County Department of Health and Human Services Strategic Plan 2006-2011 (listed below).

Community Needs for Montgomery County:

Increase Access to Quality Health Care (Physical, Oral and Behavioral Health)

Improve the Public's Health

Protect the Health and Safety of the Public through Emergency Preparedness and Response

Addressing Community Needs:

1. Increase Access to Quality Health Care (Physical, Oral and Behavioral Health)

Proyecto Salud Clinic-Community residents without health insurance have a place to go in Olney for primary care thanks to the new partnership between Montgomery General Hospital and Proyecto Salud Clinic.

Proyecto Salud, an independent primary care clinic in Wheaton, has opened a satellite operation on the campus of Montgomery General Hospital. The satellite clinic was arranged as part of Montgomery Cares, a program that provides primary healthcare to medically uninsured, low-income adult residents of Montgomery County and is funded in part by the county government to help support a network of independent, nonprofit clinics. Montgomery Cares formed in 2005 to respond to the growing number of county individuals without insurance, estimated at 80,000. The organization aimed to serve at least half, about 40,000, and area hospitals were encouraged to support the effort.

Under the terms of the three-year agreement, Montgomery General Hospital provides the clinic office space to Proyecto Salud free of charge as well as funded start-up operations and marketing support. A team of MGH employees have also been designated to attend quarterly meetings with Proyecto Salud as well as work with them throughout the year to improve the referral process and plan strategically. The clinic's services focus on primary adult healthcare including physical examinations, health counseling and education, and basic laboratory services. In addition, the clinic offers a seasonal flu clinic focused on prevention with vaccinations. Prescription medications are made available through the Montgomery Cares program. The clinic also provides referrals for county specialty services, STD, HIV programs/WCCP, FP/maternity and affordable alcohol treatment and rehabilitation. The most common conditions currently treated include chronic illnesses, such as diabetes and hypertension.

Proyecto Salud in Olney was established to provide healthcare services for community residents without health insurance, and to address hospital emergency room wait times that result from community residents using hospitals for primary care services. The clinic provides easy access and enables community members to take advantage of its services at the onset of issues without waiting until they are emergent.

Fees are based on a sliding scale. Approximately 90 percent of patients are members of the Hispanic community, but the clinic is open to all residents of Montgomery County. The clinic employs bilingual

staff (English and Spanish), and other languages are available there including French and Mandarin. In Fiscal Year 2009, 478 patients were seen in the Proyecto Salud Olney clinic.

Addictions and Mental Health Services: An integral component of Montgomery General Hospital for three decades, the Addiction and Mental Health Center (AMHC) has earned a reputation for the efficient and compassionate delivery of a broad range of fully integrated inpatient, outpatient, crisis, and community education and outreach services. Today, the AMHC is the most comprehensive treatment center based at a general hospital in the Baltimore-Washington area.

Through the Addiction and Mental Health Center, MGH maintains a free, 24-hour, mental health help line. This crisis intervention line is staffed around-the-clock, seven days per week by a licensed therapist. On average, the therapists spend six hours a day assisting community members experiencing or affected by a crisis, providing them with information about resources in the community. Staff spent approximately 1,800 hours on the phone during the last fiscal year.

2. Improve the Public's Health

Improving community health among neighbors and friends is important to Montgomery General Hospital. This year MGH contributed \$1,294,408 towards community education and outreach, health screenings, support groups, health fairs, counseling, and self-help and wellness programs.

In November, 2007, MGH joined other hospitals in Montgomery County in establishing a tobacco-free campus. We felt strongly that a tobacco ban was consistent with our mission – to improve the health of the community we serve – and would demonstrate our commitment to healthy living. By going tobacco free, we've eliminated the health and safety risks that the use of the product poses for our patients, employees and visitors.

Community health lectures, workshops and support groups: Community-based education is provided to local residents through free community health workshops and support groups. These events educate the community on health related illnesses. This year's topics included I Can Cope, Look Good and Feel Better for Cancer Survivors, Heart Healthy Living, Prostate Health, Chronic Sinusitis, Head Injuries/Concussions in Sports, Prevention and Treatment of Skin Cancer, Home care for the Elderly, Adolescent Drug Use, Advance Directives and Stroke Signs and Symptoms.

Community education programs: Health education and wellness programs are offered to all members of the community, elementary-aged through seniors. Classes are conducted throughout the year. In 2009, these classes included AARP Driver Safety, ACLS for Healthcare Professionals, Babysitting Plus CPR, Big Brother/Sister, Blood Drive, Cardiac Rehab, Caregivers Support Group, Childbirth, First Aid, Heartsaver & AED, Home Alone, Lamaze Techniques, Mommies with Muscle, Mommy & Me, SIDS, Smoking Cessation, Yoga, Tai Chi and Zumba.

Dare to C.A.R.E. provided free screenings for cardiovascular disease for those age 60 or over, or those age 50 or over with a history of diabetes or smoking. The screening included a non-invasive ultrasound examination of the carotid arteries in the neck, the aorta in the abdomen, and an evaluation of the circulation in the legs. Nutritional counseling, BP screenings, and podiatry evaluations were included in the Dare to C.A.R.E. program. Due to the increasing demand of this event, we more than doubled the number of Dare to C.A.R.E. screenings that were offered in 2008 and served approximately 200 members of the community.

Annual Health EXPO provided free screenings for blood pressure, body fat/waist hip ratio, podiatry, sleep apnea, vision, prostate, breast exam and carotid artery. Up-to-date information on prevention, early detection, treatment, diagnosis and care for various diseases was offered. Attendees enjoyed physician lectures by MGH medical staff, giveaways, and multiple interactive health booths. In 2009, 159 members of the community attended this event.

Cancer screening and treatment: Educating the community about cancer prevention and treatment is a priority at MGH. An oncology certified registered nurse is available to guide patients' families and physicians through the many facets of tests and treatments that often accompany a cancer diagnosis. This "Cancer Care Navigator" is a nurse experienced in the care, treatment and education of cancer patients. The Navigator not only educates patients about cancer and treatments but provides emotional support and encouragement. A culturally competent Community Outreach Specialist with a public health specialty improves our reach directly into the communities where the uninsured underserved of Montgomery County gather with relevant programs to address their cancer awareness, especially in prostate and breast Cancer.

3. Protect the Health and Safety of the Public through Emergency Preparedness and Response

Protecting our Community

In 2009, Montgomery General Hospital invested \$325,981 and dedicated over 8,000 staff hours to improve community building through activities that support systems within the community.

Emergency Preparedness

The Montgomery County Healthcare Collaborative on Emergency Preparedness consists of Montgomery General Hospital, Shady Grove Adventist Hospital, Suburban Hospital, Washington Adventist Hospital, Holy Cross Hospital, Montgomery County Public Health, Montgomery County Fire/Rescue, Montgomery County Dept of Homeland Security, and Kaiser Permanente. It was chartered in November 2001 to help prepare Montgomery County health care providers respond to large-scale emergency events in a coordinated, collaborative manner. To this end, a Memorandum of Understanding was signed by the participating hospitals establishing what is known as EMAS, the Montgomery County Emergency Mutual Aid System.

During the fiscal year, Montgomery General Hospital continued to collaborate with other hospitals and health care providers in the county regarding emergency preparedness. This will allow MGH to provide better urgent care to the community in the event of a local, regional, and/or national disaster. MGH representatives met with other area hospitals and staff to assess the county's overall ability to handle a crisis situation.

The vision at MGH is to increase the hospital's value to the community by continuously offering the best of modern medicine in a caring, professional and ethical environment to patients and their families, professional staff, employees and volunteers. The community comes first and as the community grows, so does the commitment to serving its diverse needs.

Gaps in the Availability of Specialist Providers for the Uninsured

Since joining MedStar in February of 2008, the affiliation has significantly improved MGH's specialty resources.

In 2009 we have been able to access our sister institutions of Georgetown and Washington Hospital Center for emergent neurosurgical cases. The Medstar transfer/transport services are fast, efficient and professional, and have significantly improved the care of any patient requiring emergent neurosurgical care.

We have also been in consultation with another Medstar institution, National Rehabilitation Hospital, to help appropriate patients with orthopedic injuries who can benefit from state of the art acute rehabilitation services.

Emergent facial fractures or severe dental injuries can be problematic to find coverage at times. Although we have one oral maxillary surgeon who is very responsive, most emergent cases are transferred to Washington Hospital Center or Shock Trauma.

Resolution

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to MGH. Since joining MedStar, which includes the Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, Union Memorial Hospital, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center, we now have access to MedStar's entire medical staff, including specialty resources.

MGH is currently planning for the third medical office building on its campus. This will allow more physicians to treat and follow-up with patients in close proximity to the hospital.

Our planned 20,000-square-foot Emergency Department will not only allow us to treat more patients but to provide enhanced care, especially to those suffering a heart attack or stroke. When the new ED opens in 2010, our current emergency room will become home to an expanded medical imaging department. As we continue to grow our departments, programs, personnel and facilities, it's important to understand that we do so without losing sight of our roots. We have spent 90 years delivering quality patient care and developing a reputation as one of the most dependable and respected community-based health care institutions in the region. We look forward to continuing to our community, and staying close to our patients.

We will continue to work with MedStar physicians to complement our own staff. In building these relationships with other MedStar physicians we hope to see the gaps in specialty services significantly decrease over the coming years.

Physician Subsidies

Included in MGH's Community Benefit Report are subsidies for losses from physician services. These stem from serving patients that are uninsured or underinsured as well as absorbing the cost of providing on-call specialists 24/7 to our community.

Category 1:

The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are also uninsured. Providing 24/7 Psychiatry physicians to serve this patient population ensures that community needs are being met.

Because of the low volumes of specialty surgical volumes that come in through our emergency department, it is difficult to staff with orthopedic and general surgery specialists around the clock. MGH has arranged for on-call surgical specialists. With service offering, our patients do not have to be transported to other facilities to get the services they need.

Category 2:

Hospitalists provide 24/7 primary care services which focus on preventive health measures and health status improvement for the community.

Appendix 1

About our Charity Care Policy

Montgomery General Hospital (MGH) is dedicated to serving our community by providing high-quality, personalized healthcare services. In doing so, the hospital pledges to offer accessible services to individuals who do not have the resources to pay for necessary medical care.

MGH will provide access for urgent or emergent medically necessary health care services for free or at a reduced fee to all patients who meet the criteria. The determination of urgent or emergent medically necessary health care services is the sole discretion of MGH. Each applicant for financial assistance or reduced fee arrangements must meet criteria set by MGH. Hospital financial aid is not a substitute for employer-sponsored, public or individually purchased insurance.

Detailed description of how MGH informs patients of the Charity Care Policy:

There are signs in English and Spanish at every registration point in the hospital regarding financial assistance. All registration staff have copies of the financial assistance application in English and Spanish to give to patients.

There are signs in the hospitals main lobby in English and Spanish informing them that MGH has a financial assistance program.



Greeter desks also have copies of the financial assistance application in English and Spanish to give to patients. Billing and Customer Service also have copies of the financial assistance application in English to give to patients. The Financial Assistance policy is posted on our website. Once a year we post a notice of financial assistance availability in our local newspaper for public notice.

For all self pay patients who come to the Emergency Department a financial assistance applications is mailed to the patient within one week of their ED stay.

For all self pay patients who are inpatients the Customer Service department has the patient speak with our internal Montgomery County Social worker to see if they will qualify for medical assistance or an outside agency that specializes in obtaining medical assistance for hospital patients . If the patient does not meet criteria to apply for medical assistance the patient is referred to the Billing Department for payment or to obtain a financial assistance application.

All inpatients also receive a discharge package/envelope. Within the envelope is a Patient Financial Services brochure which explains MGH's billing policies and financial assistance program. These brochures are housed in several areas of the hospital for patient's convenience.

Financial assistance is granted to the uninsured who reside in Montgomery General Hospital's primary and secondary service area. The patient's household income is reviewed against Federal poverty guidelines. If the patient's income and household size is 200% or less than the Federal poverty guidelines than 100% of the bill is written off to charity. A sliding scale is then used for income and household size greater than 200% and less than 400% of the Federal poverty guidelines.

For self pay patients, billing statements are sent after service is rendered then 21 days later, 15 days later, and then 10 days latter asking them for payment or to contact the Billing Department for further assistance.

Appendix 2

Charity Care Policy FY2008 (has not changed for FY09)

Policy: The Hospital will provide access for urgent or emergent medically necessary health care services free or at a reduced fee to all patients who meet the criteria. The determination of urgent or emergent medically necessary health care services is the sole discretion of Montgomery General Hospital. Each applicant for financial assistance or reduced fee arrangements must meet criteria as set by Montgomery General Hospital. Hospital financial aid is not a substitute for employer-sponsored, public or individually purchased insurance. The Hospital will make an effort to provide Financial Assistance application, policies, procedures, and information available in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Procedure: 1. Notice of the availability of charity care shall be published in local news media on an annual basis. Notice will also be posted in the Admissions Office, Business Office, and Emergency areas within the hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Individual notice of the availability of charity care, the potential for Medicaid eligibility and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission or admission. Montgomery General Hospital will make an effort to provide Financial Assistance Application, policies, procedures and information in English, Spanish and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Request for charity or reduced fee arrangements can be made prior to or after service is rendered. To request charity or reduced fee arrangements, the patient must complete a Uniform Financial Assistance Application available from a Montgomery General Hospital representative or via the hospital website. A completed "Uniform Financial Assistance Application" must include a completed demographic section as well as a completed income section. To be considered "complete" MGH will require proof of income and verification of number of dependents based upon the previous year's tax return. If this is not available, the last two months' paycheck stubs will be accepted. Dependents must meet IRS definition of dependents to qualify as household members. Photo id and/or proof of residency is required.

MGH staff will then review the application for the following:

- a. If patient is a Maryland resident and the patient lives in MGH's primary or secondary service area as defined by the following zip codes: 20832, 20833, 20850, 20851, 20853, 20855, 20860, 20861, 20866, 20868, 20872, 20874, 20876, 20877, 20878, 20879, 20882, 20886, 20902, 20904, 20905, 20906, 20910, then the individual is eligible for consideration for charity care. If no, then charity or a reduced fee will not be granted.
 - b. P.O. Box addresses will not be accepted.
6. Determination of probable eligibility for financial assistance will be reviewed on a weekly basis. A letter will be mailed to patient via certified mail notifying of the review results within 3 business days of the initial decision.

7. Patients may appeal any denial or partial fee payment arrangements. The appeal process will include the entire completed Uniform Financial Assistance Application along with accompanying documents of proof of Liquid Assets, Other Assets, and Monthly Expenses. Appeals must be received within 30 days of the patient receiving his/her letter of denial or partial fee payment arrangement. Appeals must be submitted in writing to the Senior Vice President/Chief Financial Officer (CFO). The appeal will be reviewed by the CFO that person and the President.

8. The patient who is appealing will be notified in writing of the appeal decision within 5 business days of MGH receiving appeal. Again, notification will be sent by certified mail.

There is no second level of appeal.

If an account was not classified as charity following the steps above it will be classified as charity for financial statement purposes if an outside collection agency determines the account is “uncollectible” and the patient or guarantor is considered destitute. In this scenario, the charity amount will be entered into the accounting system as a journal entry reclassifying from bad debt to charity.

As a MedStar facility Montgomery General will follow the MedStar Financial Assistance for Uninsured Policy statement.

Training &

Education: All Patient Financial Services employees (Billing, Registrars and Customer Service) will be oriented to this policy as part of their initial training, annually and throughout the year as necessary.

Auditing &

Monitoring: The Patient Financial Services Director monitors financial assistance applications to ensure that all employees of PFS are offering the application in an appropriate and timely manner. Additional education will be provided as needed.

Appendix 3

Montgomery General Hospital's mission is to enhance our community's health and well being by offering high quality, compassionate, and personalized care.

Our mission statement was originated as part of the development of our FY09 - FY11 strategic plan. It was meant to blend the MGH's goals and strategies with that of our new parent company. Our management team was instrumental in crafting the statement which was approved and endorsed by MGH's board.

In developing our mission statement, it was important to include "a proud member of MedStar Health" in the language which was key in blending our goals and strategies with those of our new parent company. Through focus group work, "compassionate and personalized care" were adjectives used to describe MGH. The management team also agreed these were traits that are evident in our culture and should continue to be part of the mission of the hospital. "High quality" is a priority as part of our focus.

Appendix 4

MedStar Health and each entity (hospital and diversified business) share a common vision and set of values. MedStar Health's common vision is to be the trusted leader, caring for people and advancing health. MedStar Health's common set of values are services, patient first, integrity, respect, innovation and teamwork. Each entity has a unique mission, or purpose for which it exists. MedStar Health's mission is to serve our patients, those who care for them and our communities. Montgomery General Hospital's mission is to enhance our community's health and well being by offering high quality, compassionate, and personalized care.

Below is an illustration of MedStar Health's mission, vision and values for reference.



Northwest Hospital, Inc.
FY 2009 Community Benefit Narrative Report

1. The **licensed bed designation** at Northwest Hospital is 247, 218 Acute and 29 Subacute. **Inpatient admissions** for FY 09 were 13,785, 12,793 Acute and 992 Subacute.
- 2.
3. **Community Description:** Northwest Hospital is located in the Randallstown community of Baltimore County, serving both its immediate neighbors and others from throughout the Baltimore County region. Northwest's primary service area consists of six zip codes: 21136 (Reisterstown), 21133 (Randallstown), 21117 (Owings Mills), 21208 (Pikesville), 21244 (Windsor Mill) and 21207 (Gwynn Oak). As a whole, this primary service area is home to 228,702 residents with an average household income of \$80,585. In 2008, the unemployment rate was 4.5%, and 14.2% of families had a household income under \$25,000. Also in this area, 87.8% of residents graduated from high school or higher education. Racial distribution in this area is 55.9% Black, 35.5% White, 3.2% Hispanic, 3.2% Asian/Pacific Islander and 2.2% other.

The six zip codes that represent the largest number of admissions to the hospital in 2009 are, in descending order of admissions:

Zip Code	21133	21244	21207	21117	21208	21136
Total admission %	17%	12%	13%	11%	13%	7%
ER %	17%	17%	14%	11%	8%	6%
Primary racial composition	72% Black	73% Black	80% Black	68% White	64% White	82% White
Median income	\$57,126	\$44,359	\$41,375	\$60,005	\$56,671	\$56,458
% households below poverty level	5.1%	6.5%	8%	4.1%	2.2%	2.6%

The life expectancy for the primary service area of Northwest Hospital is not available. Northwest Hospital is located within Baltimore County. The life expectancy for African Americans in Baltimore County is 75.8 years, for Whites 78.5 years with an overall life expectancy of 78.1 years. In FY 09, the hospital saw a total of 100,333 cases, 22% of these cases were either on Medical Assistance or self-paid. In the ER 38% of cases were either Medical Assistance or self-paid, and 16% of inpatient cases were also in this category.

3. Identification of Community Needs:

3a. Processes used in identifying community needs

Community needs assessments are done in a variety of ways, according to the hospital departments involved and the constituencies they serve. The following are used most

commonly: A) clinical department need recognition based on daily patient care and professional experience, B) participation in community coalitions, C) program development based on expressed client needs, and D) formal needs assessment conducted by an external consultant.

Method A) Clinical Department recognition based on daily patient care and professional experience.

For many of the clinical departments informal needs assessments are performed as a by-product of daily patient care as staff encounter the needs of those who seek services. For example, our domestic violence identification and intervention program recognized in their routine crisis response that women with the most potentially lethal domestic violence, including strangulation, needed additional identification and outreach.

Method B) Participation in community coalitions.

Another way of participating in community needs assessment is when hospital staff serve on community coalitions that perform a planning function. In the above example, our domestic violence staff was familiar with an evidence-based lethality assessment tool and the need to implement its use with medical providers and police because of their participation on a statewide coalition that identified the need to better identify the victims most at risk for being killed by an intimate partner.

Method C) Program development based on expressed client need.

In some situations hospital staff develop community benefit programming for groups with whom they may have experience, but for whom they wish to provide new programming or services to meet their specific expressed needs and interests. For example, Community Health Education staff have much experience providing health promotion programming to senior citizens in community residential settings. In FY09 this department sought to expand programming to seniors living in the Weinberg senior housing facilities. In this new initiative, the WellBerg project, approximately 400 senior residents were given a needs and interest survey to determine which health education topics were of most interest or importance to them as well as to assess which screenings would be most popular and relevant to them.

Method D: Formal needs assessment conducted by an external consultant.

Finally, on occasion the hospital commissions an external consultant to conduct a formal needs assessment on community health needs. During FY 05 we used this means to conduct a needs assessment necessary to identify a priority community health need and develop an intervention in response, as charged by the health system's Board and President. As part of that assessment process, the consultant interviewed key informants including hospital staff and leadership, community service providers and other community representatives. The consultant also performed an extensive review of public health data from City, County, and State health departments. In addition, she interviewed the Health Commissioners of both Baltimore City and Baltimore County to determine their priorities, existing programs, and potential for partnerships.

3b. Consultation with Health Department

As part of the formal needs assessment conducted by the external consultant in 2005 the City and County health departments were consulted on what they identified as the needs of the community. Additionally, City, County and State health department data was used in that assessment. As a routine practice, program development is usually guided by such data.

4. Health needs identified by assessment processes:

Using the methods described above the following major community needs were identified.

Method A) Clinical Department recognition based on daily patient care and professional experience.

As a result of seeing many victims of intimate partner abuse, our domestic violence identification and intervention program recognized that women with the most potentially lethal domestic violence needed heightened identification and follow up. Particularly with potential strangulation they realized that some victims were only receiving cursory examinations and the police were treating the cases as misdemeanor crimes, instead of felonies. The program determined that there was a community need to train police and medical staff to better respond to strangulation victims by improving treatment, documentation and prosecuting the act as a felony crime.

Method B) Participation in community coalitions.

Through participation in a state-wide initiative to identify and address the most lethal domestic violence situations and reach out to those victims, the domestic violence identification and intervention program identified a need to use a lethality assessment in the hospital setting.

Method C) Program Development based on expressed client need.

When the Community Health Education staff wished to expand programming to meet the specific expressed needs and interests of senior citizens, they gave a survey to determine which health education topics and screenings were of most importance to 400 senior residents of local senior housing facilities. The survey also asked for preferred times and dates to offer such programs. The top four educational programs and screenings chosen were the ones that are being provided.

Method D: Formal needs assessment conducted by an external consultant.

The 2005 Consultant's formal needs assessment identified cardiovascular disease and specifically heart failure as a major health issue for the Northwest Hospital community.

5. Those involved in decisions re: community needs addressed through community benefit activities: Decisions regarding the selection of community needs to address depend on the hospital departments involved and the constituencies they serve. Decisions may also involve how the community assessment was done, and for what purpose.

Method A) Clinical Department recognition based on daily patient care and professional experience.

In the informal needs assessment process done on a regular basis by clinical departments as a by-product of daily patient care when staff encounter the needs of those who seek services, decisions are made within those departments by the caregivers and departmental administrators. If additional resources are required to support a new community benefit program, then ultimately those decisions must be made by executive management.

Method B) Participation in community coalitions.

Departmental representatives attend community coalitions; in the above example, the Coordinator of the Domestic Violence Program is a member of the statewide coalition. She then brought back information on the evidence-based lethality assessment, then made the decision to introduce it into the domestic violence crisis response protocol.

Method C) Program Development based on expressed client need.

In the new initiative, the WellBerg project, referred to above, Community Health Education staff used the needs and interest survey information, to make decisions within the department about program development.

Method D): Formal needs assessment conducted by an external consultant.

When a formal needs assessment by a consultant is commissioned by the hospital, the intent is to respond to identified needs with a new community benefit program. For example the most recent consultant needs assessment (FY 05) discussed above, was a result of a charge by the health system's Board and President to identify a priority community health need and develop an intervention in response. In that case, the highest level of decision makers drove the process through their charge. However, the specific health problem selected to focus on was driven by the information the consultant gathered from key informant interviews and from public health data from City, County, and State health departments. The consultant then made recommendations of priority areas, and the executive management and Community Mission Committee of the Board made the selection of a specific health need, Congestive Heart Failure, to address with a community benefit intervention.

6. Community Benefit program initiatives to address needs in #4: As noted above, we develop community benefit programming based on identified needs and hospital resources available to address those needs.

Example A - As a result of needing to address the needs of strangulation victims, the Domestic Violence Program developed the "Strangulation Response Project" in conjunction with the Woodlawn police precinct. This project trains police and medical staff to better respond to strangulation victims by improving treatment, documentation and prosecution as a felony crime. The project has worked with Emergency Department Physicians to create a medical protocol for these victims to make certain appropriate medical tests are done. Funding for a forensic light source that will help show underlying bruising has also been obtained.

Example B - the Domestic Violence Program implemented the use a lethality assessment screening for all identified victims of intimate partner violence. The Lethality Assessment screen was developed by a committee consisting of law enforcement, a prosecutor, an

investigator, a parole and probation agent, domestic violence advocates and researchers. The screen consists of eleven questions that are based on Dr. Jacquelyn Campbell's research on a validated Danger Assessment. Initially designed for responding police officers for domestic violence calls to assess which victims are at highest risk for a lethal incident, it is also being used in hospital settings.

The Domestic Violence Program staff use this tool during their initial crisis intervention with victims of domestic violence. In addition, in FY09 the Baltimore County Police Department began using the Lethality Assessment. Once a victim screens as highly lethal, a call is immediately placed to a 24/7 domestic violence hotline. Subsequently, the Police Domestic Violence Coordinator and an advocate from a local domestic violence program visit the victim within the next 24 to 48 hours after the incident. The Domestic Violence Program at Northwest Hospital provides this service for the Pikesville and Franklin precincts.

Example C – The Community Health Education staff developed new programming in a new location based on the needs assessment survey they gave to seniors living at those locations. They chose topics and provide screenings the residents selected.

Example D - A major need in Northwest's community identified by the consultant needs assessment process is high rates of cardiovascular disease. Because the hospital had a sizable number of repeat admissions for Congestive Heart Failure (CHF), we decided to target those patients for an in-home intervention. For three years (FY06-09) we provided an initiative that identified patients admitted to the hospital for CHF, then offered them an educational program that provided community health nurse visits, telephone monitoring and educational materials to assist them and their families in monitoring and controlling their blood pressure, fluid status and medications following discharge. Though this program was successful it was terminated in 2009 due to budget constraints.

Another cardiovascular community benefit program, a Woman's Heart Screening program, was already in existence when the consultant performed her needs assessment. It has a different purpose, prevention and early intervention, and it has been quite successful in achieving its outcomes (see #7 below) so it continues to provide a community benefit.

7. Evaluation efforts:

An example of a departmental evaluation of a community benefit program is the regular evaluation of behavior or lifestyle change by participants in our Women's Heart and Lifestyle Screening Program discussed in # 6 above. We evaluate this program on an ongoing basis as part of the program protocol; the data provided in the following description is from FY09.

The program is evaluated by process and outcome measures.

Process measures tally:

1. numbers of attendees per screening
2. number of screenings held per year

3. number of persons identified at risk day of the screening
4. level of satisfaction among program participants
5. likelihood that program participants will recommend program to other people.

Outcome measures determine:

1. percentages of program participants who are identified at risk or high-risk of developing heart disease or having a heart related incident
2. percentages of program participants who make at least one behavior change three (3) months post screening event
3. percentages of program participants who require follow up counseling from the program nurse
4. percentages of program participants who follow up with either a primary care or Cardiologist or other health care provided as part of the screening.

Results: In FY 2009 363 people were screened in the program. Of the 363 attendees, 122 were determined to be at high-risk. 11 screenings were held with an average attendance of 33 per screening. 98% of persons screened stated they would recommend the program and were very satisfied.

Note: If blood pressures are extremely high or other signs and symptoms are alarming screening participants are immediately sent to the ER. All screening participants receive education and counseling by nurses at the end of the screening session.

One (1) month following the screening a comprehensive health report is mailed to all screening program participants regardless of risk. The report contains bio-metric data obtained from participants the day of the screening (total cholesterol, blood pressure, body composition, glucose and other blood work as well) as well as results from a heart health assessment questionnaire also completed the day of screening. For persons identified at risk, the program Cardiologist writes remarks on the health report to suggest steps each person can take to improve their health and suggestions for follow up with either a primary care physician, cardiologist or other health care provider. Program nurses contact 100% of persons identified at risk to provide education and counseling related to heart disease prevention and to determine if participants had any questions about their health or the information provided in their reports.

Three (3) months post screening, letters are sent to all program participants to determine what behavioral changes they have made, whether they have followed up with their physician, etc. Of the 363 screening participants, 187 (51%) responded. Of those 187 respondents, 65% were considered high risk and needed follow up. Additionally, 158 or 85% of the 187 respondents made at least (1) behavior change (lost weight, quit smoking, increased their daily consumption of fruits and vegetables, reduced their blood pressure medication, etc). And 72% or 135 respondents had seen or had an appointment scheduled to share results of their report with their primary care doctor or health care provider. Finally, 12% or 23 respondents saw a cardiologist and 15 of those were high risk.

In order to evaluate the initiatives for Congestive Heart Failures, as discussed in #6, the CHF program used two different tools. One was based on questions from the RAND S-36 Survey used in Rehabilitation Circles. For the other measure, the program manager

used questions adapted from the Minnesota Living with Heart Failure Questionnaire which is widely used in the treatment of heart failure. These were then used in determining if the CHF program met the previously determined goals. This program was indeed, quite successful in meeting those goals.

8. Gaps in availability of specialty providers:

Northwest is a community hospital with an attending staff of approximately 700 physicians, including several specialties. Those specialties include Neurology, Neurosurgery and Infectious Disease. While we have closed the gaps in Gynecology, Vascular, Colorectal and Orthopedic Surgery there are still gaps in Ophthalmology, Dermatology, Rheumatology, Infectious Diseases, Physiatry, and Orthopedic Specialties in hand and spine.

9. Physician subsidies:

The hospital employs hospitalists, who provide 24/7 services in the hospital. They provide care for patients who do not have a primary care physician and who are admitted through the ER; many of these patients are uninsured. Because the hospitalists provide 24/7 coverage and these patients are often uninsured or underinsured, this service results in a negative profit margin to the hospital.

When uninsured patients are admitted, their care is managed by either a hospitalist (50% of the time) or a voluntary member of the medical staff who is on call for the Emergency Department. We employ specialists in order to provide continuous care for patients admitted to the hospital through the Emergency Department. In these cases the hospital covers these specialists' consultation fees and fees for procedures for all indigent patients. If the hospital did not cover these fees, these specialists could not otherwise afford to provide this service to uninsured or under-insured patients.

Northwest Hospital
Financial Assistance Procedures

The following describes means used at Northwest Hospital to inform and assist patients regarding eligibility for financial assistance under governmental programs and the hospital's charity care program.

- Financial Assistance notices, including contact information, are posted in the Patient Financial Services areas and in Patient Access areas, as well as, other Hospital points of entry.
- Patient Financial Services Brochure '*Freedom to Care*' is available to all inpatients; brochures are available in all outpatient registration and service areas.
- Northwest Hospital employs a Financial Assistance Liaison who is available to answer questions and to assist patients and family members with the process of applying for Financial Assistance.
- A Patient Information Sheet is given to all inpatients prior to discharge. This information will be available in Spanish by the end of September 2009.
- A Patient Information Sheet is mailed to all inpatients with the Maryland Summary Statement.
- Northwest Hospital's uninsured (self-pay) and under-insured (Medicare beneficiary with no secondary) Medical Assistance Eligibility Program screens, assists with the application process and ultimately converts patients to various Medical Assistance coverages and includes eligibility screening and assistance with completing the Financial Assistance application as part of that process.
- A message referencing the availability of Financial Assistance for those who are experiencing financial difficulty and contact information regarding Northwest's Financial Assistance Program is being added to our patient statements. Northwest Hospital outsources this process to contracted vendors. This process will be completed by the end of August.
- All Hospital Patient Financial Services staff, active A/R outsource vendors, collection agencies and Medicaid Eligibility vendors are trained to identify potential Financial Assistance eligibility and assist patients with the Financial Assistance application process.
- Northwest Hospital hosts and participates in various Department of Health and Mental Hygiene and Maryland Hospital Association sponsored campaigns like 'Cover the Uninsured Week'.

NORTHWEST HOSPITAL

Title: Financial Assistance

PURPOSE: To assist patients who do not qualify for Financial Assistance from State, County or Federal Agencies but may qualify for uncompensated care under Federal Poverty Guidelines.

POLICY: To provide Financial Assistance applications to patients experiencing financial difficulty paying for their hospital bill(s). Eligibility is based on gross income and family size according to current Federal Poverty Guidelines.

Financial Assistance information is made available to the public through multiple sources including: 1) the admission packet, 2) signage and pamphlets located in Admitting, the Emergency Room, Patient Financial Services, as well as other patient access points throughout the hospital, and 3) Patient Access and Patient Financial Services staff.

Financial Assistance eligibility determinations cover facility/hospital patient charges only. Physicians and ancillary service providers outside of Northwest Hospital are not covered by this policy.

PROCEDURE: Implementation procedures are different for non-emergent and emergent services.

A. Unplanned, Emergent Services and Continuing Care Admissions

1. Unplanned and Emergent services are defined as admissions through the Emergency Department. Continuing care admissions are defined as admissions related to the same diagnosis/treatment as a prior admission for the patient.
2. Patients who believe they will not be able to meet their financial responsibility for services received at Northwest Hospital will be referred to the Self Pay Account Manager or Collection Representative in Patient Financial Services.
3. For inpatient visits the Self Pay Account Manager will work with the Medical Assistance Representative to determine if the patient is eligible for Maryland Medical Assistance. The patient will provide information to make this determination. The Medical Assistance Representative will determine probable Medicaid eligibility within two (2) business days of initial application.
4. If the patient does not qualify for Maryland Medical Assistance, the Self Pay Account Manager or the Collection Representative will determine if the patient has financial resources to pay for services rendered based on Federal Poverty Guidelines.
5. If the patient does have the financial resources according to the Guidelines, the Self Pay Account Manager or the Collection Representative will arrange for payment from the patient following Northwest Hospital's payment arrangement guidelines.
6. If the patient does not have the financial resources according to the Guidelines, the Self Pay Account Manager or the Collection Representative will assist the patient with the Financial Assistance application process.
7. Patients may request Financial Assistance prior to treatment or after billing.
8. Patients must complete the Financial Assistance application and provide the Self Pay Account Manager or Collection Representative documented proof of income for consideration. At least one of the following items is required:

NORTHWEST HOSPITAL

- a. Patient's recent paycheck stub
 - b. Copy of the prior year's tax statement and/or W-2 form
 - c. Verification of income with employer via telephone
 - d. Verification of other household income, i.e. Social Security Award Letter, retirement/pension payment, etc.
9. A new application must be completed for each new course of treatment with the following exceptions:
 - a. Approved Medicare inpatients and outpatients are certified for one year from approval date. Medicare patients are required to provide a copy of their Social Security Award letter on a yearly basis.
 - b. Non-Medicare inpatients and outpatients are certified for six months from approval date. However, if it is determined during the course of that period that the patient meets Maryland Medical Assistance eligibility requirements, we will assist the patient with this process while still considering requests for Financial Assistance.
 - c. Outpatient surgical procedures may be certified for one time only. Additional services would require a new application.
 - d. Dates of service outside the Financial Assistance consideration period, prior to the approval date, will be considered on a case-by-case basis.

At the time of application, all open accounts are eligible for consideration including accounts previously written-off to bad debt, which are reviewed on a case-by-case basis.

10. Financial Assistance is based upon the Federal Poverty Guidelines published in the Federal Register. The poverty level guidelines are revised annually. Patients with an annual income up to 200% of the Federal Poverty Level may have 100% of their hospital bill(s) covered by Financial Assistance.
11. Patients slightly above 200% annual income may have a portion of their medical bill covered by Financial Assistance based on a sliding scale. The Financial Assistance amount is calculated as follows:
Identify the annual income based on the income tax form or W-2 (A). Identify 200% of the Federal Poverty Level for the patient based on household size (B). Subtract B from A. This is the maximum amount for which the patient would be responsible (C). Failure to pay the patient responsibility will result in a reversal of the Financial Assistance adjustment resulting in the patient being responsible for total charges. Subtract C from the patient liability on the hospital bill(s). This is the approved Financial Assistance amount.
12. The Director of Patient Financial Services or his/her designee approves or denies the Application.
13. Patients will receive determination of probable eligibility of Financial Assistance within two (2) business days from application receipt date.

B. Planned, Non-Emergent Services

1. Prior to an admission, the physician's office or hospital scheduler will determine if a patient has Medical insurance. If the patient does not have medical insurance, the physician's office or hospital scheduler will call a Financial Counselor in Patient Access. The Financial Counselor will work with the Self Pay Account Manager to screen the patient for Maryland Medical Assistance eligibility. Working together probable determination of eligibility will be made within two (2) business days from the initial application.
2. The Self Pay Account Manager will obtain information from the patient to determine Maryland Medical Assistance eligibility. If the patient qualifies, the appointment is confirmed and the patient will receive service as scheduled.

NORTHWEST HOSPITAL

3. If the patient is scheduled for service prior to Maryland Medical Assistance probable Eligibility determination, the Financial Counselor will contact the physician's office to postpone the service. If the physician does not want to postpone the service, the Financial Counselor will inform the physician that the Vice President of Revenue Cycle and/or the Vice President of Finance will review and determine whether the case will be postponed, provided or denied. The Vice President of Revenue Cycle and/or the Vice President of Finance will contact the physician regarding the case. The Vice President of Revenue Cycle and/or the Vice President of Finance will review the case, including clinical and financial information, business impact and location of the patient's residence in determining whether Financial Assistance should be provided. Final determination will be made on a case-by-case basis.
4. If the patient does not qualify for Maryland Medical Assistance, the Financial Counselor will determine an estimate of charges for services to be provided. The Financial Counselor will contact the patient for payment.
5. For planned, non-emergent services, Self Pay patients who are United States citizens must pay at least 50% of estimated charges prior to service, with an agreement to pay the remaining 50% not to exceed two (2) years. For patients who are not United States citizens, 100% of the estimated charges must be paid prior to date of service. Financial Assistance eligibility may be considered on a case-by-case basis for non-emergent, yet medically necessary services, based on the policies documented herein. Vice President of Revenue Cycle and/or Vice President of Finance approval is required.
6. If an agreement is made, the patient must provide payment at least three (3) business days prior to service and sign the LifeBridge Health Installment Agreement Form. If the patient has the financial resources according to the Federal Poverty Guidelines, but fails to pay prior to service or sign the Self Pay Agreement Form, the Financial Counselor will contact the physician's office to request that the planned service be cancelled due to non-payment.
7. If there are extenuating circumstances regarding the patient, the patient's clinical condition, or the patient's financial condition, the patient or the physician may seek an exception from the Vice President of Revenue Cycle and/or the Vice President of Finance. If an exception is requested, the Financial Counselor will gather documented proof of income as stated in the emergent section of this procedure. The Vice President of Revenue Cycle and/or the Vice President of Finance will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether Financial Assistance should be provided. Final determination will be made on a case-by-case basis.

Original Date: 7/92

Revised Date: 9/96, 5/98, 9/01, 12/02, 8/04, 5/06, 1/09

Review Date: 1/11

Eric Wexler
President

NORTHWEST HOSPITAL

Anthony K. Morris
Vice President, Revenue Cycle



POLICY MANUAL – SECTION I: LEADERSHIP, GOVERNANCE, MANAGEMENT AND
PLANNING 1.00

SUBJECT: MISSION, PHILOSOPHY, VISION

EFFECTIVE DATE: JULY 2, 2004

SUPERSEDES: AUGUST 1998

APPROVALS: Final – President

MISSION

Northwest Hospital Center's mission is to:

- Function as an integral component of LifeBridge Health, acting in close coordination with other LifeBridge Health providers. Deliver a broad array of appropriate inpatient and outpatient hospital and health care services to communities along the northwest corridor, including Baltimore County, southern and eastern Carroll County, Baltimore City and northern Howard County.
- Commit to being a community focused hospital center that meets the continuum of health care needs of the people we serve-either directly through joint programs with other providers and health related agencies or as an advocate for alternate sources of care-regardless of their ability to pay.
- Provide, in partnership with the medical staff, a patient centered environment committed to the continuous improvement of the quality of services provided.
- Maintain an attractive and up-to-date facility equipped with proven state-of-the-art technology that meets the needs of both patients and physicians and is accessible to all.
- Provide an environment in which patients are treated with the utmost safety in mind and all customers are treated with respect and dignity.
- Maintain and foster a caring family atmosphere in which to work, practice medicine, volunteer, visit, and most importantly, receive care.
- Stress education and focus resources on providing quality education to meet the

health information needs of the communities we serve, the continuing education needs of our employees and medical staff to facilitate quality care, and clinical experience for students.

SUBJECT: MISSION, PHILOSOPHY, VISION

1.00

- Continue to be a cost-effective organization which manages its resources prudently to ensure its long-term financial viability and, thus, its ability to carry out its mission.

PHILOSOPHY

Northwest Hospital Center, a not-for-profit organization, is committed to creating and maintaining an environment where exceptional quality care and service is achieved and recognized by our patients and their families, members of the medical and allied health staffs, employees, volunteers and the communities we serve. Care and service are provided without regard to age, sex, race, religion, disability or financial status.

VISION

Northwest Hospital Center will be a recognized leader in customer care and clinical quality in the services we choose to offer by exceeding expectations of patients, physicians, employees and the community.

Global/1.00



1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

FY '09	Licensed Beds	Inpatient Admissions	Inpatient Days
Adult	362	21,266	93,803
Newborn	28	2,195	6,751
Transitional Care Unit (Hospital based skilled nursing facility)	30	837	9,651

2. Describe the community your organization serves. The narrative should address the following topic: (The items below are based on IRS Schedule H, Part VI, Question 4).

Peninsula Regional Medical Center is located in Salisbury, Maryland, an approximately 116 mile drive from both Washington D.C. and Baltimore, Maryland. The Medical Center defines its primary service area in general terms as Wicomico County, Worcester County and Somerset County on Maryland's Eastern Shore. Certain primary service area statistics are tabulated not on the basis of county boundaries, but on the basis of the 43 zip codes all or part of which are in those primary service area counties. In fiscal year 2009, approximately 76% of the patients discharged from the Medical Center were residents of the primary service area, which had an estimated population of approximately 176,000 in 2009. The primary service area population has grown by an estimated 13% since 2000.

The secondary service area, accounting for 19% of Peninsula Regional's 2009 discharges, consists of 14 zip codes in the southern portion of Sussex County, Delaware and the northern portion of Accomack County, Virginia. These two counties had a population of approximately 233,000 in 2009 and have experienced growth since 2000 of 19.6%. The primary and secondary service areas combined accounted for 95% of Peninsula Regional's total patient discharges in fiscal year 2009. Additional demographic information indicates the number of elderly (those aged 65+) represent a greater portion of the total population in both the primary and secondary areas as compared to the State of Maryland (26.6% and 25.5% respectively vs. 12.3%). The elderly have additional chronic conditions, consume health care resources at higher rates, and generally require more time and attention than other population segments. Additional demographic characteristics for the Medical Center's population are as follows:



2009 Demographic Information

	<i>Maryland</i>	<i>5 Co. Service Area</i>	<i>3 Co. Primary Service Area</i>
Median Household Income	67,767	44,112	
Race/Ethnicity			
White	59.0 %	65.3 %	
Black	30.1 %	29.5 %	
Hispanic	6.4 %	4.5 %	
Other	4.5 %	0.7 %	
Unemployment	7.2 %		7.9 %
Uninsured	14.3 %		22.8%
Cancer Death Rates per 100,000	193.3		221.4
Persons Below the Poverty Level (2007)	8.3%		15.2%

Finally, much of the Medical Center's primary service area has been identified as a Health Professional Shortage Area and a Medically Underserved Area by the Health Resources and Services Administration. Peninsula Regional, based upon the findings of a Medical Staff Needs Study requires an additional 100 physicians of varying specialties to meet current and future needs.

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (based on IRS Schedule H, Part VI, Question 2).

Peninsula Regional Medical Center in cooperation with the Wicomico, Worcester and Somerset Counties, Health Departments, the Atlantic General Hospital and the Edward W. McCready Memorial Hospital, has been conducting community health surveys of the Tri-County area since 1995. These surveys, administered by Professional Research Consultants (PRC) of Omaha, Nebraska were administered in 1995, 2000 and 2004. A fourth survey is currently being conducted, but results will not be available until January 2010. In addition to these adult surveys, a separate adolescent survey was conducted in 2000 and in 2005 and is being administered again in concert with the adult survey currently in the field. The surveys are conducted via the telephone using a random digit dialing technique of households in Wicomico, Worcester and Somerset counties. To ensure accuracy, selected households were weighted in proportion to the actual



characteristics of the tri-county population distribution at the zip code level. All survey administration, data collection and analysis was conducted by PRC. For statistical purposes, the maximum rate of error for our total sample was +/- 3.5% for the adult survey and +/- 3.9% for the adolescent survey at the 95% level of confidence. Survey findings were compared to earlier studies and to national benchmarks.

Results of these surveys are used by the participants to plan future services. Of particular note was the development of the Tri-County Diabetes Alliance, which is a cooperative venture between all the partners and community agencies to reduce the incidence of diabetes in the tri-county area. Other outcomes resulting from the survey findings include smoking cessation programs, other early detection and screening programs for heart and cancer as well as health promotion and education with a focus on prevention. Survey results are also used to obtain grants for specific testing and treatment programs.

In addition to the Community Health Assessment, Peninsula Regional uses input from its Health Council (community), local and national community health organizations such as the American Cancer Society, the March of Dimes, and American Diabetes Association, local health departments, and state and national data sources such as the CDC Healthy People 2010 and the Maryland State Vital Statistics reports to identify the health needs of our community.

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

Yes, the three local Lower Shore Health Departments were partners in this community health needs process and were extensively involved in questionnaire design and results reporting and analysis.

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

Survey responses revealed that many aspects of health status in the Tri-County area are very similar to those recorded nationwide. However, in comparison national benchmarks, health status in the Tri-County area is below average in the following regard:

Chronic Illness. The local prevalence of chronic illness is particularly high in the Tri-County area for diabetes/high blood sugar, arthritis/rheumatism, and skin cancer.



In terms of modifiable health risks as compared to national benchmark data: Residents of the Tri-County area are much more likely than those nationwide to be overweight; further, a full seven in 10 local adults are at an unhealthy weight (including both over-and underweight).

Blood Pressure and Cholesterol. In comparison to the nation as a whole, residents of the Tri-County area exhibit a much higher prevalence of both hypertension and high cholesterol levels.

Substance Abuse. Local adults are more likely to be binge drinkers when compared with adults across the United States.

In terms of prevention, adults in the Tri-County area exhibit higher levels of consistent seat belt usage (including child seats/seats belts for children under 5), and local residents are consistently higher than the nation in certain aspects of cancer screening (colorectal screening and Pap smears). Other measured aspects of prevention in the Tri-County area are similar to findings across the United States.

Access is a key issue for communities across the county and individuals living at the lowest income levels as well. African-American residents were far more likely to indicate cost or lack of insurance has prevented a physician visit for them in the past two years. African-Americans and those living at or near the poverty level were two to four times more likely than residents overall to indicate they have had trouble getting dental care in the past two years. One-third of individuals living at the lowest income levels and one-fifth of African-Americans are without health insurance coverage, both segments being higher than the community overall. One positive finding is that local residents were more likely to have a regular sources of care when compared to national findings.

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

Based on the information gathered through the most recent Community Health Assessment and the guidelines set forth in Healthy People 2010, the following “health priorities” represent a significant opportunity for health improvement:

- Diabetes
- Heart Disease & Stroke
- Nutrition
- Access to Health Care Services



In addition to these areas, there are multiple other priorities and contributing factors that each partner assessed in conjunction with this survey.

In identifying priorities for community action and designing strategies for implementation, a number of criteria were applied to the consideration process, including:

Impact: The degree to which the issue affects or exacerbates other quality of life and health-related issues.

Magnitude: The number of persons affected, also taking into account variance from benchmark data and year 2010 targets.

Seriousness: The degree to which the problem leads to death, disability or impairs one's quality of life.

Feasibility: The ability of organizations to reasonably impact the issue, given available resources.

Consequences of inaction: The risk of exacerbating the problem by not addressing at the earliest opportunity.

Each partner (Wicomico, Worcester and Somerset Counties, Health Departments, the Atlantic General Hospital and the Edward W. McCready Memorial Hospital) was responsible for engaging in activities specific to the geography within which they operate. Each partner used the results of the survey to plan screenings and/or interventions tailored to the needs of their population. Partners shared plans and collaborated where possible.

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

In addition to the programs already presented, a number other initiatives from the community health survey have been started including:

- Under the priority area of access to care, access to dental services – particularly for children was identified. As a result, grants and gifts were received to expand dental programs at the local Health Department,
- For heart disease, a state grant supplied the money to do work site wellness programs including screenings,



- For cancer, money from the cigarette restitution fund was used to provide colorectal screenings including prevention, education, diagnosis and treatment. Additionally, funds were obtained from a grant to provide mammograms for low income women.
- In terms of obesity, a three year federal grant provided funds targeted at African-American families to participate in a program to make lifestyle changes, quit smoking, control their blood pressure, exercise (through a walking program) and meetings with a nutritionist to modify their eating behavior.
- For substance abuse, a new suboxone (a heroin alternative) clinic was established with great success. This is the only such clinic on the Eastern Shore
- And finally, for mental health care, a new clinic co-located in a primary care site expands care for mental health patients without the stigma of being seen in a Mental Health Clinic.

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

Evaluation of Outreach Services Rendered

In an effort to evaluate our Community Outreach, the Medical Center developed an evaluation postcard so that we can receive feedback regarding services provided to the community on an ongoing basis. Cards are distributed to audience members of community programs. It asks two brief questions:

- 1) Overall, how satisfied were you with the information/service provided to you?
- 2) How beneficial to your health was the information/service you received?

FY 09 Results

Based on the evaluation postcards we received, the following average score has been tabulated for each question:

Question #1

On a scale of 1 – 10 (1 = Very dissatisfied; 10 = Very Satisfied)



Our overall satisfaction score was 9.4%

Question #2

On a scale of 1 – 10 (1 = Very dissatisfied; 10 = Very Satisfied)

Our overall “benefit of services rendered” score was 9.6%

Conclusion:

Peninsula Regional Medical Center continues to show high satisfaction scores and high benefit scores for the services and programs we offer to the community. We continually strive to meet the needs of the underserved/underinsured by providing free wellness screenings at local festivals and health fairs on the lower Delmarva Peninsula.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

2009 Health & Wellness Expo

The second annual Health & Wellness Expo, sponsored by Peninsula Regional Medical Center and the Wicomico County Convention & Visitors Association March 27 and 28, drew approximately 3,200 people to the two day event, which was the largest of its kind on the Delmarva Peninsula.

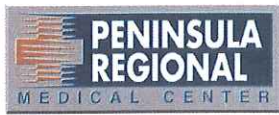
Many uninsured and underinsured individuals participated in the Health & Wellness Expo and were able to access over 30 different free health screenings and resources that were beneficial to their health and wellness. Those screenings included blood pressure, stroke assessment, vision, hearing bone density, skin cancer, diabetes risk assessment, cholesterol/blood glucose and foot care. The Medical Center’s Wagner Wellness Van was also in attendance serving as the screening location for hearing testing.

Community Flu Shots

The mission of the Medical Center is to “*Improve the health of the communities we serve.*” In fiscal year 2009, the Medical Center provided over 1,500 free flu shots to the communities in Wicomico, Worcester, Somerset and Sussex counties.

Altantic United Methodist Church/Diakonia/Phillips Restaurant – 100

Lower Shore Enterprises – 75



Salisbury Substance Abuse Center- 29
Laurel King's Methodist Church – 25
New Macedonia Baptist Church – 75
Homeless Community – 280
Salisbury Urban Ministries/God's Kitchen – 150
Wal-Mart – 51
Westside Fire Department – 13
Trinity United Methodist Church – 200
Oak Ridge Baptist Church – 80
St. James Free Methodist Church – 40
Weeping Mary Full Gospel Church – 20
Joseph House Crisis Center – 180
Village of Hope Clinic – 105
Three Lower Counties (TLC) – 46
Seton Center – 42
Hispanic Health Fair – St. Francis de Sales Church - 77

Wagner Wellness Van

The Wagner Wellness Van has multiple uses. It is on site at local community outdoor festivals with staff providing the following screenings: blood pressure, pulse oximetry, body fat analysis, grip strength, and vision. During FY 09 we screened **365** members of the community with varied "at risk" levels. ***(This only represents our van presence at major community initiatives, and does not represent the multitude of community appearances made by other Medical Center departments at health fairs on the Delmarva Peninsula.)***

In October 2008, in an effort to expand our mobile service to the at-risk and underserved populations, Peninsula Regional Medical Center formed a partnership with the Wicomico Health Department to offer diabetes, stroke and hypertension education and screenings to these populations (sites recommended by the health department). The van went out twice a month between October 2008 – December 2008 screening **80** at-risk community members.



From March 2009 - May 2009 we expanded this outreach effort to include Somerset County. The van was then scheduled to go out each Wednesday of the month, alternating between the two counties. During this time we experienced a decline in participants and, in May, as a collaborative agreement, we put this schedule on hiatus until such time a more definitive goal could be developed and staffing could be identified to support this schedule (i.e. determine what audience we should target: seniors, African Americans, Latino, and what additional screenings we should offer). Based on feedback from the community we have found that the public is better at managing their health care; they are more informed via the internet, and are now seeking more sophisticated services in mobile health outreach. However, during this time we did screen 79 at-risk community members.



APPENDIX 1

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

Peninsula Regional Medical Center makes every effort to make financial assistance information available to our patients including but not limited to:

- An annual notice regarding financial assistance will be published in a local, widely circulated newspaper.
- Appropriate notices will be posted in patient registration, financial services, the emergency department, labor and delivery and on the PRMC website.
- Individual notice to patients and other persons regarding our financial assistance policy are available at community outreach events, prenatal services, pre-admission, and admission.
- Information insert is included in every patient bill.
- Information pamphlet is provided to patients at registration.

Further detail information can be found in the attached policy found in Appendix 2.



APPENDIX 2

Peninsula Regional Medical Center Policy/Procedure

Finance Division

Subject: Financial Assistance

Affected Areas: Patient Accounting, Financial Services

**Policy/Procedure
Number:** FD-162

Policy:

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients, who, according to their diagnosis and/or their physician, cannot have their procedure postponed, will be helped with obtaining assistance from agencies. If no other assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Procedure:

When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, the following procedure will occur.

- 1) The Financial Data Form should be completed by staff to make initial assessment of eligibility.
- 2) Compare patient's income to current Federal Poverty Guidelines (on file with Collection Coordinator). The Collection Coordinator will get new guidelines as

APPENDIX 2

published in the Federal Register annually. If patient is not eligible, stop here and pursue normal collection efforts.

- 3) If eligible per Guidelines, send completed Financial Data Form and Request for Financial Assistance Form to patient/guarantor for signature. Patient should attach appropriate documentation and return to representative within 10 days.
 - a. If ineligible, forward to Collection Coordinator for determination. Collection Coordinator will inform patient as per 4.a.
- 4) Upon receipt of the financial assistance request, the Representative will review income and all documentation. The patient must be notified within two business days of their probable eligibility and informed that the final determination will be made once the completed form and all supporting documents are received, reviewed, and the information verified.

If the patient is over 200% of the Federal Poverty Guideline for household income, the patient is not eligible for financial assistance.

If the patient is under the income criterion, the patient may qualify for financial assistance.

If the patient is under the income criterion but has net assets that indicate wealth, the patient does not qualify for financial assistance. If the balance due is sufficient to warrant it and the assets are suitable, a lien will be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to hospital upon sale or transfer of the asset. Refer account to Collection Coordinator for filing lien.

Accounts over \$5,000 with net assets of less than the requested financial assistance will be reviewed on an individual basis to determine if a lien will be placed.

If eligible, request an itemized bill and forward all information to Collection Coordinator.

- a. If ineligible, the Representative will send the denied request back to the patient and resume normal dunning process and file denial with account. The denials will be kept on file in the collection office.
5. Collection Coordinator will review documentation.
 - a. If eligible, and under \$2,500, the account will be written off to financial assistance and the "Request for Financial Assistance" form finalized. One copy of the form is to be returned to the Representative who talked with

APPENDIX 2

the patient; and one copy is to be retained by Collection Coordinator. The Representative will call the patient and notify them of the final determination of eligibility.

- b. If eligible, and the balance is \$2,500 or above, the Collection Coordinator will get appropriate signature and continue as per 5.a.

Peninsula Regional's financial assistance policy is to review only those accounts where the patient or guarantor inquire about financial assistance or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the request process.

When patients indicate the inability to pay the total bill but will be able to pay a portion, an allowance may be made for the partial amount, if eligible, by following the above guidelines.

Pre-planned service may only be considered for financial assistance when the service is medically necessary. For example, no cosmetic surgery will be eligible. Inpatient, outpatient, emergency, and physician charges are all eligible.

Special exception – Financial assistance could be considered if patient is over income criterion, but has excessive medical debts. A letter of request must be presented by patient and reviewed by Patient Accounts Manager with Director of Patient Financial Services and appropriate documentation placed in the file. This may only be considered in cases of very large debt and no assets.

The patient/guarantor will be required to pay an amount equal to the amount his/her annual household income is over 200% of the Federal Poverty Guideline.

APPENDIX 2

Example: Patient's household consists of patient and spouse (2 people). Household annual income is \$26,750.

The sum of the household's self-pay accounts with Peninsula Regional is \$20,000.

200% of the Federal Poverty limit for a 2 person household is \$24,980.

Formula to determine amount eligible for financial assistance write off:

Household Income	\$26,750
Less Federal Poverty Limit	- <u>\$24,980</u>

Amount patient/guarantor must pay \$ 1,770

Account balance	\$20,000
Less amount patient/guarantor must pay	\$ <u>1,770</u>

Amount to written off to Financial Assistance	<u>\$18,230</u>
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Special exception – A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for PRMC's Financial Assistance program. In cases where PRMC is unable to obtain a provider number for a particular line of business (e.g., Physical Medicine), those accounts may be written off to Financial Assistance with verification of Medicaid eligibility.

Once a request has been approved, service three months before the approval and three months after the approval may be included in the adjustment if a written request is made by the patient/guarantor. If this should occur, a copy of the letter and original request should be attached to the original account and a copy should be retained by the Collection Coordinator. Service dates outside this six-month window may be included if approved by a Supervisor, Manager, or Director.

Financial assistance requests should be finalized through write-off in the month of service whenever possible.

APPENDIX 2

The following have authority as noted to make financial assistance adjustments to accounts; no other individuals may make adjustments:

- (1) Chief Financial Officer – Unlimited
- (2) Controller – Adjustments up to \$80,000.
- (3) Director of Patient Financial Services – Adjustments up to \$50,000.
- (4) Manager of Patient Accounts – Adjustments up to \$20,000.

Note: This policy was formerly part of FD-30 established in 11/85. Name was changed from Charity Care 8/05.

Date: 6/03 Split into policies FD-30 & FD-162.

Reviewed: 7/86, 7/89, 7/91

Revised: 9/88, 4/92, 6/93, 2/95, 8/97, 7/98, 9/99, 6/02, 6/03, 9/04, 4/05, 8/05, 5/09



APPENDIX 2

Peninsula Regional Medical Center Policy/Procedure

Finance Division

Subject: Self-Pay Follow-Up

Affected Areas: Financial Services, Patient Accounts

**Policy/Procedure
Number:** FD-141

Policy:

- A. Peninsula Regional Medical Center (the hospital) operates on an entirely non-discriminatory basis.
- B. No patient needing emergency or urgently medically necessary care will be denied service.
- C. Payment is due when services are rendered.
- D. In lieu of payment, the hospital will accept assignment of third party benefits when proof of coverage is presented at the time of registration.
- E. Any amounts not paid by third parties are the responsibility of the patient/guarantor.
- F. The hospital will make every reasonable effort to collect monies due through use of HIS tools, generally accepted collection/follow-up practices in accordance with all federal and state regulations; cognizant of the hospital's mission, corporate values, and in the spirit of exceptional customer service.
- G. After the hospital has exhausted reasonable efforts (mailing of statements, letters, and phone calls), accounts not paid will be referred to outside agencies and/or attorneys for further collection action.
- H. Outside agencies/firms may utilize accepted collection tools and processes up to and including reporting of debt to credit bureaus, pursuit of litigation and placement of liens and/or wage attachments, within the scope of all federal and state regulations; and cognizant of the hospital's mission and corporate values.

APPENDIX 2

- I. The hospital retains all rights and controls over accounts placed with agencies/firms.

Procedure:

- A. Accounts determined to be self-pay at the time of registration will be placed in financial class "P," statement code "U."
- B. Statement messages and collection letters will be sent as set up in the letter/statement parameters of the system.
- C. Accounts determined to be self-pay after insurance has paid a portion of the claim will retain the financial class initially assigned, but will be changed to statement code "R." Accounts determined to be self-pay after insurance has denied or rejected a claim will retain the financial class initially assigned but will be changed to statement code "Q."
- D. Upon receipt of payment and/or notice of denial/rejection, the statement code will be changed to "R" via account overview or automatically via the cash posting module.
- E. A demand letter will be generated explaining the reason the account is now considered self-pay.
- F. Additional statement messages and collection letters will be sent as set up in the letter/statement parameters of the system.
- G. In addition to automated statements and letters, accounts with large balances will be reviewed and calls made to the patient/guarantor to resolve the unpaid balance.
- H. All phone calls and interaction with the patient/guarantor will be documented in the Patient Accounts System.
- I. After a minimum of three (3) statements and/or letters and a period of sixty (60) days from the point of self-pay determination/notice, the account will be considered for referral of bad debt and placement with an outside agency/firm.
 1. Any placements prior to 60 days/3 statements are reviewed by a senior collector prior to acceptance as a bad debt.
 2. Any placements prior to 60 days/3 statements must be reviewed by the Patient Accounts Manager or his/her designee prior to transfer. After review, normal sign-off authority is to be used.



APPENDIX 2

Note: Policy changed from PA-9528 to FD-141 during 9/99 revision

Date: 4/79

Reviewed: 8/97, 7/98

Revised: 6/93, 2/95, 9/99, 5/09



APPENDIX 2

Peninsula Regional Medical Center Policy/Procedure

Finance Division

Subject: Collection Agencies – Use of

Affected Areas: Patient Accounting, Patient Registration

**Policy/Procedure
Number:** FD-166

Purpose:

To ensure only qualified, approved collection agencies are used by the Finance Division, and to ensure that our community image is not adversely affected by our collection practices to the extent possible.

Policy:

Collection agencies must be approved for use by the Chief Financial Officer prior to providing any services for the Finance Division.

Procedure:

The Controller will seek approval from the Chief Financial Officer for use of an agency for collection related functions. When adding or changing agencies, the Director of Patient Financial Services and the Controller will jointly review the need(s) and the agency's qualifications. The agency must agree to abide by the Medical Center's patient billing and legal practices. The significant portions will be described in a written document to be signed by the agency prior to their beginning service for the Medical Center.

Collection agencies may suggest legal action in concert with PRMC policy; however, no legal action can advance without the prior case-by-case sign-off by an authorized PRMC employee (including Collection Coordinator, A/R Supervisor, Director of Patient Financial Services, Controller).

Date: 11/04
Reviewed:
Revised:



APPENDIX 2

Peninsula Regional Medical Center Policy/Procedure

Finance Division

Subject: Adjustments to Bills, Bad Debt, and Other
(Uncompensated Care)

Affected Areas: Patient Accounting, Financial Services

**Policy/Procedure
Number:** FD-30

Policy:

Peninsula Regional Medical Center will make available to all patients the highest quality of medical care possible within the resources available. Finance is responsible for collection of accounts and through interaction with patients and based on procedure will make decisions regarding disposition of accounts.

Procedure:

Uncompensated care and other adjustments are any services given for which the medical center does not receive reimbursement. The following are examples of this:

1. Charity - Based on income and lack of substantial assets, the patient is not able to pay full charges. See policy on Financial Assistance, FD-162.
2. Bad Debt - The patient/guarantor does not qualify for financial assistance and/or patient has not cooperated in completing required forms or documentation for financial assistance or another type of uncompensated care; and/or the patient guarantor does not respond to phone calls or written correspondence.
 - a. Hospital, physician, unregulated.
3. Customer Service Reductions - Based on unmet needs or unfavorable conditions, some portion of charges are reduced.
 - a. Hospital, physician, unregulated.
4. HSCRC permitted discounts.

APPENDIX 2

- a. Hospital charges only.
5. Employee discount of 25%.
 - a. Hospital, physician, unregulated.
6. Denied days and charges due to non-acute status or not necessary.
 - a. Hospital charges only.
7. Out-of-state Medical Assistance amounts over their allowable, and total charges where Peninsula Regional cannot bill due to contractual discounts.
 - a. Hospital, physician, unregulated.
 - b. The hospital will have no contract for regulated services which includes hospital acceptance of less than full charge for any regulated charges. This does not preclude the hospital from billing out-of-state Medical Assistance MCO's and recouping partial reimbursement.
8. Amounts over allowable fees (does not pertain to hospital).
 - a. Physician and unregulated charges.
9. Contracted capitation limits.
 - a. Physicians and/or unregulated charges.
10. Risk management reductions.
 - a. Hospital, physician, unregulated.
11. Late charge allowance under \$50.
 - a. Hospital only.
12. Small balance write-off under \$10 and over 90 days old.
 - a. Hospital, unregulated.
 - b. \$5 for physicians.
13. Peninsula Regional Worker's Comp. and employee health, and physicals.

APPENDIX 2

- a. Hospital, physician, unregulated.
- 14. Medical Assistance unbillable due to billing time elapse.
 - a. Hospital, physician, unregulated.
- 15. Bad Debt adjustment, reduction of a bad debt balance.
 - a. Hospital, physician, unregulated.
- 16. Error Write-Offs – Write Offs resulting from not obtaining proper authorization, not following up timely, or any other reasons related to processing.
 - a. Hospital, physician, unregulated

Each category above will have associated transaction adjustment code(s) and will be recorded in the general ledger and financial statement.

The following have authority as noted to make adjustments to accounts, no other individuals may make adjustments:

- 1) CFO - Unlimited
- 2) Controller - Adjustments of any type up to \$80,000.
- 3) Director of Patient Financial Services - Adjustments of any type up to \$50,000.
- 4) Patient Accounts Manager - Adjustments of any type up to \$20,000.
- 5) Billing Supervisor/System Specialist - Insurance adjustments, late charges, with balances up to \$10,000.
- 6) Collection Coordinator - Adjustments of any type up to \$2,500; bad debt up to \$10,000.
- 7) Patient Accounting Coordinators or Exception Clerk - Adjustments other than bad debt and charity, up to \$2,500.
- 8) Physician Billing Reps. - Adjustments other than bad debt and charity, up to \$2,500.
- 9) Cashiers and Voucher Processor - Adjustments other than bad debt and charity, up to \$2,500.

BAD DEBT

Any account where the patient continues to refuse to pay, does not qualify for financial assistance, has not cooperated in completing required forms or supplying documentation for financial assistance or another type of uncompensated care; and/or the

APPENDIX 2

patient/guarantor does not respond to phone calls or written correspondence will be considered Bad Debt.

Normal collection process requires that a patient be given a minimum of 60 days from the first statement (which shows that the amount is now due from the patient) before referral to an outside collection agency. Exception to the 60-day rule may be made for repeated bad debt patients and for those who clearly state they will never pay.

A lien or wage attachment may be placed against the patient when other collection efforts fail.

A lien will be filed against the estate of every deceased adult patient with accounts totaling \$5,000 or more.

Body attachments (bench warrants) will not be used without the written permission of the Director of Patient Financial Services.

Accounts may not be written-off with the bad debt transaction code for any reason other than referral to an agency, filing of a lien, wage attachment, or bankruptcy.

OTHER

All Patient Accounting personnel are responsible for requesting necessary adjustments to bills. These should be recorded on the appropriate adjustment form and given daily to the Collection Coordinator (at end of month all adjustments must be turned in on next to last business day of month).

Discounts: The HSCRC has strict guidelines regarding discounts. Regulations are on file in the Budget & Reimbursement area.

Discounts in lieu of commercial insurance audits are not permitted.

Note: Section on Financial Assistance became policy FD-162 at 6/03 revision.
Date: 11/85
Reviewed: 7/86, 7/89, 7/91
Revised: 9/88, 4/92, 6/93, 2/95, 8/97, 7/98, 9/99, 6/02, 6/03, 9/04, 3/09



APPENDIX 2

Peninsula Regional Medical Center Policy/Procedure

Finance Division

Subject: Patient Payment Arrangements

Affected Areas: Emergency Admitting, Patient Registration
Patient Accounting, Financial Services

**Policy/Procedure
Number:** FD-53

Policy:

- A. Payment is due when services are rendered; charges related to medical necessity and delivery of emergency care are not required to be paid at time of service. We do not withhold emergency treatment based on payment.
- B. Every effort will be made to obtain payment in full, always keeping Peninsula Regional's Corporate Values and Customer Service Goals in mind.
- C. Patient/guarantors should be encouraged to use bank loans, credit cards and other financing options prior to establishing payment arrangements.
- D. In situations where patient/guarantor cannot pay balance due, payment arrangements will be made to clear the account.
- E. When proposed payments exceed twelve (12) months, the Financial Data Sheet must be completed in order to determine payments that are acceptable to both the patient/guarantor and the Hospital (if account is less than \$500 and will clear within one year data sheet does not need to be completed).
- F. Any account that will exceed three months to clear will be sent to an outside agency for contract monitoring.
- G. Liens may be filed against any real property where balances exceed \$5,000 and/or payment exceeds two years. If payment plan is followed, no lien will be placed.
- H. Payments large enough to clear the account as quickly as possible will be made.
- I. The minimum acceptable payment is \$25, if less a supervisor must approve (if the account will clear as in K, supervisor does not need to approve).

FD-53

APPENDIX 2

- J. Patients who fail to make payments as agreed will be transferred to bad debt and referred to agency.
- K. Authority to make payment arrangements is as follows:
- | | |
|---|-----------------|
| Billers, Collectors, Financial Service Reps, Registrars | Up to 12 months |
| Coordinators | 1 -- 2 years |
| Supervisors | 2 -- 5 years |
| Director of Patient Financial Services | 5 -- 10 years |
| Controller | Over 10 years |

Procedure:

- A. Requests for payment arrangements exceeding a staff member's authority (and all generated outside of Patient Accounts) will be written up on the Contract Pay Approval Form. Requests generated outside of Patient Accounts should be sent to the Collections Office which will follow through with the necessary remaining steps. All contracts should be filed in the Collections Office.
- B. Upon approval of payments, the account will be changed to Statement Code "I".
- C. Payment arrangement information will be entered under the Contract portion of the Account Overview Screen. The contract form letter will be sent to the patient/guarantor if account will be paid within three months. The I5 letter will be sent to patient/guarantor if account will exceed three months to clear.
- D. The outside agency sets up account for monitoring. If no payment has been made in sixty days, the account is then referred back to PRMC for investigation. Then if no payment, transferred to regular collections at the collection agency. The agency code should be changed to reflect the change in status. A record of this should be kept in the Finance area.
- E. Clear notes and comments related to the patient/guarantor's financial situation and payment negotiations will be entered in the system.
- F. Patients whose payments are delinquent 15 - 30 days will be sent Collection Letter I2 and the action documented in patient notes.
1. If payment is received, further action will not be necessary.
 2. If payment is not received within twenty days of the I2 letter, the account will be referred.



APPENDIX 2

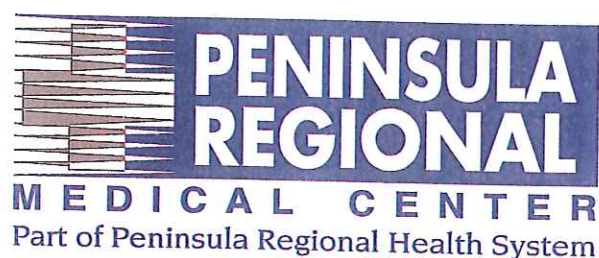
NOTE: 3/97 revision changed from Patient Accounting Policy to Finance Division Policy.

Date: 5/93
Reviewed: 7/98
Revised: 2/95, 3/97, 8/97, 9/99, 3/03, 11/04



APPENDIX 3

Peninsula Regional Medical Center is committed to the people of Delmarva. We strongly believe it is not just our job to care for you when you are ill but it is our mission to “improve the health of the communities we serve.”



MISSION

Improve the health of the communities we serve.



VALUES

- Respect for every individual
- Delivery of exceptional service
- Continuous improvement
- Safety, effectiveness
- Trust and compassion
- Transparency



VISION

As the Delmarva Peninsula's referral medical center, we will be the leader in providing a system of regional access to comprehensive care that is interconnected, coordinated, safe and the most clinically advanced. We will deliver an exceptional patient and family experience, while fostering a rewarding environment for physicians and employees. Together, Peninsula Regional Medical Center and its physicians will be a trusted partner in improving the health of the region.



Dimensions Healthcare System

**COMMUNITY BENEFITS REPORT
FOR THE FISCAL YEAR
JULY 1, 2008 – JUNE 30, 2009**

**Prince George's Hospital Center
3001 Hospital Drive
Cheverly, Maryland 20785
301-618-2000**

INTRODUCTION:

Prince George's Hospital Center (PGHC) has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 60 years, Prince George's Hospital Center has grown to become a major tertiary care center for the region and one of its largest employers. However, our greatest service to the community is that Prince George's Hospital Center is a private not-for-profit hospital with a tremendous public mission.

Prince George's Hospital Center was founded in 1944 and is an acute care teaching hospital and regional referral center located in Cheverly, Maryland. Prince George's Hospital Center is a member of the Dimensions Healthcare System.

Leadership: Chairman, Board of Directors – Ric MacPherson
CEO – G. T. Dunlop Ecker
President and COO – John A. O'Brien
Chief Nursing Officer – Ruby Anderson

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 266 (plus 40 bassinets)

No. of inpatient admissions: 16,308

No. of Employees: 1,460

Specialty services:

A comprehensive range of inpatient and outpatient medical and surgical services including:

- Emergency and trauma services (designated Level II regional trauma center for southern Maryland)
- Critical care services
- Cardiac care services (comprehensive cardiac care – only program of its kind in the County)
 - Open-heart surgery
 - Two cardiac catheterization labs (diagnostic & therapeutic cardiac caths, cardiac stenting)
 - 10 bed CCU and 66 telemetry beds
 - Cardiac diagnostic evaluation center

- Cardiac rehabilitation
- Laboratory and pathology testing
- Medical and surgical services (virtually all adult specialties performed)
- Maternal and child health
 - Labor and delivery postpartum units
 - Perinatal diagnostic center
 - Diabetes and pregnancy program
 - Neonatal intensive care unit (designated Level III, regional center for Prince George's County)
 - Inpatient pediatric unit
 - Chronic pediatric inpatient unit and outpatient program

Other specialty services:

- Ambulatory and outpatient services
 - Surgical short-stay center
 - Special procedures
 - Diabetes treatment center
 - Glenridge Medical Center (internal medicine, family practice, ob/gyn)
- Behavioral health services
 - Inpatient psychiatric unit for adults
 - Hospital-based sexual assault center
 - Partial hospitalization program
 - Emergency psychiatric services
- Graduate medical education, internal medicine residency programs

Facilities:

- Intensive services pavilion houses 10 operating suites, a 24-bed intensive care unit, cardiac catheterization labs and endoscopy suites.
- Emergency department includes 15 acute care rooms, 4-bed resuscitation area, 2 isolation rooms, an 8-bed ambulatory emergency area, 2 dedicated trauma rooms, a stat lab and blood bank.

Ownership:

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

Prince George's County Demographics:

According to the U.S. Census Bureau, 2006 American Community Survey (ACS), Prince George's County has an estimated population of 841,315, making it the second most populous jurisdiction in Maryland. The County, immediately north, east, and south of Washington, D.C. has a population that is 64.6% African-Americans, 22.7% White and reported as 11.7 % of Hispanic origin. Of all Maryland counties, this County has the

largest percent of its population who belong to either a racial or ethnic minority group. In addition, approximately 7.2 % of the population is under 5 years old and 74.3% of the population is age 18 years or over. Persons age 65 years and older represent 8.6% of the population.

Statistics from the ACS, 2006 report revealed that the median household income for County residents as of 2006 was \$65,851 (in 2006 inflation-adjusted dollars). This is above the national average of \$48,451 as well as slightly above the state average of \$65,144 reported by the 2006, US Census Bureau. Also reported in the ACS figures is that for the Prince George's population age 16 years and over, 73.5 % are in the labor force that is higher than the national average of 65.0%. The County poverty level sits at 7.7%, which is slightly below Maryland's average of 8.5%. Additionally, for the > age 25 population in Prince George's County 86.3% of this age group are high school graduates or higher as opposed to 84.1 % of the general US population.

Community Challenges & Health Statistics:

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians on comparison with national figures, the County does contain several pockets of low socioeconomic status. The 2005 CENSUS based Small Area Health Insurance Estimate data reveal that medically vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) number approximately 253,659.

According to the CDC document Summary Health Statistics of the U.S. Population: National Health Interview Survey (2004) being poor and uninsured are two of the strongest determinants of whether a person "did not receive medical care", or whether they "delayed" seeking care.

As a result, issues such as diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality all represent significant health challenges for community members. Furthermore, persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George's County Medicaid beneficiaries. County and Maryland State health statistics are in similar to national trends regarding the status of minority health. For example:

- **All cause mortality by race:** The Maryland Vital Statistics Administrations (MD-VSA), 2006 report reveals that African-Americans in Prince George's County have higher rates of mortality than whites for all-cause mortality and five others of the top eight causes of death for the County. In addition to all-cause mortality, the MD-VSA numbers of chronic disease deaths for Prince George's County reported as "significantly above the Maryland average" are associated with diseases of the heart and diabetes. The leading causes of death by race and sex (2006).

- **Age adjusted death rate for diabetes by race:** Racial and ethnic minorities have 1.5 to two times the prevalence of diabetes as non-Hispanic Whites for adults age 20 or older. Of Maryland counties Prince Georges is second to Baltimore City for the number of diabetes related deaths. These figures are from the 2006 MD-VSA. Examining the figures by racial groups, year 2000 age-adjusted African-American mortality rate (67.6 per 100,000) in the County is more than double that seen among County white residents (25.1 per 100,000) and is also significantly higher than the African American rate for Maryland (57.9 per 100,000).
- **Age adjusted death rate for heart disease:** The MD-VSA 2006 figures show that the death rate from heart disease is 1.55 times higher in African-Americans than in whites in Prince George's County.
- **Obesity:** BRFSS, 2007 data reveal that 68.8% of County adults are overweight (39.2 %) or obese (29.6 %). While African-American adults bear the brunt of this epidemic with a reported 75.2 % compared to 58.5 % of whites, it's a significant problem for both groups. Obesity's link with multiple cardiac risk factors (e.g. insulin resistance, diabetes, hypertension, hyperlipidemia, physical inactivity) along with other health problems (e.g. some cancers, degenerative joint disease, asthma, depression) is of concern. According to the County's 2002 Child and Adolescent Health Assessment, 33.7% of African American children age 2 to 19 in Prince George's County were overweight compared to 19.6% of their white counterparts.
- **Age adjusted death rate for strokes:** The MD-VSA 2006 figures show that the death rate from cerebrovascular disease is 1.48 times higher in African-Americans than in whites in Prince George's County. Furthermore, the County leads all others in Maryland for the numbers of "essential hypertension and hypertensive renal disease" deaths.
- **Age adjusted death rate for breast and prostate cancer:** African -American women have lower cancer incidence but higher cancer mortality than whites. Prince George's County has the third highest County figure for deaths from breast cancers. Prostate cancer deaths in the County are 2nd to Baltimore County.
- **Age adjusted death rate for HIV by race:** Figures reported by DHMH / AIDS Administration for Prince George's County show that the burden of cases is found in the mid-County inner beltway zip codes. Within Maryland the HIV mortality ratio disparity is greatest for African Americans who have 5.7 times the HIV death rate in comparison to whites. Also, the County's incidence and prevalence is second only to Baltimore.
- **Infant mortality by race:** Regarding a history of either late or no prenatal care this was the case for 6% of African American women compared to 3.4% of white women. Additionally, according to DHMH, the infant mortality rate for African-American infants is 10.8% as compared to 5.5% for white infants.

Identification of Community Needs:

- A Prince George's County Health Profile Snapshot Report was completed by PGHC in June 2006. The Report was generated as a result of a collaborative effort of PGHC and the Prince George's County Health Department.
- In March 2008, the PGHC Board of Directors established a Community Health Task Force (CHTF) committee. The CHTF includes collaborations with such organizations as the Prince George's County Health Action Forum and the Prince George's County Health Department. The purpose of the CHTF is to assist management in the development of relationships and a plan to work with identified community-based health services and to make an optimal range of services more widely available to improve community health status. To date, the CHTF has focused attention on community health needs, provided improved health information, and is currently working the National Institute of Health – National Library of Medicine (NIH – NLM) to identify sustainable community health delivery initiatives such as the NIH – NLM Consumer Health Resource Information Service (CHRIS) program.
- PGHC management has provided a tremendous amount of community health needs information to the Prince George's County Hospital Authority. The Authority is currently in the process of restructuring the Prince George's County healthcare delivery system.
- PGHC management has carefully reviewed the Prince George's County healthcare assessment report recently completed by the RAND Corporation for the Prince George's County Government.

**PRINCE GEORGE'S HOSPITAL CENTER
CHEVERLY, MARYLAND
HOSPITAL CENTER MEMORANDUM 5-5 JUNE 21, 2005**

CHARITY CARE

1. **PURPOSE:** To establish the Hospital Center's policy on the provision of charitable care.
2. **CANCELLATION:** This policy supercedes Hospital Center Memorandum 5-5, "Charity Care", dated January 28, 2000, which is canceled.
3. **POLICY:** Prince George's Hospital Center will, on an annual basis, provide charity care to those patients that qualify, in accordance with Public Health Services Act, 42 CFR, Part 124 (Hill-Burton) and/or the Hospital Charity Program.
4. **PROCEDURE:**
 - A. All patients/guarantors are given the individual notice regarding uncompensated care.
 - B. When a patient or potential patient requests charity care, the Hospital Center will supply the appropriate application forms to the patient.
 - C. The Hospital Center will make a written determination of eligibility within thirty (30) working days of receipt of the completed application.

ORIGINATOR: Business Office

DISTRIBUTION: Hospital Policy Manual
Vice Presidents
Directors/Dept. Managers

G. T. Dunlop Ecker,
President and CEO, Dimensions Healthcare System
Charity Care 5-5 (Revised: 6/21/2004, 1/28/2000, 3/1/1996)

PRINCE GEORGE'S HOSPITAL CENTER

COMMUNITY BENEFIT REPORT

July 1, 2008 – June 30, 2009

APPENDIX 1

**DESCRIPTION OF GAPS IN THE
AVAILABILITY OF SPECIALIST PROVIDERS**

Although Prince George's Hospital has one of the largest populations of uninsured patients in the State, we believe that all patients should receive the highest level of care regardless of economic standing. This goal can only be achieved with experienced specialist physicians caring for all of our patients even when so many of our patients cannot afford to pay. To overcome this obvious dilemma, we pay physicians to cover their bad debts so the "gap" exists in the hospital's profits but not in patient care. We get no funds from the regulated system to offset these physician payments but we will always put the patients first.

PRINCE GEORGE'S HOSPITAL CENTER

COMMUNITY BENEFIT REPORT

July 1, 2008– June 30, 2009

APPENDIX 2

DESCRIPTION OF FINANCIAL ASSISTANCE PROGRAM

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

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

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

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

PRINCE GEORGE'S HOSPITAL SYSTEM

COMMUNITY BENEFIT REPORT

July 1, 2008 – June 30, 2009

APPENDIX 3

FINANCIAL ASSISTANCE PROGRAM POLICY

See attached Dimensions Healthcare System Corporate Policy #200-41

APPENDIX 4

MISSION, VISION AND VALUE STATEMENT (POLICY)

See attached Dimensions Healthcare System Corporate Policy #200-24

MISSION, VISION, VALUES AND SERVICE PRIORITIES

MISSION

Our mission is to provide high quality and efficient healthcare services to preserve, restore and improve health status, in partnership with our community.

VISION

To be recognized as a premier regional healthcare system.

VALUES

Our values consistently show that Dimensions **CARES**. These values include:

- **Compassion** - We demonstrate care, concern and consideration for our patients, their families and each other. We take seriously our role as patient advocates. We strive to bring the “human touch” to all our interactions and help each other.
- **Accountability** - We take responsibility for our actions. We strive to achieve excellent results and accept responsibility for overcoming problems. We avoid blaming others. We never say “It’s not my job”. We are committed to honesty in words and actions.
- **Respect** - We treat all patients, visitors, and staff equally and with dignity. We show our respect by the courtesy we extend to everyone. We greet everyone politely and appropriately. We are forgiving of one another. We recognize the value, diversity and importance of each other, those we serve and the organization.
- **Excellence** - We show excellence in the way we strive to exceed expectations in everything we do. We demand competence and encourage professional and personal growth for every member of our healthcare team. We pursue excellence through teamwork, continuous improvement and prudent resource management.
- **Service** - We strive to do the “right thing” and ensure our actions are in line with our mission, vision and values. We are committed to understanding and meeting the needs and expectations of patients and customers.

SERVICE PRIORITIES

- **Safety** - We work to ensure that all employees, patients and visitors are protected from danger, risk or injury while on the premises of any Dimensions Healthcare System facility

DIMENSIONS HEALTHCARE SYSTEM
POLICY No. 200-24

APRIL 6, 2006

Page 2 of 2

- **Courtesy** - We strive to make each person we encounter feel important and respected. We pleasantly greet fellow employees, physicians, patients and visitors. We identify ourselves whether the encounter is in person or over the telephone.
- **Caring** - We empathize, show compassion and concern to those we encounter each day.
- **Efficiency** - We work collaborative and effectively, taking advantage of economies of scale when possible. We continually evaluate the effectiveness of procedures and processes.

APPROVED:

G. T. Dunlop Ecker
President/CEO

FINANCIAL ASSISTANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

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

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

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

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

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

PROCEDURE:

A. Identification of Potentially Eligible Patients:

- Admitting 1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:
- a) Routine and comprehensive demographic data.
 - b) Complete information regarding all existing third party coverage.
2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- Dir., PFS 4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. Determination of Eligibility:

- PFS 1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.
2. Requests for financial assistance may be received from:
- a. the patient or guarantor;
 - b. Church-sponsored programs;
 - c. physicians or other caregivers;
 - d. various intake department of the institutions;
 - e. administration;

- f. other approved programs that provide for primary care of indigent patients.
 - 3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.
 - 4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.
 - 5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.
 - Dir., PFS 6. Approval for financial assistance for amounts up to \$50,000 should be approved by the Director of Patient Financial Services. Those greater than \$50,000 should be approved by the CFO.
 - PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).
 - 8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee's review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).
 - 9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.
- C. Notification of Eligibility Determination:**
- PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

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

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

D. Availability of Policy:

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

E. Application Forms:

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

F. Monitoring and Reporting:

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

- a. account number,
 - b. date of service,
 - c. application mailed (y/n),
 - d. application returned and complete (y/n),
 - e. total charges,
 - f. self-pay balances,
 - g. amount of financial assistance approved,
 - h. date financial assistance was approved.
2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

G. T. Dunlop Ecker
President & Chief Executive Officer

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

ATTACHMENT:

Application for Financial Assistance

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
<i>Liquid Assets</i>	
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

**HSCRC Community Benefit Narrative
St. Agnes Hospital
Fiscal Year 2009**

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

St. Agnes Hospital was licensed for a total of 307 beds in fiscal year 2009. The Hospital had 23,367 admissions in FY 09.

2. Describe the community your organization serves. The narrative should address the following topics:

Describe the geographic community or communities the organization services:

St. Agnes serves the following geographic areas:

- Baltimore City (Including the South, West and Southwest areas of the City)
- Baltimore County (Woodlawn, Catonsville and Arbutus areas)
- Northern Anne Arundel County (Brooklyn, Linthicum, Glen Burnie and Pasadena)
- Northern Howard County (Ellicott City)
- Southern Carroll County

Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates)

Please refer to section V. *Community Health Indicators* of the included Community Needs Assessment (Appendix 5) for an in-depth analysis of the demographic features of St. Agnes' service area.

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done

St. Agnes completes a formal community needs assessment every three years to identify the health needs of its community. The assessment is driven by quantitative review of data in relation to the communities' demographic trends, socioeconomic status, and health status indicators that include chronic disease, maternal and infant health, major disease prevalence, and health resource utilization/needs. The analysis uses readily available data sets across 41 indicators and a comparative methodology to evaluate community performance in relation to the Central Maryland average. Based on the

assessment, community needs are prioritized and action plans are developed. The last community needs assessment was done in the spring of 2007. This document is attached as appendix 5 for the HSCRC review.

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

At the time Saint Agnes completed its most recent Community Needs Assessment, the Baltimore City Health Department did not have a comprehensive community needs assessment for Baltimore City in place. Subsequently, Saint Agnes did participate with the Baltimore City Health Department in Winter/Spring of 2008 when the Department did conduct a comprehensive community assessment. Saint Agnes participated in Task Force established by then Baltimore City Health Commissioner Dr. Joshua Sharfstein, M.D. (?) to assist with identification of community health assessment methodology.

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

Based on the 2007 Community Needs Assessment, St. Agnes has identified two primary goals its community health program to improve access to care and reduce medical disparities. As such, over the course of the next several years St. Agnes will refocus its existing community health resources to align with the identified goals and implement programmatic initiatives to address prioritized needs and develop performance-based outcomes measures for those programs.

1. To **improve access to care** St. Agnes will embark on the following objectives:
 - ❖ Capitalize on Baltimore Medical Systems and Maryland Physician Care (Medicaid HMO) relationships to promote and align the uninsured and underinsured in the service area with these two organizations.
 - ❖ Utilize platform of Mission Health Partners to promote and advance community health agenda through collaborative efforts.
 - ❖ Through the Advocacy Plan, function as a catalyst between community leaders, local business, and City and State government agencies to address transportation barriers that limited access to St. Agnes campus.
2. To **reduce medical disparities** St. Agnes will reposition its community education and screening programs to focus on cancer, cardiovascular, diabetes/obesity, and infant mortality within geographic areas where it can achieve meaning, measurable, and sustainable improvements in individual and community health status. Community health outcome measure will be established, tracked, and reported on annual basis.
 - ❖ Primary Geography: 21229 – Carroll Park
 - ❖ Secondary Geography: 21223 – Baltimore City & 21230 – Baltimore City

❖ Tertiary Geography: 21227 – Arbutus & 21228 – Catonsville

3. To address other needs that impact health status, continue to serve as catalyst to facilitate community dialogue with community leaders, local and state government, private sectors, and others that results in collaborative partnerships and networks to implement solutions.

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

Saint Agnes established a multi-disciplinary group of community health providers, physicians, and members of leadership team to review and recommended community health need priorities based on the comprehensive community health needs assessment. The community health need priorities were reviewed and approved by the hospital's Executive Team as well as the Board of Directors Planning Committee (comprised of broad physician representation including primary care, cancer, cardiovascular, orthopedics, general surgery, and general medicine) and the Board of Directors.

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

The following Community Benefit Initiatives respond to identified community health needs:

- i. Federally Qualified Health Center (FQHC) partnership with Baltimore Medical System, Inc. This partnership preserved service area access to primary (adult internal medicine, OB/GYN, and Pediatrics) for the uninsured and underinsured in Southwest Baltimore region.
- ii. Morrell Park Wellness Center: A faith-based partnership provides health screening and preventive education classes for residents in Morrell Park community.
- iii. Red Dress Sunday: Comprehensive annual health education event in partnership with faith-based churches targeted to African-American women to address disparities screening, diagnosis, and treatment for heart disease. In 2008, Saint Agnes Hospital collaborated with Providence Hospital to expand this event into areas of Prince George's County and Washington, D.C.
- iv. African American Heritage Festival and African American Men's Health Conference: Events providing screenings, education and counseling. Addressed the health disparities that exist in the African American Community (cancer and cardio vascular disease).
- v. Woman to Woman, Heart to Heart: Event co-sponsored with Mid-Atlantic Cardiovascular Foundation focusing on heart health awareness geared towards African American Women. The event provided screenings, education and counseling to nearly 100 women.

- 7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.**
For example: for each major initiative where data is available, provide the following:
- a. Name of initiative:***
 - b. Year of evaluation:***
 - c. Nature of the evaluation: (i.e., what output or outcome measures were used);***
 - d. Result of the evaluation (was the program changed, discontinued, etc.); or***
 - e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?***

Cardiovascular Health

Despite a decline in the heart disease mortality rate in Baltimore since 2000, city residents are still roughly 30 percent more likely to die from the disease than residents elsewhere in the state. St. Agnes has made amazing strides in preventing and treating this deadly condition through education and clinical program development. A community initiative centered on cardiovascular health awareness is blood pressure screenings provided at no cost at various locations in the service area. During fiscal year 2009, over 2,600 screenings were performed at 13 locations. Screenings are provided on both an on-going and one-time basis for participants. Participants identified as “at-risk” are provided prevention education and encouraged to return for on-going screenings. The on-going screenings and education for these participants has a positive impact on the rate of “at risk” screenings as evidenced in the table below. The results demonstrate that prevention and education provided through these screenings are effective tools in promoting cardiovascular health. St. Agnes plans on continuing these valuable screenings as part of its overall mission to address this community need.

FY 2009 Blood Pressure Screenings	One-Time Screenings	On-Going Screenings
Total Screenings	1,080	1,413
At Risk Screenings	250	12
Rate of At Risk Screenings	23.1%	0.8%

Obesity

An estimated 25 percent of Maryland adults are obese, and of those, 14 percent are morbidly obese – 100 pounds or more overweight. Numerous studies demonstrate a strong link between obesity and the risk for chronic health problems such as heart disease, type-2 diabetes, cancer, stroke, asthma and arthritis. Through its bariatric surgery program, which treats more patients than any other in the state, St. Agnes has been extremely effective not only in battling morbid obesity, but in reducing the co-morbidities that come with it.

As part of its goal to decrease obesity, St. Agnes provides weight loss education seminars throughout the community. In fiscal year 2009, over 750 members of the community attended these outreach seminars. The goal of these seminars is to educate people on the health risks associated with obesity and provide options regarding weight loss surgery. Attendees that can benefit from weight loss surgery are referred to St. Agnes' program. St. Agnes' various weight loss surgery procedures can greatly reduce patients' body mass index (BMI) leading to a decrease in co-morbidities responsible for various chronic health problems (see table below). The program has been such a success in terms of outcomes and patient satisfaction that it is recognized as a Center of Excellence by the American Society for Metabolic and Bariatric Surgery and several third-party insurance companies.

FY 2009 Avg BMI	Initial	1 Month	3 Months	6 Months	1 Year	Avg Loss after 1 Yr
Bypass	49.9	45.5	41.6	37.5	34.1	(15.9)
LapBand	44.8	42.2	40.7	39.5	38.2	(6.6)
Sleeve	47.4	43.5	39.3	35.9	35.7	(11.7)

Cancer Awareness and Treatment

The American Cancer Society estimates that more than half of all cancer deaths could be prevented if people adopted cancer prevention measures, including receiving routine check-ups, living a healthy lifestyle, and having an awareness of the early signs of cancer. Cancer can be discovered early or prevented altogether through periodic check-ups and screening procedures. Cancer screening tests are recommended to the public at certain baseline ages to detect and remove cancer in its earliest and most curable stage. St. Agnes provides a number of free screenings that target those cancers most prevalent in the community – breast, lung, colon and prostate cancers. The table below summarizes the screenings provided by St. Agnes in fiscal year 2009 and the cases referred for additional follow up because of abnormalities.

FY 2009 Cancer Screenings	Colonoscopies	CT Scans - Lung	Prostate Exams
Total Screenings	53	554	52
Referred for Additional F/U	14	54	17

Infant Mortality

Mothers and children make up one of the most vulnerable populations in the St. Agnes service area. An estimated 40 percent of children in the areas we serve live in poverty, which has far-reaching implications for their health. Teen pregnancy, lack of adequate prenatal care, low birth weight and birth defects create increased demands for health care. In fiscal year 2009, St. Agnes continued its long tradition of providing vital OB/GYN and pediatric care to these underserved patients.

There are several examples of St. Agnes' continued initiative to serve this vulnerable population. Two full-time, in-house perinatologists joined the medical staff in 2009 making high-risk OB services more accessible to our community. St. Agnes continues to provide Spanish-speaking OB/GYN services at the Esperanza Center, a resource center in Fells Point for new immigrants to the Baltimore area. Through its strong relationship with Baltimore Medical System, a federally qualified health center, St. Agnes provides perinatal, OB/GYN and pediatric services to uninsured and underinsured women and children in the community this past year.

As a result of these initiatives, steady improvement can be seen in key indicators measuring access and outcomes. Hispanic births increased from 150 in 2008 to 186 in 2009, a 24% increase. The Hospital's percent of Medicaid neonatal discharges increased from 39% in 2008 to 43% in 2009. In terms of health outcomes, the severity of neonate cases measured by the APR-DRG system decreased 2.0% in fiscal year 2009. St. Agnes believes these already favorable results will continue to show improvement as these initiatives take further hold in the community.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

St. Agnes Hospital currently has the 4th-busiest Emergency Department (ED) in the state. Like many urban-based hospitals with significant ED volumes, a large proportion of the indigent and charity care provided by the hospital overall is generated through the ED. The increasing community need for indigent care coverage through the ED, coupled with declining physician reimbursement and greater malpractice exposure, has created greater "gaps" in the availability of specialist physicians to treat these patients. Consequently, mission-based hospitals like St. Agnes, with an imperative to care for the poor and underserved, feel a duty to respond to fill in these gaps.

Specifically, various physicians who are not being compensated for their services to this at-risk community have sought assistance from the hospital, which receives at least a portion of their uncompensated care in rates. For FY09, this subsidy paid by the hospital for this coverage amounted to almost \$1.5 million.

9. If you list Physician Subsidies in your data, please provide detail.

Costs in the table below have been included in line "C5 – Physician ED Indigent Care Subsidies".

Specialty	Annual Stipend
Hand Surgery	\$94,800
Orthopedic Surgery	182,500
Thoracic Surgery	18,250
Vascular Surgery	36,500
Podiatry	36,500
ENT	225,000

Plastic Surgery	80,100
Urology	109,500
Neurosurgery	127,750
General Surgery	183,000
Pediatric Surgery	185,700
Total Subsidy	\$1,279,900

In addition, St. Agnes further compensates specialist physicians for serving poor and vulnerable populations in our FQHC-based Community Clinic. These portions have been included in line “C5 – Community Care Center”.

Specialty	Annual Stipend
OB/GYN, Peds and Primary	\$126,580
Dermatology	11,700
Ophthalmology	3,500
Orthopedic Surgery	49,450
Plastic Surgery	16,200
Podiatry	11,125
Total Subsidy	\$233,055



Community Needs Assessment

April, 2007

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I. Executive Summary

Our Call to Action is clear...Health Care That Works, Health Care That is Safe, and Health Care That Leaves No One Behind. The cornerstone of this mission is providing access to quality healthcare for all.

Beginning in 1862, and continuing over the last 144 years, St. Agnes Hospital has been providing for the health care needs of the communities of Southwest Baltimore. The 2006 Community Needs Assessment will be a valuable tool to provide focus and direction to our Call to Action.

This assessment is about improving health - the health of individuals, families, and communities. The objective of the assessment is to evaluate the health status of the people residing in the communities surrounding St. Agnes Hospital and to identify the geographic regions and populations within the service area that have higher needs for service improvements. The assessment will be completed through four steps, updating community needs, identifying priorities, establishing goals and funding requirements, and finally integrating goals and requirements into the Integrated Strategic Financial Plan.

The assessment is driven by quantitative review of data in relation to the communities' demographic trends, socioeconomic status, and health status indicators that include chronic disease, maternal and infant health, major disease prevalence, and health resource utilization/needs. The analysis uses readily available data sets across 41 indicators and a comparative methodology to evaluate community performance in relation to the Central Maryland average. Central Maryland, defined as Harford, Baltimore, Carroll, Howard, and Anne Arundel Counties, as well as Baltimore City, is compared against the communities within the St. Agnes service area.

In addition to identifying the communities of the service area with the greatest health needs, the study also illustrates the relationship between socioeconomic status and health status. This finding highlights the persistent and challenging barriers to health care that go beyond traditional definition of access and include financial, cultural, and environmental factors. These major social issues will likely represent the greatest challenge to health care providers. There are insufficient resources within the health care system to address these issues. Yet, the health care system itself will continue to be impacted as these conditions further erode the health of the individuals and communities that we serve. To address the complex array of influences that determine health, St. Agnes will need to invest its time and talent in health care issues as well as acting as a catalyst for community advocacy and partnerships to provide:

**Health Care That Works,
Health Care That is Safe,
Health Care That Leaves No One Behind**

II. Introduction & Background

Beginning in 1862, and continuing over the last 144 years, St. Agnes, through the sponsorship of the Daughters of Charity, has been providing for the health care needs of the communities in Southwest Baltimore. For the Daughters of Charity, the mission in Baltimore is a continuation on their centuries-old ministry of health care begun by St. Vincent de Paul and St. Louise de Marillac in Paris, France. The first Catholic hospital in Baltimore, St. Agnes was originally created to provide nursing care for the poor. Over the course of its history, the hospital has adapted itself to meet the health needs of the communities served. While initially formed as an acute care hospital, for a brief period St. Agnes was reorganized as a sanitarium, and then reverted back to a full-service hospital in 1906. Originally located on Lanvale Street in Baltimore City, St. Agnes moved to its present location in 1876. A replacement facility was planned and constructed in the late 1950's and opened in 1961.

Throughout its history, regardless of location or organizational model, the essential element of St. Agnes has been its dedication to addressing the health needs of the communities served, especially for the sick poor. This core focus echoes in the Mission Statement adopted by the Board of Directors in 2000.

We, St. Agnes Healthcare, commit ourselves to spiritually-centered health care which is rooted in the healing ministry of Jesus.

In the spirit of St. Elizabeth Ann Seton, and in collaboration with others, we continually reach out to all persons in our community with a special concern for those who are poor and vulnerable.

As a Catholic healthcare ministry and member of Ascension Health, we are dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve. We are also called to advocate for a just society.

Through our words and deeds, our ministry is provided in an atmosphere of deep respect, love and compassion.

The objective of the 2006 Community Needs Assessment is to evaluate the health status of the people residing in the communities surrounding St. Agnes Hospital and to identify the geographic regions and populations within the service area that have higher needs for health care services.

The 2006 Community Needs Assessment will be completed through four steps. The first step, or assessment phase, includes a review of health status indicators from readily available data sources to establish overall need of the communities that comprise St.

Agnes's primary and secondary service area. This report represents the completion of the health assessment phase. The Community Needs Committee will use this report to identify and prioritize community health needs, and then establish community benefit goals and resource requirements, which represent the second and third steps. The final step involves integrating goals, outcomes and funding requirements into the FY08-FY12 Integrated Strategic Financial Plan (ISFP).

St. Agnes Hospital serves a wide variety of communities within its service area. These communities range from those that are completely urban, to those that are largely rural; as well as those that are very affluent to those that are extremely poor. This varying population, along with rising costs of healthcare and insurance, creates an environment where health care is more accessible to some than others. It is important, however, not to generalize the needs of each community as many of them are made up of diverse populations themselves. As a result, there are varying levels of health care needs within communities as well.

The existence of disparities is a common trend in health care throughout the country. These disparities refer in general to the higher rates of chronic illness as well as the barriers to health care experienced by minority populations. The different socioeconomic and environmental backgrounds among different populations, creates variations in access to health care. The inclusion of racial disparities in this assessment provides a more accurate picture of which factors are driving high levels of need within each community. Furthermore, this allows the comparison of similar populations from one community to another, highlighting the influence of socioeconomic factors on health care needs. To accomplish this, indicators throughout this study are divided into white and nonwhite, allowing the rates of hospitalization to be relative to the total white and nonwhite population of each community.

As noted in the St. Agnes HealthCare Mission Statement, our goal is, "*the art of healing to sustain and improve the lives of the individuals and communities we serve.*"

However, the actions of St. Agnes alone will not improve the health of the service area.

Rather, St. Agnes must recognize themselves as part of a larger, systematic approach to health improvement. Through this assessment process, St. Agnes must serve as a catalyst to encourage health care providers, local government, voluntary agencies, business leaders, and the community leaders of Southwest Baltimore to join in coordinated efforts to achieve measurable community health status improvements. Collectively, this report should inspire efforts that promote healthy behaviors, create healthy environments, and increase access to health care services.

III. Assessment Methodology

Similar to the 2003 Community Needs Assessment, this assessment is driven by a quantitative review of data in terms of the communities' demographic trends, socioeconomic status, health status indicators that include chronic disease, maternal

and infant health, major disease prevalence, and health resource utilization/needs. Also, as in the 2003 study, the focus of this assessment is directed to health indicators. While it is recognized that issues beyond the traditional boundaries of health, such as crime rates and other environmental factors, are important to the overall health status of a community, the inclusion of these factors tends to “muddy” the waters and diminishes the overall effectiveness of our actions. As a large regional health provider, St. Agnes is best suited to address and respond directly to health care needs as opposed to addressing larger social issues that impact health status. For the social issues, the assessment highlights where St. Agnes should focus its future advocacy initiatives as well as those areas where it could be a catalyst for broader community action.

To understand the health status of a population, it is essential to evaluate the consequences of the determinants of health. Seventy percent of all premature deaths are a factor of individuals’ behaviors and environmental factors. Individual biology and behaviors influence health through their interaction with each other and with the individuals’ social and physical environments (Healthy People 2010.) This interaction is displayed in the Figure 1.

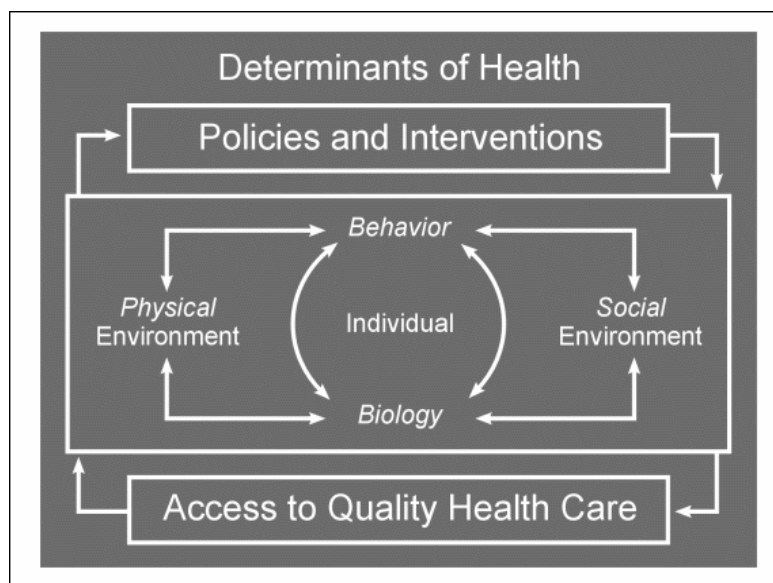


Figure 1 – Source: *Healthy People 2010*

The health status of a community can be measured by a variety of methods. These include birth and death rates, life expectancy, quality of life, morbidity, health insurance coverage, health resources availability, and population data. To the extent possible, this assessment seeks to consider many of these areas.

For the purposes of this assessment, health status indicators have been selected in four key areas: demographics, socioeconomic status, health status, and health resource utilization/physician manpower needs. To support the analysis, readily available data

was gathered utilizing the 2000 U.S. Census, Maryland discharge databases for inpatient and emergency services, and population forecast.

The health status indicators included in the assessment include:

1. Demographics
 - Population Density
 - Population Age ≤ 5
 - Population Age ≥ 65
 - Female Population Age 15-44
 - Female Population Growth Age 15-44
 - Population Growth Age ≥ 75
 - Minority Population
2. Socioeconomic Status
 - Percent of Households (HH) in Poverty
 - Children Living in Poverty
 - Average HH Income
 - Population of Uninsured
 - Population Age 18-24 without High School Diploma
 - Total Population without High School Diploma
 - Population with Disabilities
 - Unemployed Civilian Labor Force
 - Level of Rental Housing
 - Level of Vacant Housing
3. Health Status
 - Ambulatory Sensitive Hospitalizations
 - Asthma
 - Congestive Heart Failure (CHF)
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Diabetes
 - Hypertension
 - Pneumonia
 - Maternal and Infant Health
 - Level of Births to Teens Moms
 - Level of Low Birth Weight Infants ($< 2,500$ grams)
 - Level of Birth Defects
 - Level of Infant Mortality
 - Level of Births with Insufficient Prenatal Care
 - Major Disease Prevalence
 - Cancer Discharges per 1,000 Population
 - Cardiovascular Discharges per 1,000 Population
 - Stroke Discharges per 1,000 Population

- Lifestyle Behaviors (Inpatient & Emergency Discharges)
 - Obesity
 - Mental Health
 - Substance Abuse
 - Tobacco Use
 - HIV
- 4. Health Resource Utilization and Physician Manpower Need
 - Acute Care Discharges per 1,000 Population
 - Acute Care Inpatient Days per 1,000 Population
 - Outpatient Emergency Visits per 1,000 Population
 - Primary Care Physician Need
 - Specialty Care Physician Need

This assessment provides a comparative analysis of the communities that comprise St. Agnes's service area. The primary methodology utilized is a ranking of the community scores for each indicator against the Central Maryland average. An index is created where 1.0 is the average of Central Maryland. In the analysis, any score above 1.0 is worse than the average and anything below 1.0 is better than average. Composite scores are developed for each of the four major assessment areas and these are then summarized to generate a composite "overall need" index. This methodology is modeled after the approach formerly utilized by the Maryland Department of Health and Mental Hygiene for the statewide Primary Care Access Plan.

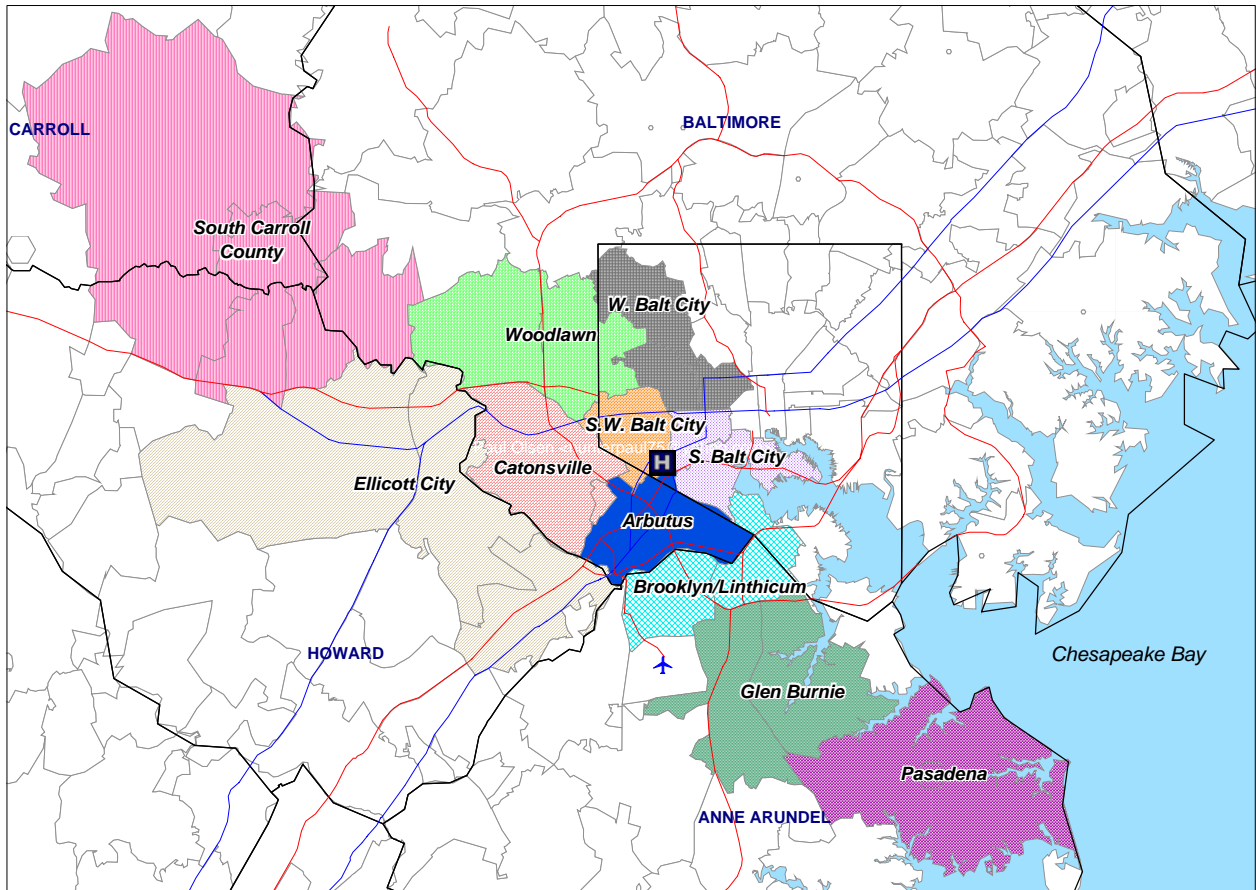
IV. Study Area Community Profiles

The areas surrounding St. Agnes have a diverse socioeconomic composition with a mix of urban and suburban communities that are consistent with the range of communities found in any large metropolitan region. For St. Agnes, the challenge of serving these communities lies in meeting the different needs associated between some of the poorest and most affluent neighborhoods in Central Maryland all located within a 3-mile radius of the Caton and Wilkens campus. A further challenge is the rapidly changing composition of the neighborhoods located most immediate to St. Agnes. Over the last five years, these communities have experienced degrees of urban blight reminiscent of Baltimore's inner city prior to its renaissance of the 1970s and 1980s.

For the purpose of this assessment the zip codes that comprise the St. Agnes service area have been grouped to create homogeneous populations. The grouping resulted in 11 communities identified. These are shown in the Table 1A and 1B as well as on the map located on page 8.

Community Needs Assessment Study Area - Definition Table 1A		
Community Name	Zip Code(s)	County
Arbutus	21227	Baltimore
Brooklyn/Linthicum	21225, 21090	Anne Arundel & Baltimore City
Catonsville	21228, 21250	Baltimore
Ellicott City	21042, 21043, 21075	Howard
Glen Burnie	21060, 21061	Anne Arundel
South Carroll	21104, 21163, 21784	Baltimore, Carroll, and Howard
Pasadena	21122	Anne Arundel
South Baltimore City	21223, 21230	Baltimore City
Southwest Baltimore City	21229	Baltimore City
West Baltimore City	21215, 21216, 21217	Baltimore City
Woodlawn	21207, 21244	Baltimore & Baltimore City

COMMUNITY NEEDS ASSESSMENT: HEALTH SERVICE AREA



**Community Needs Assessment
Study Area Community Profiles
Table 1B**

Community	Zip Codes	Description
Arbutus	21227	Older suburban community of 10.7 square miles with visible signs of urban decay located just south of Caton & Wilkens campus. Traditional blue collar with lower-middle to middle income; average education level; minimal minority population; greater concentration of seniors; declining population growth for females 15-44 and mildly growing total population.
Brooklyn/ Linthicum	21225 21090	Urban/older suburban community of 13.3 square miles located southeast of the Caton & Wilkens campus. Traditionally, largely an industrial area blue collar community has transition to much poorer community with higher than average levels of HHs below 200% of poverty level; higher than average uninsured; lower education levels; higher than average concentration of seniors; minimal minority population; flat population growth and significant population declines for females 15-44.
Catonsville	21228 21250	Older suburban community of 16.8 square miles located just west of the Caton & Wilkens campus. Traditionally, a white collar community has undergone a suburban renaissance as housing stock is rehab'd by new families; very significant senior population due to presence of Charlestown; lower than average minority population; higher than average education level; projected with better than average total population growth and stable population of females 15-44.
Ellicott City	21042 21043 21075	Suburban community of 68.4 square miles located west-southwest of the Caton & Wilkens campus. Largely a white collar bedroom community for Baltimore-Washington DC region has experienced significant population increases over last decade; minimal minority and senior populations; upper-middle to upper income levels; above average education levels; rapid growth projected across most population cohorts.
Glen Burnie	21060 21061	Older suburban community of 25.7 square miles located to the southeast of the Caton & Wilkens campus. Traditionally a blue collar community, Glen Burnie has been challenged with aging suburban infrastructure. Lower concentration of seniors; minimal minority population; average education level; average income level; better than average projected population growth.

**Community Needs Assessment
Study Area Community Profiles
Table 1B**

Community	Zip Codes	Description
South Carroll	21104 21163 21784	Suburban community of 93.6 square miles located to the northwest that is geographically the farthest from the Caton & Wilkens campus. Traditionally a very rural community, over the past decade has increasingly transition to a bedroom community for Baltimore-Washington DC region; above average income and education levels; minimal population of seniors or minorities; projected for continued significant growth across all populations.
Pasadena	21122	Suburban community of 30.8 square miles that is geographically the farthest community southeast of the Caton & Wilkens campus. Largely a bedroom community with substantial growth over the past decade; minimal population of seniors or minorities; upper-middle income, above average education level; significant population growth forecasted.
South Baltimore City	21223 21230	Older inner city area of 8.6 square miles located east-southeast of Caton & Wilkens campus. Largely, low income community with higher than average concentration of HHs living in poverty and uninsured; higher than area average population of minorities; lower than area average senior population; lower education level; significant projected population declines, especially for females 15-44.
Southwest Baltimore City	21229	Older suburban community of 6.1 square miles that is home of Caton & Wilkens campus and rapidly transitioning to a more urban character; many neighborhoods struggling with urban decay; significant senior and minority populations above area average; significant portion of HHs living in poverty; high concentration of uninsured; lower education levels; moderate decreases projected across most population cohorts.
West Baltimore City	21215 21216 21217	Older inner city area of 12.3 miles located northeast of the Caton & Wilkens campus. Largely an African-American community, challenged with all the social issues of an urban inner city area. Significant senior population; greater than half of HHs live in poverty; large concentration of uninsured; lower education levels; significant decreases projected across all population cohorts, especially females 15-44.
Woodlawn	21207 21244	Suburban community of 23.6 square miles located northwest of the Caton & Wilkens campus which experienced significant housing expansion over the last decade. Largely an African-American community; lower than area average senior population; middle income level; better than average education levels; stable population of females 15-44; moderate population

Community Needs Assessment Study Area Community Profiles Table 1B		
Community	Zip Codes	Description
		growth projected.

As shown in Table Two, based on FY 06 data, the study area generates 81% of total discharges for St. Agnes. The communities of Arbutus and Catonsville rely heavily upon St. Agnes for their inpatient health care needs, at 47% and 53% respectively. The next greatest level of community reliance is from Southwest Baltimore City (21229) at just over 41%. However, examining discharge trends from FY 03 to FY 06, St. Agnes has

Community Needs Assessment SAHC Study Area Volume Profile Table 2					
Community	FY06 SAH Cases	SAH Market Share	Mkt Shr % Point Chg FY03-06	SAH Dependence	SAH Chg Dependence FY03-FY06
Arbutus	2,694	47.2%	-3.0%	11.4%	-1.2%
Brooklyn/Linthicum	691	7.4%	-0.4%	2.9%	-0.2%
Catonsville	3,945	53.2%	-3.1%	16.6%	-1.3%
Ellicott City	1,360	15.7%	0.9%	5.7%	0.2%
Glen Burnie	553	4.1%	-0.2%	2.3%	-0.6%
South Carroll	304	5.6%	1.6%	1.3%	0.2%
Pasadena	324	4.0%	0.4%	1.4%	-0.2%
South Baltimore City	2,215	14.6%	0.0%	9.3%	-1.1%
Southwest Baltimore City	3,975	41.2%	0.0%	16.8%	-0.7%
West Baltimore City	1,645	5.1%	1.5%	6.9%	0.8%
Woodlawn	1,443	11.1%	0.6%	6.1%	-0.1%
Total	19,193	15.0%	0.1%	80.9%	-4.1%

experienced an increasing reliance from nearly all communities in the study area, most notably, South Carroll and West Baltimore City. However, there was a decrease of market share in St. Agnes's two most reliant communities, Arbutus and Catonsville. This shift in community reliance has significant clinical service mix and financial implications.

St. Agnes is dependent upon four communities for 55% of its total discharges:

Catonsville (16.6%), Southwest Baltimore City (16.8%), Arbutus (11.4%), and South Baltimore City (9.3%). Although market share in key communities has decreased, overall market share remains stable. As dependence on these key communities is reduced, it is stabilized by the higher percentage of volume seen from Howard County.

Of all St. Agnes cases, 8.4% now come from Howard County, increased from 6.6% in 2003. The increased dependence may be partially due to the addition of the OB-GYN group based in Howard County.

V. Community Health Indicators

Demographic Characteristics

The demographic characteristics of the communities (Table 3) were explored to obtain a perspective of the population total and composition. Special populations such as young children, women of childbearing age, seniors, and the elderly were included so that the populations that typically have the highest utilization of health care services could be highlighted. Included as well is racial diversity, represented by the percent of diversity

Table 3

Health Service Area	2005 Population									
	Total Population	Index	Pop Density (P/SqMi)	Index	Age < 5	Index	Age >=65	Index	Females 15-44	Index
Arbutus	32,569	0.01	3,027	2.62	2,223	0.01	4,092	0.01	7,283	0.01
Brooklyn/Linthicum	40,350	0.02	3,025	2.62	2,905	0.02	5,744	0.02	8,421	0.02
Catonsville	48,707	0.02	2,899	2.51	2,555	0.02	8,876	0.03	10,077	0.02
Ellicott City	98,400	0.04	1,438	1.25	6,854	0.04	8,747	0.03	21,104	0.04
Glen Burnie	75,774	0.03	2,954	2.56	4,901	0.03	9,163	0.03	16,621	0.03
South Carroll	51,055	0.02	544	0.47	3,193	0.02	5,293	0.02	10,298	0.02
Pasadena	59,882	0.02	1,946	1.68	3,917	0.02	5,896	0.02	71,641	0.13
S Balt City	58,859	0.02	6,858	5.94	4,313	0.03	6,952	0.02	13,474	0.02
SW Balt City	47,133	0.02	7,776	6.73	3,425	0.02	6,664	0.02	10,309	0.02
W Balt City	132,712	0.05	10,831	9.38	9,706	0.06	19,816	0.06	28,438	0.05
Woodlawn	81,618	0.03	3,461	3.00	5,801	0.04	8,689	0.03	18,881	0.03

Total H.S.A.	727,059	0.28	2,345	2.03	49,793	0.30	89,932	0.29	157,576	0.28
Central MD	2,583,746	1.00	1,155	1.00	165,227	1.00	314,862	1.00	554,037	1.00

Health Service Area	Projected Population Growth 2010								Avg Demo-graphic Index
	Females 15-44	Index	Age >= 75	Index	All Ages	Index	% Racial Diversity	Index	
Arbutus	-6.9%	2.24	1.8%	0.26	-2.2%	(0.64)	21.2%	0.63	0.64
Brooklyn/Linthicum	-6.3%	2.05	0.9%	0.13	-0.5%	(0.16)	33.0%	0.98	0.71
Catonsville	-4.7%	1.52	0.3%	0.04	0.5%	0.15	29.6%	0.88	0.65
Ellicott City	3.1%	(1.01)	19.5%	2.75	11.0%	3.25	24.3%	0.72	0.88
Glen Burnie	-7.7%	2.50	9.9%	1.40	0.0%	0.00	22.6%	0.67	0.90
South Carroll	7.9%	(2.56)	19.2%	2.70	15.4%	4.56	10.0%	0.30	0.69
Pasadena	-3.1%	1.01	15.9%	2.24	4.6%	1.36	7.8%	0.23	0.84
S Balt City	-12.6%	4.10	-6.3%	(0.89)	-7.8%	(2.29)	53.3%	1.59	1.06
SW Balt City	-11.3%	3.68	-4.3%	(0.60)	-6.2%	(1.82)	77.9%	2.32	1.30
W Balt City	-11.6%	3.77	-7.4%	(1.04)	-8.4%	(2.48)	88.9%	2.65	1.56
Woodlawn	-3.0%	0.98	3.4%	0.48	2.0%	0.58	85.6%	2.55	0.96

Total H.S.A.	-5.4%	1.74	2.6%	0.36	5.2%	1.55	47.0%	1.40	0.99
Central MD	-3.1%	1.00	7.1%	1.00	3.4%	1.00	33.6%	1.00	1.00

compared to the total population. Current health information about the biologic and genetic characteristics of varying racial and ethnic populations does not explain the health disparities experienced by these groups compared to Caucasian counterparts. Rather, the differences in health status are most likely the result of the complex interaction among genetics, environmental factors and specific health behaviors.

The demographics of St. Agnes's service area average out to be the same as Central Maryland overall. However, independently each indicator varies substantially from Central Maryland. Diversity, as well as population density are much higher in the service area, however a lower population as well as a low projected growth rate for seniors balance the two average indices. The most populous community and the one with the greatest density is West Baltimore City with a total population of just over 130,000 persons. The population has declined by 10,000 since last reported in 2003. The least populous community is Arbutus with a population of slightly less than 33,000 persons. Catonsville had the highest concentration of people age 65 and older at 18.2%. The service area average was 12.4%. Seniors have greater health care needs and generally experience higher rates of chronic disease such as diabetes, lung disease and heart disease. The greatest level of racial and ethnic diversity is in the communities that comprise the Southwest corner of Baltimore City and Baltimore County, where nearly 90% of the population in West Baltimore City represents non-white racial or ethnic groups. Overall, service area racial diversity is slightly less than 50%, or one in two persons are non-white. Despite significant population decrease in urban areas, as compared to the 2003 study, the ratios of seniors as well as diverse populations remain relatively stable in each community.

Typical of an urban environment, each community located in Baltimore City is projected to experience a population decline through 2010. The greatest level of decline is forecasted in South Baltimore City and West Baltimore City at nearly 8% in both communities. This exceeds the rates reported as of 2003, at 6% each. These areas will experience the greatest population decreases in women of childbearing ages at nearly 12%. The greatest population growth rate is forecasted for South Carroll at 15%, significantly faster than 10% growth as of 2003. The growth rate for Howard County was reported as the highest in the previous study, at 16%, however the rate has slowed to 11% making it the second highest currently.

West Baltimore City, as in 2003, continues to have the most needy demographic characteristics with a demographic index of 1.39, while Arbutus and Catonsville have the least needy demographic indices.

Socioeconomic Status

Lower socioeconomic status is highly correlated with poor health outcomes, decreased access to health services, and unhealthy lifestyles. Tables 4A and 4B provide a detailed breakdown of these indicators for each community. Aside from direct health status, on a deeper level, the indicators in this section speak to the long-term vibrancy and viability of communities and the overall quality of life for the residents.

Table 4A

INCOME CHARACTERISTICS	Total Pop	Low Income		Low Income Children			Household Income		Uninsured	
		% HH	Index	Population <=17	Est % Poor	Index	Average HH	Index	Rate	Index
Arbutus	32,569	35%	1.17	7,169	35%	1.17	\$ 57,191	1.46	15%	0.95
Brooklyn/Linthicum	40,350	46%	1.52	9,381	46%	1.52	\$ 60,013	1.39	30%	1.92
Catonsville	48,707	26%	0.85	9,071	26%	0.85	\$ 74,213	1.13	12%	0.80
Ellicott City	98,400	14%	0.48	26,992	14%	0.48	\$ 101,620	0.82	6%	0.40
Glen Burnie	75,774	31%	1.02	16,477	31%	1.02	\$ 59,010	1.42	14%	0.93
South Carroll	51,055	15%	0.49	13,787	15%	0.49	\$ 100,042	0.84	6%	0.36
Pasadena	59,882	15%	0.50	14,308	15%	0.50	\$ 82,309	1.02	7%	0.44
S Balt City	58,859	52%	1.74	12,585	52%	1.74	\$ 47,202	1.77	36%	2.32
SW Balt City	47,133	48%	1.60	10,349	48%	1.60	\$ 46,593	1.79	28%	1.82
W Balt City	132,712	59%	1.96	28,887	59%	1.96	\$ 39,014	2.14	39%	2.54
Woodlawn	81,618	35%	1.16	19,994	35%	1.16	\$ 56,789	1.47	15%	0.99
Total H.S.A.	727,059	40%	1.33	169,000	40%	1.33	\$ 68,017	1.23	20%	1.30
Central MD	2,583,746	30%	1.00	588,115	30%	1.00	\$ 83,587	1.00	16%	1.00

A total of nine socioeconomic indicators are included in the assessment. West Baltimore City has the least favorable index in eight of the total nine indicators. Similarly, South Baltimore has the second least favorable index on seven of the nine. Southwest Baltimore and Brooklyn/Linthicum areas received unfavorable indices as well. These four communities had the highest concentration of low-income households, the greatest level of uninsured and unemployed, the greatest percentage of young people with less than a high school diploma, and the greatest percentage of vacant housing. These findings correlate well with the level of urban deterioration that is apparent in these areas. Collectively, these four communities produce 36% of St. Agnes acute care discharges.

Overall, the St. Agnes service area is marked by a less favorable socioeconomic status than that of Central Maryland as a whole. Indices are divided as urban communities are less favorable and suburban are more favorable than the Central Maryland average.

West Baltimore City had the worst socioeconomic status index at 2.07, followed closely by South Baltimore City at 1.95. Both of these communities are areas where St. Agnes is either the leading resource for health care services, or has a growing influence. The most favorable socioeconomic conditions were noted in Ellicott City with an index of 0.51, followed by South Carroll and Pasadena with indices of 0.52 and 0.61, respectively.

Table 4B

Table 4B

	Education: Less than High School Diploma						Unemployment	
	Age 18-24		Age >= 25					
SOCIAL & ECONOMIC CHARACTERISTICS	Population	% Less than High School Diploma ¹	Population	% Less than High School Diploma ¹	Index	Disability Index	% of Civilian Labor Force ¹	Index
Arbutus	2,973	21.1%	22,032	25.2%	1.38	1.08	5.2%	0.86
Brooklyn/Linthicum	3,619	36.0%	26,391	30.0%	1.65	1.35	7.1%	1.17
Catonsville	5,940	8.9%	33,305	12.7%	0.70	0.76	4.5%	0.74
Ellicott City	7,398	17.6%	51,394	7.1%	0.39	0.56	2.2%	0.36
Glen Burnie	6,766	22.8%	51,394	20.8%	1.14	1.01	3.3%	0.55
South Carroll	4,588	18.3%	27,756	11.6%	0.64	0.58	3.5%	0.58
Pasadena	5,085	17.7%	37,976	16.5%	0.91	0.79	3.3%	0.55
S Balt City	5,057	38.1%	41,731	41.0%	2.25	1.67	11.7%	1.94
SW Balt City	4,168	23.9%	32,310	28.1%	1.54	1.39	10.6%	1.75
W Balt City	13,889	33.8%	92,018	34.1%	1.87	1.77	13.6%	2.25
Woodlawn	7,004	21.8%	50,974	17.5%	0.96	1.26	6.1%	1.01
Total H.S.A.	66,487	25.2%	472,807	22.9%	1.26	1.34	6.7%	1.11
Central MD	242,686		1,663,062	18.2%	1.00	1.00	6.0%	1.00

HOUSEING CHARACTERISTICS	Total Housing Units	% Rented	Index	% Vacant	Index	Average SES Index
Arbutus	13,523	34%	1.12	4%	0.52	1.08
Brooklyn/Linthicum	17,097	34%	1.10	8%	1.14	1.43
Catonsville	19,309	26%	0.86	3%	0.42	0.79
Ellicott City	32,261	21%	0.70	3%	0.44	0.51
Glen Burnie	31,797	38%	1.24	4%	0.59	0.99
South Carroll	14,423	12%	0.37	3%	0.38	0.52
Pasadena	21,097	13%	0.41	4%	0.58	0.61
S Balt City	30,668	39%	1.28	18%	2.57	1.95
SW Balt City	20,816	39%	1.27	7%	0.95	1.54
W Balt City	66,922	45%	1.46	17%	2.37	2.07
Woodlawn	32,641	41%	1.34	6%	0.84	1.12
Total H.S.A.	300,554	34%	1.11	9%	1.23	1.24
Central MD	1,031,372	31%	1.00	7%	1.00	1.00

Sources: U.S. Census Bureau 2005 American Factfinder; Solucient; 2005, 2010 Zip Code estimates.

¹ Data represents 2000 Census statistics, 2005 unavailable.

Income and education attainment can be causal factors for many health disparities in the community. Higher education attainment provides greater potential for higher income, which enables increased access to medical care, better housing, access to safer neighborhoods, and increased likelihood of developing healthier lifestyle behaviors. These indicators directly correlate to health and echo the quality of life for residents within each community.

Health Status

This section of the assessment, similar to that of 2003, covers 19 of the 41 indicators included in the study as a whole. The indicators have been grouped into the following four categories: Ambulatory Sensitive Hospitalizations, Maternal and Infant Health, Major Disease Prevalence, and Lifestyle Behavior Impacts. These indicators were selected to demonstrate the breadth of health care resources that could be required, such as improved access to primary care, acute care needs, education, prevention and screening initiatives, and special clinical program development for target populations or diseases. Unlike the previous study, this assessment adds an additional dimension as indicators are divided into white and nonwhite populations. This division highlights the racial disparities present within each community and the influence on health status and hospitalization rates.

Ambulatory Sensitive Hospitalizations

Ambulatory Sensitive Hospitalizations are acute care hospital admissions that potentially could have been prevented through better overall patient management, primarily through primary care systems. As cited in the 1997 DHMH Primary Care Access Plan, the publication, Primary Care: America's Health in a New Era, the Institute of Medicine concludes from a review of several studies that "communities in which residents report lower access to medical care (largely, primary care) had higher rates of preventable admissions for chronic medical conditions." Table 5 includes indicators included in this analysis: asthma, congestive heart failure, COPD, diabetes, hypertension, and pneumonia. The data included is based on FY 2006 discharges defined by the identified ICD-9 diagnosis codes. For each chronic illness, the rate calculates the number of white discharges per 100 people in the white population, as well as nonwhite discharges per 100 people in the nonwhite population.

Similar to the socioeconomic trend, the overall least favorable indices are present in South Baltimore, Brooklyn/Linthicum, Southwest Baltimore, as well as West Baltimore. The average rate of hospitalization in South Baltimore is 2.13 times higher than that of Central Maryland. Conversely, with the lowest average rate of hospitalizations per 100 people, Ellicott City's average is less than 50% of the Central Maryland average, and 20% of the South Baltimore average.

In the comparison of the racial disparities, the rate of hospitalization in the St. Agnes service area proves to be influenced by socioeconomic factors more so than race. In less affluent communities, the nonwhite population had a higher rate of hospitalization than the white population of the same community. However, the inverse is true in affluent communities where the nonwhite population has a lower admission rate than their white counterparts. As an example, in Woodlawn, which is a more affluent community with over 80% diversity, the rate of hospitalization for the white population is higher than the nonwhite population across all diseases. In West Baltimore, where the community is marked by poverty and there is a similar level of diversity, the rate is

higher for the nonwhite population.

Overall, the service area has higher rates of admission across all diseases in the study when compared to the Central Maryland average, resulting in less favorable indices.

The findings in this analysis highlight the need for improved access to primary care services, improved coordination and management of chronic disease, as well as systems which address the underlying lifestyle behaviors which impact the occurrence of these conditions such as diet, exercise and smoking. It is equally important to note the existence of barriers to care involving financial, socio-cultural, and geographic factors. These concepts should be further explored during the priority setting and recommendation phase.

Table 5
FY06 AMBULATORY CARE SENSITIVE HOSPITALIZATIONS - DISCHARGES PER 100 POP

HEALTH SERVICE AREA	ASTHMA				CHF				COPD			
	White		Non-White		White		Non-White		White		Non-White	
	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX
Arbutus	1.51	1.44	1.65	0.80	2.45	1.42	0.81	0.41	2.67	1.44	0.66	0.56
Brooklyn/Linthicum	1.74	1.66	3.68	1.77	2.95	1.71	3.06	1.55	3.10	1.68	1.64	1.38
Catonsville	0.86	0.82	0.99	0.47	2.27	1.31	2.17	1.10	2.16	1.17	1.15	0.97
Ellicott City	0.58	0.56	0.61	0.29	0.79	0.46	0.44	0.22	0.87	0.47	0.22	0.19
Glen Burnie	1.46	1.40	1.53	0.74	2.51	1.45	1.50	0.76	2.83	1.53	0.98	0.82
South Carroll	0.80	0.76	1.13	0.54	1.08	0.62	1.13	0.57	1.13	0.61	0.50	0.42
Pasadena	0.98	0.94	1.64	0.79	1.70	0.99	1.47	0.74	1.72	0.93	0.82	0.69
S Balt City	2.23	2.14	3.64	1.75	2.66	1.54	3.27	1.66	3.59	1.94	2.39	2.02
SW Balt City	1.38	1.33	2.34	1.12	3.27	1.89	2.97	1.50	3.25	1.76	1.60	1.35
W Balt City	1.38	1.32	3.11	1.50	2.80	1.62	3.19	1.61	1.92	1.04	1.88	1.59
Woodlawn	1.74	1.66	1.54	0.74	3.48	2.02	1.57	0.80	2.58	1.40	0.80	0.67
Total H.S.A.	1.17	1.12	2.34	1.13	1.97	1.14	2.40	1.21	2.06	1.12	1.41	1.19
Central MD	1.04	1.00	2.08	1.00	1.73	1.00	1.98	1.00	1.85	1.00	1.19	1.00

HEALTH SERVICE AREA	DIABETES				HYPERTENSION				PNEUMONIA				AVG INDEX
	White		Non-White		White		Non-White		White		Non-White		
	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	
Arbutus	3.70	1.47	2.28	0.61	8.10	1.35	4.17	0.55	1.30	1.51	0.77	2.30	1.18
Brooklyn/Linthicum	4.06	1.61	4.88	1.31	9.34	1.56	9.76	1.29	1.76	2.04	1.86	5.56	1.64
Catonsville	2.75	1.09	3.93	1.05	7.10	1.19	7.59	1.01	1.17	1.37	1.05	3.14	1.06
Ellicott City	1.23	0.49	1.03	0.28	3.33	0.56	2.17	0.29	0.61	0.71	0.37	1.10	0.44
Glen Burnie	3.82	1.52	2.87	0.77	8.27	1.38	5.67	0.75	1.23	1.43	0.85	2.53	1.22
South Carroll	1.63	0.65	2.31	0.62	4.03	0.67	4.04	0.54	0.59	0.69	0.63	1.88	0.61
Pasadena	2.47	0.98	2.38	0.64	5.49	0.92	5.16	0.68	0.79	0.92	0.74	2.22	0.86
S Balt City	4.05	1.61	5.46	1.46	8.47	1.41	11.60	1.54	1.84	2.14	2.12	6.33	1.86
SW Balt City	3.82	1.52	4.76	1.28	8.41	1.40	9.56	1.27	1.91	2.22	1.61	4.82	1.56
W Balt City	3.96	1.57	5.69	1.53	9.27	1.55	11.76	1.56	1.23	1.43	1.67	5.01	1.78
Woodlawn	4.48	1.78	3.33	0.89	9.88	1.65	6.74	0.89	1.66	1.93	0.79	2.35	1.01
Total H.S.A.	2.82	1.12	4.32	1.16	6.48	1.08	8.84	1.17	1.08	1.26	1.32	3.95	1.20
Central MD	2.52	1.00	3.73	1.00	5.98	1.00	7.54	1.00	0.86	1.00	0.33	1.00	1.00

Source: Market Share Analyst, FY06 ICD-9 Inpatient Disease Estimates, All Ages, Levels 1-15

Maternal and Infant Health

One of the most potentially vulnerable populations in the service area is women and their children, especially for those living in poverty. The socioeconomic analysis revealed that an estimated 40% of children in the service area are living in poverty, with the urban areas experiencing rates of greater than 50%. The quality of life and health status of women and children has far reaching implications. Teen pregnancy,

lack of adequate prenatal care, low birth weight, and birth defects generate increased demands for future health care needs and impact not just this generation, but subsequent generations as the cycle of poverty is continued. Findings of the Maternal and Infant Health indicators are illustrated in Table 6.

As in previous analyzes, the most unfavorable conditions for women and infants are found in South Baltimore City and West Baltimore City, where the overall indices are nearly twice as unfavorable as the Central Maryland average. Southern Carroll County receives the most favorable index overall, followed closely by the other suburban communities including Ellicott City and Pasadena. Unlike ambulatory hospitalization, the nonwhite populations have substantially higher rates of births to teen mothers,

Table 6

Health Service Area	% Births to Teen Moms				% Low Birth Weight				% Birth Defects			
	White	Index	Non-White	Index	White	Index	Non-White	Index	White	Index	Non-White	Index
Arbutus	5.3%	3.21	2.8%	0.53	11.7%	1.16	14.9%	1.02	14.7%	1.67	22.3%	1.40
Brooklyn/Linthicum	4.2%	2.54	10.5%	1.95	14.5%	1.43	16.8%	1.15	6.6%	0.75	13.0%	0.81
Catonsville	2.7%	1.62	3.9%	0.73	8.7%	0.86	13.2%	0.90	14.3%	1.62	26.4%	1.66
Ellicott City	0.9%	0.56	0.5%	0.09	7.3%	0.72	10.0%	0.69	12.8%	1.45	17.6%	1.10
Glen Burnie	1.8%	1.07	4.4%	0.82	9.3%	0.92	16.5%	1.13	8.0%	0.91	10.9%	0.68
South Carroll	0.7%	0.42	0.0%	0.00	6.2%	0.62	13.6%	0.93	9.4%	1.06	12.1%	0.76
Pasadena	3.5%	2.10	3.8%	0.70	10.2%	1.01	4.8%	0.33	6.0%	0.68	8.4%	0.53
S Balt City	3.6%	2.20	10.8%	2.00	10.5%	1.03	16.9%	1.16	15.1%	1.70	21.3%	1.33
SW Balt City	0.8%	0.51	7.2%	1.33	12.1%	1.19	17.6%	1.20	15.5%	1.76	19.1%	1.20
W Balt City	0.5%	0.33	9.5%	1.76	8.3%	0.82	16.0%	1.10	7.8%	0.88	15.2%	0.95
Woodlawn	1.8%	1.09	3.9%	0.72	10.3%	1.02	14.4%	0.99	10.3%	1.17	15.2%	0.96

Total H.S.A.	2.4%	1.44	6.8%	1.27	9.5%	0.94	15.3%	1.04	10.5%	1.18	16.4%	1.03
Central MD	1.6%	1.00	5.4%	1.00	10.1%	1.00	14.6%	1.00	8.8%	1.00	15.9%	1.00

Health Service Area	Infant Mortality				% Insufficient Prenatal Care				Avg Maternal/Infant Health Index
	White	Index	Non-White	Index	White	Index	Non-White	Index	
Arbutus	0.3%	0.91	0.0%	0.00	2.8%	1.82	7.1%	0.85	1.04
Brooklyn/Linthicum	0.3%	0.94	0.9%	1.37	5.8%	3.76	11.7%	1.41	1.52
Catonsville	0.6%	1.73	1.3%	1.95	1.2%	0.77	5.9%	0.71	1.10
Ellicott City	0.5%	1.36	0.5%	0.73	0.9%	0.60	3.7%	0.45	0.71
Glen Burnie	0.5%	1.59	0.7%	1.00	0.7%	0.44	7.1%	0.85	0.84
South Carroll	0.2%	0.68	1.7%	2.47	0.7%	0.45	3.3%	0.40	0.53
Pasadena	0.5%	1.52	0.0%	0.00	0.7%	0.45	2.5%	0.30	0.70
S Balt City	1.0%	3.02	0.2%	0.29	4.1%	2.68	12.5%	1.51	1.76
SW Balt City	0.0%	0.00	0.8%	1.15	1.7%	1.09	8.2%	0.98	1.51
W Balt City	0.0%	0.00	0.7%	1.05	3.8%	2.47	12.9%	1.55	1.80
Woodlawn	0.0%	0.00	0.6%	0.89	2.7%	1.75	7.8%	0.94	1.24

Total H.S.A.	0.5%	1.33	0.6%	0.94	1.8%	1.20	9.6%	1.16	1.24
Central MD	0.3%	1.00	0.7%	1.00	1.5%	1.00	8.3%	1.00	1.00

Low Birth Weight defined as: Birth Weight <2,500g.

Source: Market Share Analyst FY06: Birth defects (ICD-9 740-759.9), Insufficient Prenatal Care (ICD-9 V23.7), Infant Mortality (ICD-9 656.4).

infants with low birth weight, infants with birth defects, as well as births with insufficient prenatal care in all communities.

Major Disease Prevalence

Traditionally, mortality data is utilized to evaluate the impact of leading causes of disease and illness in the community. However, vital statistic data is not readily available at the zip code level. As a proxy to evaluating the impact from the leading causes of mortality such as cancer and cardiovascular, this assessment utilized acute care discharges per 1,000 people. Appropriate ICD-9 or DRG codes were identified for cancer, cardiovascular, and stroke. It is recognized that all patients diagnosed with these diseases may not necessarily experience an acute care admission, therefore, these rates do not represent disease incidence rates. Rather, the value in this analysis is the ability to access patterns of illness across a number of indicators and communities. The presence of these diseases in the community may indicate a high incidence of “at risk” behaviors such as smoking, poor diets, or lack of adequate exercise, with which they are associated. Further, their presence may indicate insufficiencies in the education, prevention and screening programs related to these conditions. Also, based on the methodology employed, higher rates would be expected in communities where a larger percentage of the population is over the age of 65, since these diseases increasingly manifest themselves within these age cohorts.

The results of this analysis are shown in Table 7. As in previous tables, the population of each community is divided into white and nonwhite for all three diseases. As expected, this division provided varying results as to the least favorable community for each major disease. For the white population, the Brooklyn/Linthicum community had the highest admission ratio for Cancer as well as Cardiovascular, as Southwest Baltimore had the least favorable ratio of stroke admissions. West Baltimore, on the other hand, had the highest ratio of admissions for all three diseases within the

Table 7

FY06 MAJOR DISEASE PREVALENCE - ADMISSIONS PER 1,000 POP

100 MAJOR DISEASE PREVALENCE - ADMISSIONS PER 1,000 Yr													
HEALTH SERVICE AREA	CANCER				CARDIOVASCULAR				STROKE				AVG INDEX
	White		Non-White		White		Non-White		White		Non-White		
	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	RATE	INDEX	
Arbutus	14.78	1.26	5.34	0.52	32.73	1.30	12.24	0.44	13.33	1.47	5.21	0.49	1.13
Brooklyn/Linthicum	16.32	1.39	10.04	0.99	38.43	1.52	35.91	1.30	13.84	1.52	13.75	1.30	1.39
Catonsville	13.36	1.14	9.23	0.91	27.24	1.08	27.30	0.99	14.00	1.54	14.68	1.38	1.19
Ellicott City	8.97	0.76	4.85	0.48	11.96	0.47	7.15	0.26	4.98	0.55	3.42	0.32	0.53
Glen Burnie	14.05	1.20	7.26	0.71	33.55	1.33	18.37	0.67	13.78	1.52	8.35	0.79	1.17
South Carroll	8.20	0.70	9.86	0.97	18.80	0.74	17.58	0.64	6.40	0.70	8.79	0.83	0.72
Pasadena	10.62	0.91	8.57	0.84	23.72	0.94	19.23	0.70	8.61	0.95	7.05	0.66	0.90
S Balt City	14.07	1.20	14.33	1.41	35.51	1.41	40.07	1.46	13.50	1.49	15.77	1.49	1.46
SW Balt City	15.98	1.36	13.02	1.28	32.64	1.29	34.29	1.25	14.91	1.64	16.03	1.51	1.42
W Balt City	16.01	1.36	15.31	1.50	33.56	1.33	40.55	1.47	14.35	1.58	17.08	1.61	1.60
Woodlawn	15.60	1.33	9.69	0.95	43.07	1.70	25.06	0.91	14.11	1.55	8.36	0.79	0.99

Total H.S.A.	12.20	1.04	11.78	1.16	26.35	1.04	31.08	1.13	10.49	1.16	12.87	1.21	1.14
Central MD	11.73	1.00	10.17	1.00	25.27	1.00	27.52	1.00	9.08	1.00	10.60	1.00	1.00

Source: Market Share Analyst, FY06 admissions.

nonwhite population. Continuing the trend, the urban areas of West Baltimore, South Baltimore, Southwest Baltimore and Brooklyn/Linthicum, have the least favorable indices for these major diseases overall.

Lifestyle Behaviors

Healthy People 2010 identified 10 Leading Health Indicators, which include physical activity, obesity, tobacco use, substance abuse, sexual behavior, mental health, violence, environmental quality, immunizations, and access to health care. These indicators illustrate individual behaviors that have been identified as having the greatest impact on individual health status. It is important to recall that a significant underlying factor in these indicators is the significant influence of income and education.

As mentioned earlier, previous community needs assessments have relied upon qualitative analysis, particularly for the lifestyle risk analysis. However, utilizing a more quantitative approach, proxy indicators were developed based upon readily available acute care and emergency room visit discharge databases. Using ICD-9 diagnosis coding, utilization rates per 1,000 population were identified for obesity, mental health, HIV, substance abuse, and tobacco use, for both white and nonwhite populations. As in all the previous tables, index levels were determined and then averaged across all indicators to produce a composite index. While these utilization rates are not indicative of total incidence rates of these behaviors in the communities, the value is in the ability to examine patterns across different populations. In large part, the validity of this data is highly dependent upon the coding accuracy of the various health care providers that deliver health care services to the residents of the study area communities. Inpatient results are found in Table 8A and emergency results in Table 8B.

As in all of the previous analyzes, the highest index scores are found in the urban-based communities. Least favorable overall, South Baltimore City was found to have a composite inpatient index of 2.78, and an emergency index of 2.52, primarily due to high utilization rates for mental health, HIV, and Emergency Room substance abuse visits. Also, among the top four highest inpatient index scores was West Baltimore City at 2.16, Brooklyn/Linthicum at 1.73 and Southwest Baltimore City at 1.58. Racial disparities are evident in urban areas, where the rate of admission for the nonwhite population is significantly higher than that of the white population, especially in the cases of obesity, HIV, and tobacco use. The lowest composite index scores were noted in Ellicott City and South Carroll, which were nearly 100% below their urban community counterparts. An interesting finding was the high ER index score in Glen Burnie for obesity, tobacco use and substance abuse.

Table 8A

Health Service Area	Population	Obesity IP				Psychiatric IP				HIV Positive IP			
		White	Index	Non-White	Index	White	Index	Non-White	Index	White	Index	Non-White	Index
Arbutus	32,569	21.69	1.44	11.98	0.59	6.51	1.18	4.30	0.47	0.56	1.36	1.04	0.17
Brooklyn/Linthicum	40,350	28.84	1.92	39.04	1.91	6.47	1.17	7.77	0.84	0.64	1.55	10.33	1.71
Catonsville	48,707	11.20	0.74	13.78	0.67	5.26	0.95	4.93	0.54	0.15	0.37	3.33	0.55
Ellicott City	98,400	7.41	0.49	4.85	0.24	3.64	0.66	2.00	0.22	0.17	0.40	0.42	0.07
Glen Burnie	75,774	24.33	1.62	17.43	0.85	6.09	1.10	4.67	0.51	0.43	1.03	1.76	0.29
South Carroll	51,055	10.72	0.71	13.99	0.68	5.15	0.93	3.77	0.41	0.02	0.05	1.08	0.18
Pasadena	59,882	15.40	1.02	16.95	0.83	3.26	0.59	1.71	0.19	0.20	0.49	0.57	0.09
S Balt City	58,859	22.27	1.48	29.49	1.44	9.92	1.80	17.28	1.87	4.15	10.05	15.77	2.62
SW Balt City	47,133	16.76	1.11	19.56	0.96	8.48	1.54	8.53	0.93	0.49	1.18	7.34	1.22
W Balt City	132,712	19.48	1.29	27.86	1.36	16.68	3.02	16.12	1.75	1.13	2.75	11.55	1.92
Woodlawn	81,618	23.49	1.56	18.33	0.90	11.51	2.09	6.62	0.72	0.74	1.80	3.58	0.59
Total H.S.A.	727,059	16.58	1.10	22.09	1.08	6.01	1.09	10.40	1.13	0.61	1.48	7.60	1.26
Central MD	2,583,746	15.05	1.00	20.45	1.00	5.52	1.00	9.22	1.00	0.41	1.00	6.02	1.00

Health Service Area	Population	Substance Abuse IP				Tobacco Use IP				Avg Lifestyle/ Behavior Index
		White	Index	Non-White	Index	White	Index	Non-White	Index	
Arbutus	32,569	3.61	1.81	2.21	0.62	33.33	1.62	18.23	0.63	0.97
Brooklyn/Linthicum	40,350	4.55	2.28	5.41	1.52	47.83	2.33	54.36	1.87	1.73
Catonsville	48,707	1.03	0.52	1.67	0.47	14.46	0.70	14.42	0.49	0.61
Ellicott City	98,400	0.90	0.45	0.08	0.02	8.39	0.41	4.54	0.16	0.31
Glen Burnie	75,774	2.50	1.25	1.25	0.35	38.54	1.88	21.43	0.74	0.95
South Carroll	51,055	0.59	0.30	0.90	0.25	10.80	0.53	9.15	0.31	0.43
Pasadena	59,882	1.81	0.91	1.71	0.48	23.88	1.16	17.33	0.59	0.63
S Balt City	58,859	6.34	3.17	8.84	2.48	59.32	2.89	63.55	2.18	2.78
SW Balt City	47,133	3.60	1.80	3.99	1.12	33.61	1.64	33.50	1.15	1.58
W Balt City	132,712	2.67	1.34	6.52	1.83	23.22	1.13	49.80	1.71	2.61
Woodlawn	81,618	2.32	1.16	1.87	0.52	25.90	1.26	17.84	0.61	1.02
Total H.S.A.	727,059	2.27	1.14	4.27	1.20	25.95	1.26	34.95	1.20	1.32
Central MD	2,583,746	2.00	1.00	3.57	1.00	20.52	1.00	29.14	1.00	1.00

Rate is Admissions per 1,000 pop.

Source: Market Share Analyst, FY06 Inpatient Database.

Table 8B

Health Service Area	Population	Obesity		Psychiatric		HIV Positive		Substance Abuse		Tobacco Use		Avg Lifestyle/ Behavior Index
		ED RATE	Index	ED RATE	Index	ED RATE	Index	ED RATE	Index	ED RATE	Index	
Arbutus	32,569	2.24	1.77	36.20	1.36	0.68	0.79	13.20	1.38	35.83	1.61	1.38
Brooklyn/Linthicum	40,350	5.20	4.11	50.71	1.91	1.93	2.26	23.32	2.44	66.47	2.98	2.74
Catonsville	48,707	0.53	0.42	21.70	0.82	0.33	0.38	5.05	0.53	9.51	0.43	0.52
Ellicott City	98,400	0.49	0.39	16.11	0.61	0.12	0.14	3.34	0.35	5.93	0.27	0.35
Glen Burnie	75,774	4.21	3.33	47.65	1.80	0.29	0.34	11.47	1.20	57.30	2.57	1.85
South Carroll	51,055	0.37	0.29	11.24	0.42	0.06	0.07	2.66	0.28	1.53	0.07	0.23
Pasadena	59,882	2.27	1.80	30.86	1.16	0.18	0.21	6.65	0.69	32.78	1.47	1.07
S Balt City	58,859	1.19	0.94	42.51	1.60	4.72	5.53	28.42	2.97	35.05	1.57	2.52
SW Balt City	47,133	1.12	0.89	30.47	1.15	2.02	2.36	12.94	1.35	30.83	1.38	1.43
W Balt City	132,712	1.27	1.01	31.17	1.17	3.71	4.35	19.55	2.04	11.53	0.52	1.82
Woodlawn	81,618	0.94	0.75	24.17	0.91	0.81	0.95	6.29	0.66	7.80	0.35	0.72
Total H.S.A.	727,059	1.65	1.30	30.19	1.14	1.51	1.76	12.02	1.26	23.33	1.05	1.30
Central MD	2,583,746	1.26	1.00	26.54	1.00	0.85	1.00	9.57	1.00	22.31	1.00	1.00

Rate is Admissions per 1,000 pop.

Source: Market Share Analyst, FY06 Inpatient Database.

Overall Health Status

Table 9 displays the results of the Overall Health Status index score, which is an average of the ambulatory sensitive hospitalizations, maternal and infant health, major disease prevalence and lifestyle behavior indices. Consistent with the previous findings, South Baltimore City and West Baltimore City were defined by the highest Health Status index scores overall, 1.96 and 1.95 respectively. Brooklyn/Linthicum and Southwest Baltimore City were among the least favorable as well, with index scores of 1.57 and 1.52 respectively. Ellicott City and South Carroll were noted with the lowest Health Status index scores at 0.50 and 0.57, respectively.

Table 9

Health Service Area	Ambulatory Care Sensitive Hospitalizations Index	Maternal/ Infant Health Index	Disease Prevalence Index	Lifestyle/ Behavior Index	HEALTH STATUS INDEX
Arbutus	1.18	1.04	1.13	0.97	1.08
Brooklyn/Linthicum	1.64	1.52	1.39	1.73	1.57
Catonsville	1.06	1.10	1.19	0.61	0.99
Ellicott City	0.44	0.71	0.53	0.31	0.50
Glen Burnie	1.22	0.84	1.17	0.95	1.05
South Carroll	0.61	0.53	0.72	0.43	0.57
Pasadena	0.86	0.70	0.90	0.63	0.77
S Balt City	1.86	1.76	1.46	2.78	1.96
SW Balt City	1.56	1.51	1.42	1.58	1.52
W Balt City	1.78	1.80	1.60	2.61	1.95
Woodlawn	1.01	1.24	0.99	1.02	1.07
Total H.S.A.	1.20	1.24	1.14	1.32	1.23
Central MD	1.00	1.00	1.00	1.00	1.00

Health Resource Utilization & Physician Manpower Need

While comprehensive data was not readily available which detailed all the various providers of health care services for each of the zip codes that comprise the study area.

Therefore, using the St. Agnes Medical Staff Development plan, each community in the study was grouped into one of three geographic areas. The need for physicians is determined based on the ratio of admissions per physician in each of the three areas. The manpower need of each community in the study correlates to the broader geographic area in which they are located.

This analysis utilizes acute care admission rates per 1,000 population, acute care days per 1,000 population and Outpatient Emergency Room Visit rates per 1,000 people. The logic underlying these indicators is the fact that communities with high utilization rates have a greater need for health care resources. One could debate the level of resources required, especially given the fact that the indicators are largely inpatient based. However, it is reasonable to assume that current utilization rates are indicative of resource requirements. The next step of the assessment process should include an exploration of the appropriate level and mix of resources to address prioritized needs.

The utilization rate indicators are indexed based on the Central Maryland average, however, a different approach was required to incorporate the physician manpower needs. The study area of the Medical Staff Development project was divided into three areas. The communities in this study correlate well to the three areas in the MSD study, therefore each community was matched to one of the three areas. If an area was determined to have a need for primary care physicians, the community receives a score of 1.0. If there is also a need for specialty care physicians, then the community also receives a score of 1.0. These scores are then averaged with the utilization indexes, which result in composite index score. The results are displayed in Table 10.

Table 10

Health Service Area							Physician Manpower Need**			Average Index
	Acute Care Adms Rate*	Index	Acute Care Days Rate*	Index	ED Visits Rate*	Index	Primary Care	Specialist	Overall Need	
Arbutus	172.9	1.14	480.3	0.88	413.7	1.14	0	0	0	0.79
Brooklyn/Linthicum	218.2	1.44	898.8	1.64	661.9	1.82	1	1	2	1.73
Catonsville	150.5	1.00	431.1	0.79	222.2	0.61	0	0	0	0.60
Ellicott City	84.8	0.56	338.1	0.62	202.2	0.56	0	0	0	0.43
Glen Burnie	170.8	1.13	693.2	1.27	424.5	1.17	1	1	2	1.39
South Carroll	104.7	0.69	384.0	0.70	181.0	0.50	1	1	2	0.97
Pasadena	129.4	0.86	491.8	0.90	277.6	0.76	1	1	2	1.13
S Balt City	239.8	1.59	1,039.6	1.90	726.2	2.00	0	0	0	1.37
SW Balt City	198.6	1.31	885.6	1.62	547.0	1.51	0	0	0	1.11
W Balt City	234.0	1.55	1,049.3	1.92	675.6	1.86	0	0	0	1.33
Woodlawn	155.3	1.03	449.6	0.82	435.5	1.20	0	0	0	0.76
Total H.S.A.	169.7	1.12	669.3	1.22	443.8	1.22	0	0	0	0.89
Central MD	151.1	1.00	547.6	1.00	363.3	1.00				1.00

*Rate per 1,000 population.

**Physician Manpower Need: 0 = "No Need", 1 = "Need".

Sources: Market Share Analyst FY06 Inpatient Database for Admissions and Days;
SAH Medical Staff Development Plan: Specialty Physician Need.

As is consistent with the previous studies, Brooklyn/Linthicum, South Baltimore City and West Baltimore City were among the top four communities with the highest index scores at 1.37, 1.33, and 1.73, respectively. Glen Burnie, however, is among the least favorable in this study, with an index of 1.39, as the above average admission rate is coupled with a need for primary care physicians as well as specialists. The proximity of urban areas to major healthcare offices reduce the need for physician manpower, which consequently mitigates the effect of above average admission rates. Ellicott City and Catonsville with lower health care utilization rates and minimal identified physician manpower needs were noted with the lowest index scores at 0.43 and 0.60. South Carroll's index, although low, is marginally higher due to physician manpower needs.

VI. Needs Assessment Summary

Table 11 provides a summary of the four major components of the needs assessment analysis and the corresponding index scores of the communities for each major indicator. These indices are averaged to provide an overall composite summary need index.

Table 11

HEALTH SERVICE AREA	DEMOGRAPHICS (Table 3)	SES INDEX (Table 4A, 4B)	HEALTH STATUS INDEX (Table 9)	HEALTH RESOURCES INDEX (Table 10)	SUMMARY NEED INDEX
Arbutus	0.64	1.08	1.08	0.79	0.90
Brooklyn/Linthicum	0.71	1.43	1.57	1.73	1.36
Catonsville	0.65	0.79	0.99	0.60	0.76
Ellicott City	0.88	0.51	0.50	0.43	0.58
Glen Burnie	0.90	0.99	1.05	1.39	1.08
South Carroll	0.69	0.52	0.57	0.97	0.69
Pasadena	0.84	0.61	0.77	1.13	0.84
S Balt City	1.06	1.95	1.96	1.37	1.59
SW Balt City	1.30	1.54	1.52	1.11	1.37
W Balt City	1.56	2.07	1.95	1.33	1.73
Woodlawn	0.96	1.12	1.07	0.76	0.98
Total H.S.A.	0.99	1.24	1.23	0.89	1.09
Central MD	1.00	1.00	1.00	1.00	1.00

The communities with the four worst overall scores are West Baltimore City, South Baltimore City, Brooklyn/Linthicum and Southwest Baltimore City. In general, the Baltimore City communities of the study area scored the most unfavorably across all indices included in the analysis, particularly socioeconomic status and health status. These poor results are in spite of the fact that these communities are located more geographically proximal to a wealth of health care resources than other communities. This finding highlights the persistent and challenging barriers to access that include financial, cultural, and environmental factors that must be considered in order to make substantial inroads to improving the health of individuals and the communities.

Figure 2: Study Area Overall Need and Health Status			
Overall need	Low	Medium	High
Health Status			
Poor			S Baltimore City W Baltimore
Fair		SW Baltimore Brooklyn/ Linthicum	
Good	Arbutus Catonsville Ellicott City Glen Burnie Pasadena South Carroll Woodlawn		

Figure 2 examines the relationship between overall need and health status. The communities were stratified across a 3x3 grid where the communities with worst index scores representing the 25th percentile and most favorable scores group representing the 75th percentile. The resulting chart clearly demonstrates the huge disparity between the suburban communities and the older urban communities. The inner city communities, which are the most geographically proximal to St. Agnes are noted with the highest overall need and poorest health status.

Figure 3: Socioeconomic Status and Health Status			
Socioeconomic	Low	Medium	High
Health Status			
Poor	S Baltimore City W Baltimore		
Fair		SW Baltimore Brooklyn/ Linthicum	
Good			Arbutus Catonsville Ellicott City Glen Burnie Pasadena South Carroll Woodlawn

Figure 3 illustrates the strong correlation between socioeconomic status and health status. The communities in the upper left of the grid demonstrate both low

socioeconomic status and poor health. As mentioned previously, among the urban communities, other factors not used in this analysis such as crime rates, and housing conditions, contribute to the poor quality of life and poor health outcomes. These major social issues will likely represent the greatest challenge to health care providers. Given the significant economic pressures facing the health care industry, there are insufficient resources within the health care system to address these social issues. Yet, the health care system itself will continue to be impacted as these conditions further erode the health of individuals and communities. If we as a society are to truly succeed at leaving no one behind, then we must as a society, come together to collectively address the broad range of challenges that are facing many of the members of our community family.

To guide future organizational planning for community health status improvements, the Board of Directors Planning Committee has identified “directional” recommendations regarding their conclusions from the quantitative assessment. These guidelines provide foundational strategic thinking for the Community Needs Assessment Team in the development of the Care of Persons Who Are Poor, Community Benefits, and Advocacy Plan.

Key Findings

1. The levels of health care needs within the St. Agnes service area are as diverse as the communities themselves.
2. Overall, the St. Agnes service area has higher demonstrated need across all measures when compared to the Central Maryland region.
3. The overall need for health care is highly correlated with socioeconomic status.
4. Among these four, diversity ranges from as high as 89% down to only 33%, suggesting that racial diversity alone has less of an influence on health care status.
5. As health care costs increase, and economic conditions worsen, barriers to health care arise in communities with poor socioeconomic characteristics, resulting in poorer health status.
6. Within the St. Agnes service area, there has been an increase in services to urban areas identified as high need and erosion from suburban communities.

Community Health Improvement Guidelines:

- † St. Agnes should initiate a leadership role for community health improvement efforts in those communities located geographically proximal to the Caton & Wilkens campus, where SAHC is the dominant provider, and those that represent major access routes to the Caton & Wilkens Campus.
- † St. Agnes should act as a catalyst to bring together other community assets such as local government, community leaders and local industries to form partnerships/networks focused on community health status improvements,

especially for broader socio-economic issues that directly impact health status.

- ✚ St. Agnes should work with Bon Secours Health System and University of Maryland Health System to advance community health improvement agenda, especially to communities of the service area identified as high need.
- ✚ St. Agnes should advance advocacy initiatives on the community health needs assessment and Call to Action for Healthcare That Leaves No One Behind through current resources, particularly through Physician Advocacy Forum, Maryland Physicians Care, and Baltimore Medical System FQHC expansion.
- ✚ St. Agnes should develop an Advisory Board to include community leaders and other appropriate key representatives to become instrumental in discernment of the project.
- ✚ St. Agnes should identify and access alternative funding sources for community outreach efforts via state, federal, charitable organizations, grants, etc.
- ✚ Community health improvement initiatives lead by St. Agnes should focus on healthcare issues, and not attempt to resolve broader social issues that should be addressed within community partnerships/networks.



Community Benefits Reporting

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

St. Joseph Medical Center (SJMC) had a licensed bed designation in FY09 of 345. The number of inpatient admissions for FY09 was 9,427 (including newborns & NICU).

2. Describe the community your organization serves.

- Describe the geographic community or communities the organization serves;
- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, (concentrations of vulnerable populations] and life expectancy or mortality rates)

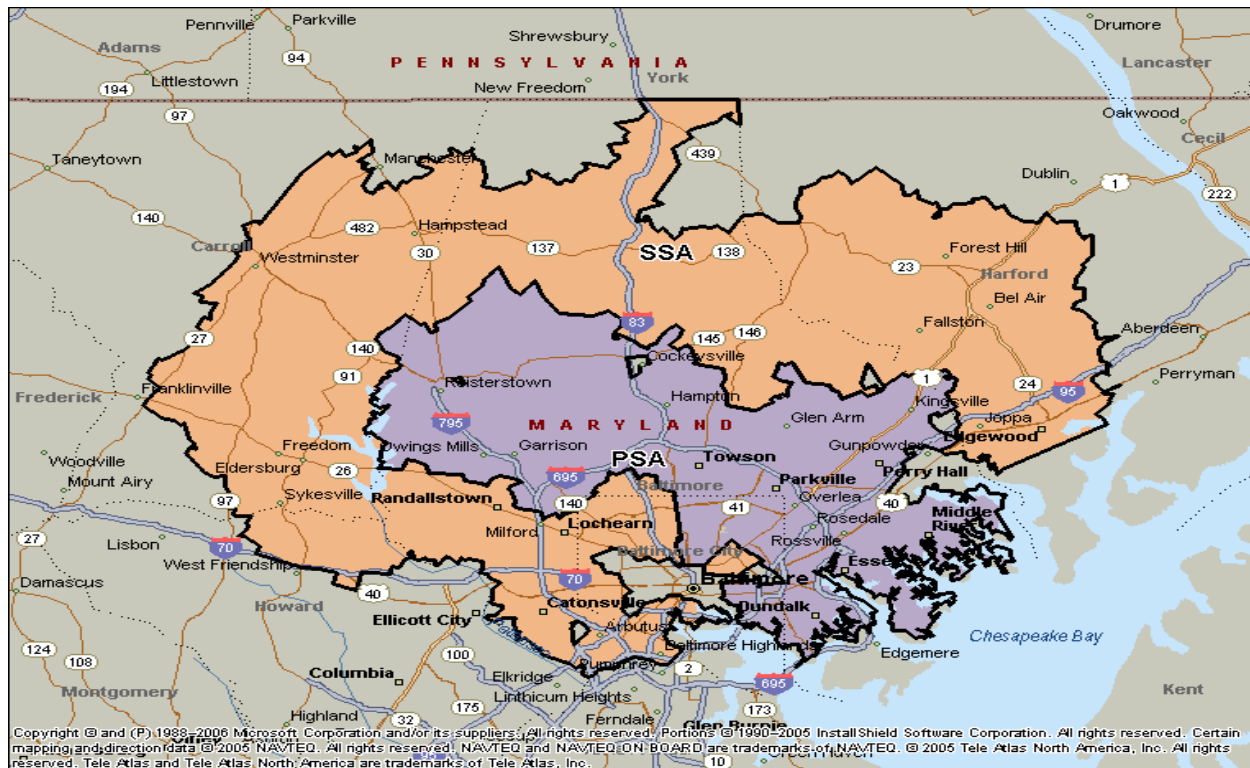
As of the of 2000, there were 51,793 people, 21,063 households, and 11,331 families residing in the Towson CDP. The population density was 3,688.7 people per square mile. There were 21,997 housing units at an average density of 1,566.6/sq mi. The racial makeup of the CDP was 86.9% White, 7.53% African American, 0.10% Native American, 3.7% Asian, 1.9% Hispanic, and 0.0% Pacific Islander.

There were 21,063 households out of which 23.1% had children under the age of 18 living with them, 43.6% were married couples living together, 7.8% had a female householder with no husband present, and 46.2% were non-families. 36.4% of all households were made up of individuals and 17.3% had someone living alone who was 65 years of age or older. The average household size was 2.16 and the average family size was 2.87.

In the CDP the population was spread out with 17.4% under the age of 18, 17.5% from 18 to 24, 24.9% from 25 to 44, 20.1% from 45 to 64, and 20.1% who were 65 years of age or older. The median age was 38 years. For every 100 females there were 82.8 males. For every 100 females age 18 and over, there were 78.8 males.

The median income for a household in the CDP was \$53,775, and the median income for a family was \$75,832 (these figures had risen to \$64,313 and \$98,744 respectively as of a 2007 estimate. Males had a median income of \$49,554 versus \$38,172 for females. The per capita income for the CDP was \$32,502. About 2.5% of families and 7.7% of the population were below the poverty line, including 3.8% of those under age 18 and 4.7% of those age 65 or over.

Cancer mortality is 211.3 per 100,000 residents and cardiac mortality is 289.0 per 100,000.



St Joseph Medical Center is located in the Baltimore-Towson metropolitan area which as of 2004, was estimated to have a population density of 8,058 people per square mile. There were 257,995 households, out of which 25.5% had children under the age of 18 living with them. The average household size was 2.42, and the average family size was 3.16. About 18.8% of families and 22.9% of the population were below the poverty line, including 30.6% of those under age 18 and 18.0% of those age 65 or over.

PSA (Primary Service Area) includes areas where SJMC captures approximately 60% of inpatient cases. PSA Zip Codes include 21030, 21057, 21087, 21093, 21117, 21128, 21136, 21204, 21206, 21208, 21212, 21214, 21218, 21220, 21221, 21222, 21224, 21234, 21236, 21237, 21239, 21252, 21286

SSA (Secondary Service Area) includes areas where SJMC captures approximately 22% of inpatient cases. SSA Zip Codes include 21009, 21013, 21014, 21015, 21040, 21047, 21048, 21050, 21071, 21074, 21082, 21084, 21085, 21104, 21111, 21120, 21131, 21133, 21152, 21155, 21157, 21163, 21207, 21209, 21210, 21211, 21213, 21215, 21227, 21228, 21229, 21230, 21244, 21784

TSA (Total Service Area) includes all of the zip codes listed in the PSA & SSA.

2005 Population (source: www.mde.maryland.gov)

Total Maryland:	5,282,580
SJMC Total Service Area:	1,415,361

Average Income (source: Thompson Reuters Market Planner Plus)

Total Maryland:	\$89,380
SJMC Total Service Area:	\$87,968

3. Identification of Community Needs:

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

The hospital has completed a needs assessment in partnership with its parent company Catholic Health Initiatives over a 5 year time frame beginning in FY06. This assessment was designed in FY06 in partnership with corporate consultants and hospital staff throughout the country. The assessment was completed during FY07 as part of a national healthy community's initiative by Catholic Health Initiatives. St. Joseph Medical Center collaborated with a number of community stakeholders in an ongoing joint assessment of community needs and assets, and we continued to participate in multiple coalitions, initiatives, and activities designed to improve overall community health in the geographic areas of Baltimore County, Baltimore City and Karatu District in Tanzania, East Africa.

Community stakeholders were collaborated with to jointly assess community needs and assets; SJMC worked to improve the overall community health by including the city, county and state officials in addition to the American Cancer Society, AAHP, and the Baltimore County and City Health Departments. Specific areas of the medical center, such as Community Outreach, the Foundation and St. Clare Medical Outreach were involved in these collaborative relationships, as well as the medical center in general through a hospital partnership called Mission Health Partners which collaborates on strategic initiatives, including Healthy Communities.

The hospital worked under national and local strategic initiatives which were developed for planning through a campaign called Vision 2010. Each year, within this framework the hospital makes the plan for the upcoming year using key operational priorities, key initiatives and success drivers.

Examples of the documents used by the hospital to determine community needs are:

- The health assessment publication from the health department, 2005
- The State of Maryland Cancer Registry
- Census update for income levels regarding provision of resources for financial assistance support.
- Feedback from community stakeholders, area physicians, and community members
- Patient surveys and feedback

Leadership from the hospital participated on boards and committees including:

- Chamber of Commerce of towns throughout the region
- The American Heart Association
- The Cancer Coalition

- Maryland Hospital Association
- The American Cancer Society
- Health Department Committees

We also have a St. Joseph Medical Center Mission Integration Committee and the Community Benefit Advisory Team. These two committees are comprised of staff, physicians and providers of health related services. Through these committees we can keep up with emerging trends of the area in which we serve. These committees give the hospital feedback on services and programs that are needed, those that are meeting the needs of the community and those services that are not.

A subsidiary of the SJMC Foundation is FANS (friends, alumni, neighbors and supporters) volunteers are another great resource for the hospital to keep our gauge of what is emerging in the community.

In the past three years the hospital has been completing planning for the growth of the Cancer Institute at St. Joseph Medical Center. We have been working closely with the American Cancer Society as well as the National Cancer Institute to learn more about health disparities. The areas of most need identified were: transportation, access to care and Lifestyle Choices.

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

Yes, staff at the hospital sit on committees of the health department. In addition, we work very closely with our local health department to plan services to meet community needs and attempt to decrease the duplication of services in the community.

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

The major needs identified were:

- Access to care
- Cancer and Related Lifestyle Choices
- Heart Disease and Related Lifestyle Choices

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

As mentioned earlier in this document, the hospital leadership was involved in the strategic planning process and developed a 5 year strategy through 2010 for the hospital. Within the framework, we set organizational goals and priorities each year. Because our leadership is so involved in the community through serving on committees and boards we have a good sense of the community health needs.

Through the planning process the SJMC completed, we engaged the medical staff, hospital leadership and management to determine the needs we believed we could impact and address in that specific year. Each individual on the management and leadership team developed individual as well as departmental goals. The executive committee of the hospital determines

the hospitals annual goals. It is through this process that the community benefit goals are determined.

Community benefit is addressed by every department in the hospital and all participate on some level. There is a Mission Integration Committee as well as a Community Benefits Advisory Team, which oversee the process. The Community Outreach Department provides oversight to the Community Benefits Advisory Team as well as all hospital departments regarding community benefits.

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

Yes, there are community benefit program initiatives which address the needs addressed.

- Cancer and Related Lifestyle Choices
- Access to care

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

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

- a. Name of initiative:
- b. Year of evaluation:
- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or
- e. If no evaluation has been done, does the hospital intend to undertake any? evaluations in the future and if so, when?

St. Joseph Medical Center did not complete an evaluation in FY09. There will be a plan to undertake a formal evaluation of each major initiative in the areas of Cancer and Access to Care in FY10. Due to a change in leadership and hospital restructuring, this was not implemented in FY09.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

SJMC is always working on recruitment of new physicians. During FY09 we began to focus on the recruitment of primary care physicians as well as building alliances with other community physicians for privileges at the hospital to meet the needs of the community we serve.

We have also increased the offering of health screenings and education for the broader community related to cancer and heart disease with a special emphasis to reach distant areas of the county. We have also offered additional flu clinics and hand washing education to the broader community to address the emerging needs related to influenza.

9. If you list Physician Subsidiaries in your data, please provide detail.

Not applicable.

Special Programs to Benefit the Community

St. Clare Medical Outreach

St. Joseph Medical Center in Towson, Maryland, supports St. Clare Medical Outreach, a primary care operation that provides free, primary care to uninsured adults at two locations in Baltimore City with \$529,425 for operational costs. This fiscal year makes eleven years of providing primary care at the Esperanza Center and Franciscan Center. The Health services at the Esperanza celebrated its first anniversary in the newly renovated clinic. The coach continues to travel to the Franciscan Center on the third clinic day. In FY09 2,452 persons were provided 2,647 primary care visits which included diagnostic testing and starter supplies of medications, where appropriate. Additional needed inpatient and outpatient services totaled \$428,911 and were provided as part of the medical center's charity care program. Additionally, forty-four specialists agreed to provide, on a pro-bono basis, consultation for 212, patients and surgery or invasive treatment to eighty –six.

St. Joseph Medical Center Village Wellness Program – Tanzania, East Africa

Established in 2002 by St. Joseph Medical Center, the Village Wellness Program (VWP) serves 70,000 villagers in 21 villages of the Karatu District of Tanzania, East Africa. The VWP is a comprehensive initiative and includes a variety of sustainable projects designed to work in tandem to improve the overall health and well-being of the villagers. St. Joseph partners with Karatu Lutheran Hospital and identifies candidates for medical and clinical scholarships to assist at the hospital and in the villages.

Addressing the root cause of illness is a key component of the VWP and to that end St. Joseph sponsors capacity building projects (mama stoves, pit latrines), animal projects and micro loan recipients. Additional VWP projects include water collection and filtration, scholarships and trainings for medical officers. In June, 2009 the VWP launched a malaria study initiative to follow and track the families utilizing the 62,000 insecticide treated bed nets. With support from friends and donors, St. Joseph Medical Center is able to extend our hearts and hands around the globe to our brothers and sisters in Tanzania. To learn more about the Village Wellness Program, please visit www.sjmcmd.org > Foundation > Tanzania Mission

Appendix 1

St. Joseph Medical Center's Charity Care Policy

Consistent with the principles of Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care at SJMC will be treated without regard to a patient's ability to pay for care. SJMC will operate in accordance with all federal and state requirements for the provision of healthcare services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The 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 based on details listed below:

- 1 Clearly posting signage in English to advise patients of the availability of financial assistance. In the event that SJMC service area consists of 10% or more of a population who does not speak English, SJMC will prepare informational notices in each of the languages that account for 10% or more of the total population.
- 2 Having staff members communicate the contents of signs to people who do not appear able to read.
- 3 Reasonable registration processes shall include asking whether an Individual is insured/and or advising the patient on eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy
- 4 After the registration process, patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition. If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be made as soon as possible but shall not exceed a period of 18 months after the provision of such services.
- 5 SJMC Billing and Payment Guidelines brochure will address patient financial assistance.
- 6 The Financial Assistance Application and accompanying instructions will clearly indicate that SJMC provides care, without regard to ability to pay, to individuals with limited financial resources, and will explain how patients can apply for financial assistance.

ST. JOSEPH MEDICAL CENTER
ADMINISTRATIVE POLICY

TITLE: Financial Assistance (Charity Care)

POLICY NUMBER: AD 9

RESPONSIBLE PARTY: Director of Revenue Cycle

POLICY EXECUTIVE: CFO

POLICY OWNER: Director of Revenue Cycle

ORIGINAL DATE: 6/99

LAST REVISION DATE: 3/05

PAGE: 1 of 20

POLICY APPROVAL STATUS:

Executive Council :

_____ (President & CEO) Date _____

Medical Executive Committee:

_____ (President of Medical Staff) Date _____

Board of Directors:

_____ (Chairman of the Board) Date _____

VALUE STATEMENT:

This policy reflects all of CHI and SJMC values. We treat our patients, families, staff and community with reverence and compassion in all our work. We work with integrity while striving for excellence in all that we do. SJMC treats all patients regardless of the ability to pay.

PURPOSE:

To outline the process for enabling qualified patients to apply for Financial Assistance who do not have the resources to pay for medical care and are not qualified for financial assistance from state, county or federal agencies.

POLICY:

I. Background – Purpose and Overview

As a Catholic health care provider and tax-exempt organization, St. Joseph Medical Center is called to meet the needs of the people who seek our care, regardless of their ability to pay for services provided. Charity care is defined as care provided to patients without expectation of payment for those services. Charity care may be provided to those who are uninsured, underinsured, or determined to be medically indigent. All patients requiring medically necessary services will have the option to apply for charity care.

II. Identifying Patients Unable to Pay for Needed Services

A. Hospitals, Outpatient Surgical Services and Clinics

1. Consistent with the principles of Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care at SJMC will be treated without regard to a patient's ability to pay for care. SJMC will operate in accordance with all federal and state requirements for the provision of healthcare services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA).

The following definitions of urgent and emergent care are provided for in this Standard.

- a) The definition of urgent care is that provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours, to avoid:
 - i. Placing the health of the patients in serious jeopardy or to avoid serious impairment or dysfunction; or
 - ii. Likely onset of an illness or injury requiring emergent services, as defined in this document.
 - b) The definition of emergent care is that provided to a patient with an emergent medical condition, further defined as:
 - i. A medical condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain, psychiatric disturbances and/or symptoms of substance abuse, etc.) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
 - Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
 - Serious impairment to bodily functions, or
 - Serious dysfunction of any bodily organ or part.
 - ii. With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.
 - iii. Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses average knowledge of health and medicine, to result in:
 - 1) placing the patient health in serious jeopardy;
 - 2) serious impairment of bodily functions; or
 - 3) serious dysfunction of any bodily organ or part.
2. Patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition. If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be

made as soon as possible but shall not exceed a period of 18 months after the provision of such services.

3. The Financial Assistance policy will apply to the variety of medically necessary services provided by SJMC. This includes all hospital services, ranging from inpatient and outpatient elective surgery, diagnostic testing, home health services, TCU services and educational programs.
4. SJMC will maintain documentation that includes an attestation from the patient's physician indicating appropriate medical necessity for all patients who apply for charity care discounts:
 - a) Medical necessity is defined as any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
 - b) SJMC will utilize SJMC medical necessity software to assure that all medical necessity determinations are administered in a consistent manner.
5. SJMC will clearly post signage in English to advise patients of the availability of financial assistance. Staff members will communicate the contents of signs to people who do not appear able to read.
6. Sharing information about charity care is differentiated into two scenarios – one for an emergency patient and another for a non-emergency patient scheduling an admission or other procedure.
 - a) Scenario – emergency patient:
 - i. Patients receiving emergency services shall be treated in accordance with SJMC's emergency services policy, developed in accordance with EMTALA and other requirements.
 - ii. SJMC will engage in reasonable registration processes for individuals requiring examination or treatment:
 - 1) Reasonable registration processes shall include asking whether an Individual is insured and, if so, the name of the insurance program utilized, if such inquiry does **not** delay screening or treatment.
 - 2) Reasonable registration process shall **not** unduly discourage patients from remaining for further evaluation. Therefore, discussions regarding financial issues shall be deferred until after the patient has been screened and necessary stabilizing treatment has been initiated.
 - 3) Once EMTALA requirements are met, patients identified through the registration process as being without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall be mailed a Financial Assistance Application within ten days of the date of service. This will ensure that all self-pay patients are informed of Financial Assistance availability in a timely manner. Compliance will be monitored through a Meditech NPR Report.

- b) Scenario – non emergency patient scheduling an admission or other procedure:
 - i. Patients without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall be mailed a Financial Assistance Application within ten days of the date of service. This will ensure that all self-pay patients are informed of Financial Assistance availability in a timely manner. Compliance will be monitored through Meditech NPR report.
- c) Under either scenario, the Financial Assistance Application and accompanying instructions will clearly indicate that SJMC provides care, without regard to ability to pay, to individuals with limited financial resources, and will explain how patients can apply for financial assistance. In addition, SJMC Billing and Payment Guidelines brochure will address patient financial assistance.
 - i. For instances in which there are significant number of patients not proficient in reading, writing or speaking English, additional information shall be provided (or assistance shall be made available) to complete necessary forms.
 - ii. In the event that SJMC service area consists of 10% or more of a population who does not speak English, SJMC will prepare informational notices in each of the languages that account for 10% or more of the total population.
 - iii. To allow SJMC to properly determine charity care eligibility, documents provided by patients to the MBO shall be written in English.
 - iv. Records maintained by SJMC to substantiate eligibility for charity care shall be completed in English.
 - v. SJMC will identify the availability of financial assistance in information booklets provided to patients and in general information provided on SJMC's website.
 - vi. SJMC will begin the process of assessing financial ability as soon as patients contact the hospital to schedule a procedure or when they register as an emergency patient (subject to the EMTALA requirements discussed above).

B. Other Services

Physician practices owned by SJMC or clinics that are an integral part of SJMC or its non-profit subsidiaries shall adopt the SJMC charity care policy. These organizations shall comply with the same charity care policy and procedures adopted by the SJMC Board of Directors.

C. Joint Operating and Joint Venture Agreements

1. SJMC under a joint operating agreement (JOA) shall adopt the CHI-SJMC charity care standard unless adoption is not permitted by language contained in the applicable JOA.
2. The CHI-SJMC charity care standard shall apply to both minority and majority owned joint venture agreements in accordance with the respective governing documents.
3. SJMC shall consider charity care obligations in agreeing upon the terms and conditions in JOA's and joint ventures.

Providing Assistance to Patients

SJMC will use the guidelines below to determine whether a patient is eligible for a charity care discount and the amount eligible for write-off or discount. SJMC will access all applications using a consistent methodology. The methodology will consider income, family size, and available resources.

The authorization of charity care discounts will be restricted to Director of Revenue Cycle up to \$10,000, the Controller \$20,000, and CFO \$20,000 and above.

A.. Authorization and Methodology

1. SJMC will utilize the *CHI Standardized Patient Charity Care Discount Application Form*.
 - **See attached Exhibit 1: Catholic Health Initiatives SJMC Financial Assistance Application** (4 pages).
2. SJMC will utilize the *CHI Standardized Charity Care Determination Checklist*.
 - **See attached Exhibit 2: Catholic Health Initiatives SJMC Financial Assistance Checklist** (1 page).
3. All available financial resources shall be evaluated before determining financial assistance eligibility. SJMC will consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g., the parent of a minor child or a patient's spouse). The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs. Patients with health spending accounts (HSAs), formerly known as medical spending accounts (MSAs), are considered to have insurance; the amount that the patient has on deposit in the HSA is to be considered insurance and not eligible for any discount.
 - **Note** The term "patient/guarantor" sometimes is used subsequently in this document to refer collectively to the patient as well as any such other person(s) having legal responsibility for the patient.
4. Eligibility for charity care discounts shall be determined based on 130% of the annually updated *HUD Geographic Very-Low Income Guidelines*, referenced later in this document, available assets and any extenuating circumstances such as an liability settlement and/or an inheritance. Thus, the standards of eligibility for the application of charity discounts must consider assets over \$2,500 as well as income.
 - d) Determinations of eligibility for charity care discounts are made for a 90-day period and applications must be submitted within 18 months of the date of service. Confirmations of continued eligibility shall be updated every 90 days for patients who require ongoing health care services. Individual claims within 90 days that are greater than \$10,000 will need signatures by appropriate person.
 - b) An individual's occupation may be indicative of eligibility for a charity care discount. Examples of low-paying jobs might include:
 - Day labor
 - Farm worker
 - Migrant worker
 - Fast food service worker
5. Information provided in the financial assistance application may indicate that a patient is eligible for financial assistance or insurance coverage not only for health care

services but also other benefits. Financial counseling staff shall assist patients in applying for available coverage.

- a) All information obtained from patients and family members shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and verbal communications. Assessment forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including the following evidence of:
 - Income from wages
 - Income from self-employment
 - Alimony
 - Child support
 - Military family-allotments
 - Public assistance
 - Pension
 - Social Security
 - Strike benefits
 - Unemployment compensation
 - Workers' compensation
 - Veterans' benefits
 - Other sources, such as income and dividends, interest or rental property
 - b) Copies of documents to substantiate income levels shall be obtained (e.g., pay check stubs, alimony and child-support documents).
6. For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year, these assets shall be evaluated as cash available to meet living expenses. Assets that shall not be considered as available to meet living expenses include; a patient's primary place of residence; adequate transportation; adequate life insurance; and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents.
- Savings, certificates of deposit, money-market or credit union accounts
 - Descriptions of owned property
7. The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about family members and/or dependents residing with the patient/guarantor, including the following information for all:
- Name, address, phone number (both work and home)
 - Age
 - Relationship
8. In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor's legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor's most recent-filed federal income tax form shall be relied upon to determine whether an individual should be considered a dependent. The patient/guarantor, shall provide employment information for the patient/guarantor as well as any others for whom the guarantor is legally obligated in regard to the well-being of the patient. Such information shall

identify the length of service with the current employer, contact information to verify employment and the individual's job title.

9. Assessment forms shall provide for a recap of average monthly expenses including:
 - Rental or mortgage payments
 - Utilities
 - Car payments
 - Food
 - Medical bills
10. Copies of rent receipts, utility receipts or monthly bank statements shall be requested. Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service and not to exceed 18 months after the date of service to enable SJMC to properly record the related revenues, net of charity care.
11. SJMC will utilize a sliding scale to provide up to a full discount of charges for patients with no third-party insurance and up to a full waiver of co-payments after the third-party insurance proceeds, based on indigence. (See attachment) The following points shall be taken into consideration.
 - a) The standards of eligibility for the application of charity discounts must consider assets, as well as income. Eligibility shall be based on 130% of the annually updated *HUD Very-Low Income Guidelines*. These HUD guidelines take into consideration family incomes that do not exceed 50% of the median family income for a geographic area and shall utilize a sliding scale approach based on income and family size.
 - b) When circumstances indicate the presence of severe financial hardship or personal loss, those patients with few resources and a high number of dependents shall receive higher levels of financial assistance. This shall be determined by the use of a sliding scale based on income and family size. The maximum income level eligibility as defined on the sliding scale represents 150% of the new base, effectively 195% of the *HUD Very-Low Income Guidelines*.
12. Patients/guarantors shall be notified when SJMC determines the amount of charity care eligibility related to services provided by SJMC. Patients/guarantors shall be advised that such eligibility does not include services provided by non-SJMC employees or other independent contractors (e.g., private, physicians, physician practices, anesthesiologists, radiologists, pathologists, etc., depending on the circumstances). The patient/guarantor shall be informed that the charity care eligibility will apply to service rendered for 90 days after approval. Patient financial records shall be flagged to indicate future services shall be written off in accordance with the financial assistance determination. Patients/guarantors shall be informed in writing if financial assistance is denied and a brief explanation shall be given for the determination provided. A copy of the letter shall be retained in the confidential central file, along with the patient/guarantor's application.
13. Completed financial assistance applications will be evaluated by the Patient Financial Eligibility Coordinator and reviewed by the Director of Revenue Cycle. On a quarterly basis, SJMC will report each account with a charity care discount threshold of \$100,000 or more to the finance committee of the SJMC Board.
14. Determining eligibility for charity care discounts shall be a continuing process. A retroactive review of accounts referred to outside collection agencies shall be conducted either annually or semi-annually to determine if any accounts would have been more properly recorded as charity care discounts and, if so, SJMC will recall such accounts

from the outside collection agency and reclassify them to charity, in accordance with generally accepted accounting principles.

15. If a fee or tuition amount is charged for an SJMC-sponsored community health educational program, SJMC will include a reference that financial assistance is available. The name, address and phone number of the Patient Financial Eligibility Coordinator shall be provided in promotional materials.
16. SJMC will retain a central file by each patient/guarantor containing financial assistance applications. To assure confidentiality, applications for financial assistance shall not be retained with the patient account registration or detailed billing information. A listing of all charity care discounts shall be maintained by the Patient Financial Eligibility office, documenting patients names, patient account numbers, date of service, brief descriptions of services provided, total charges, amount written-off to charity, dates of write-offs and the names of the authorizing individuals. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

B. Medical Indigency

The decision about a patient's medical indigency is fundamentally determined by SJMC without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients do not have appropriate insurance coverage that applies to services related to neonatal care, open-heart surgery, cancer, long and/or intensive care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets and the payment of their medical bills would be seriously detrimental to their basic financial well-being and survival.

SJMC Charity Care Committee will make a subjective decision about a patient/guarantor's medically indigent status by reviewing formal documentation for any circumstance in which a patient is considered eligible for a charity care discount on the basis of medical indigency.

1. The patient shall apply for a charity care discount in accordance with the policy in effect.
2. SJMC will obtain and/or develop documentation to support the medical indigency of the patient.
The following are examples of documentation that shall be reviewed:
 - Copies of all patient/guarantor medical bills.
 - Information related to patient/guarantor drug costs.
 - Multiple instances of high dollar patient/guarantor co-pays, deductibles, etc.
 - Other evidence of high-dollar amounts related to the healthcare costs.
3. SJMC will grant a charity care discount either through the use of the sliding scale approach or up to 100% if the patient has the following or does not qualify for MD Medicaid:
 - No material applicable insurance.
 - No material usable liquid assets.
 - Significant and/or catastrophic medical bills.
4. In most cases, the patient shall be expected to pay some amount of the medical bill, but SJMC Charity Care Committee will not determine the amount for which the patient shall be responsible based solely on the income level of the patient.

C. Presumptive Charity Care Eligibility

Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g., homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.). SJMC will grant 100% charity care discounts to patients determined to have presumptive charity care eligibility. SJMC will internally document any and all recommendations to provide presumptive charity care discounts from patients and other sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel.

1. To determine whether a qualifying event under presumptive eligibility applies, the patient/guarantor shall provide a copy of the applicable documentation that is dated within 30 days from the date of service.
2. For instances in which a patient is not able to complete an application for financial assistance, SJMC will grant a 100% charity care discount without a formal request, based on presumptive circumstances, approved by Director of Revenue Cycle or the CFO.
3. SJMC will utilize the *CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility*.
 - **See attached Exhibit 3: Catholic Health Initiatives/SJMC Uninsured /Underinsured Patient Discounts Application Form – Presumptive Eligibility** (1 page)
4. The determination of presumptive eligibility for a 100% charity care discount shall be made by SJMC on the basis of patient/guarantor income, not solely based on the income of the affected patient.
5. Individuals shall not be required to complete additional forms or provide additional information if they already have qualified for programs that, by their nature, are operated to benefit individuals without sufficient resources to pay for treatment. Rather, services provided to such individuals shall be considered charity care and shall be considered as qualifying such patients on the basis of presumptive eligibility. The following are examples of patient situations that reasonably assist in the determination of presumptive eligibility:
 - Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
 - Patient is homeless and/or has received care from a homeless clinic.
 - Patient family is eligible for and is receiving food stamps.
 - Patient's family is eligible for and is participating in subsidized school lunch programs.
 - Patient qualifies for other state or local assistance programs that are unfounded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
 - Family or friends of a patient have provided information establishing the patient's inability to pay.
 - The patient's street address is in an affordable or subsidized housing development. In this case:
 - SJMC will contact the individual state agency that oversees HUD Section 8 subsidized housing programs for low-income individuals.
 - SJMC will maintain a listing of eligible addresses in its market.
 - Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
 - Patient is deceased, with no known estate.

D. Charity Care Review Committee

SJMC will establish a Charity Care Review Committee to assist in the evaluation of subjective information related to patient accounts that do not clearly qualify under basic charity care discount eligibility criteria.

1. The types of patient accounts to be reviewed by the Committee shall include, but not limited to, the following:
 - Patients with extenuating circumstances (e.g., patients who may be medically indigent , patient who may have presumptive eligibility for a charity care discount, etc.).
 - Patient who have significant non-liquid assets.
 - Patient whose eligibility exceeds 195% of the HUD Very Low Income Guidelines and thus are not eligible for charity care discounts on the sliding scale, but whose medical bills are so large that they are unable to pay.
2. The Committee will be chaired by the Director of Revenue Cycle. At a minimum membership will include social worker, staff from mission/ministry, general accounting and patient financial services. Other members may be appointed to the Committee as deemed appropriate by SJMC.
3. The Committee shall meet monthly or on a ad hoc basis as needed.
4. The agenda for each meeting shall be comprised of patient cases requiring additional review and input by the Committee prior to the determination of charity care discount eligibility. For each patient case, the agenda will include a summary of the case, the financial situation of the patient and the other pertinent information as necessary.
5. Documentation of the Committee's meeting shall be recorded. Actions related to specific patients shall be included in the central file.

III. Recording Charity Care

SJMC will properly distinguish write-offs of patient accounts between charity care discounts and bad debt expenses. Such amounts shall be recorded in accordance with generally accepted accounting principles and properly disclosed in financial statements and other reports.

A. Generally Accepted Accounting Principles

1. Section 7.2 of the AICPA *Accounting Guide* states the following, with regard to distinguishing bad debt expense from charity care: Distinguishing bad-debt expense from charity care requires judgment. Charity care results from an entity's policies to provide health care services free of charge to individuals who meet certain financial criteria. The establishment of a policy clearly defining charity care should clearly result in a reasonable determination. Although it is not necessary for the entity to make this determination upon admission of the individual, at some point the entity must determine that the individual meets its pre-established criteria for charity care. Charity care represents health care services that were provided but never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.
2. SJMC will write off patient accounts in one of the following two categories.
 - Charity care discounts – consisting of;
 - Patients with no third-party payment source and for whom there is no expectation of payment
 -**Or**.....
 - Medicare and Medicaid patients who are determined to be financially unable to pay

applicable co-payment obligations, in which case the unpaid co-payment qualifies as a charity care discount for the MBO and can be claimed on any filing for reimbursement as a Medicare (Medicaid) bad debt.

- Bad debts – consisting of patients who have the ability to pay for health care services (including those with private insurance), where the patient or insurer does not pay the applicable obligation.

B. Financial Statement Disclosures

1. Section 2.4 of the American Institute of Certified Public Accountants (AICPA) *Audit and Accounting Guide for Audits of Providers of Health Care Services* includes the following guidance:

The level of charity care provided should be disclosed in the financial statements. Such disclosure is made in the notes to the financial statements and measured based on the provider's rates, costs, units of service, or other statistics.

2. SJMC will include information about charity care discounts in the consolidated year-end CHI community benefit disclosure.

C. IRS Reporting

SJMC will include the information noted in the preceding Section IV-B of this document in the IRS Form 990 federal reporting and required state reporting.

D. Charity Care Discounts

A line item for charity care discounts does not appear in SJMC statements of operations because the amount is netted against gross revenues. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care discounts and prior-period charity care discounts. The cost of providing charity care discounts to all patients is recorded in the appropriate natural expense classifications in the statement of operations when expenses are incurred through payroll records or accounts payable. Where scholarships are provided for community health education programs, the waived tuition or fee amounts should be tracked and reported as part of the community benefit reporting process.

E. Reserves for Charity Discounts

There is a lag between the times when services are provided and the determination is made about the eligibility for a charity care discount or financial assistance. As a result, effective July 1, 2005, SJMC will establish a reserve methodology for recording charity care discounts.

V. Recording Community Benefit

SJMC will utilize the CHI Community Benefit Handbook for determining and reporting Community Benefit.

Authors/Reviewers: Adapted from CHI Standards & Guidelines for Uninsured/Underinsured Patient Discounts.

Approved by: _____
President and CEO

St. Joseph Medical Center

7601 Osler Drive Towson, MD 21204-7582

Financial Assistance Application

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
Guarantor's Address	City, State, Zip	Home Phone #	Length of Residence
Previous Address (if less than 2 years at above)	City, State, Zip	Marital Status	# of Dependents in Household
List Names and Ages of Dependents in Household:			
Employer (Guarantor/Patient)	Previous Employer	Spouse Employer	
Address			
Job Title/Length of Employment			
Business Telephone #			
Hourly Rate			
Monthly Income Gross			
Monthly Income Net			
Other Income Source/Amount	Total Family Monthly Income	Total Family Income last 12 months	
Have you applied for Medicaid or any other State/County Assistance? (check one)	Yes	No	

Application Date		Caseworker Name/Telephone Number			
Have you filed Bankruptcy?		Chapter 7	Chapter 13	Date Filed	Date of Discharge
Yes	No				
Are you a Homeowner?		Approximate \$ Value	Approximate Balance on Loan	Years left on Loan	
Yes	No				
Bank Name	Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance	
AUTOMOBILE(S)					
1. Make:	Model:	Year:	Pymt Amount:	Balance Due:	
2. Make:	Model:	Year:	Pymt Amount:	Balance Due:	
Other Assets (Stocks Bonds, Property, Boat, Business, etc.)					
Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	\$			\$	\$
Charge Cards	\$			\$	\$
	\$			\$	\$
	\$			\$	\$
Bank Loans	\$			\$	\$
	\$			\$	\$
School Loans	\$			\$	\$
List Other Expenses Below:					
	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	\$	MEDICATION	\$	AUTO INS	\$
UTILITIES	\$	LIFE INSURANCE	\$	OTHER	\$
GAS (CAR)	\$	MEDICAL BILLS	\$	OTHER	\$
TOTAL MONTHLY EXPENSE	\$				

Note: Attach additional sheet if necessary. **Important:** income verification must be attached – W2, Pay Stub, Tax Return, etc.

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of St. Joseph Medical Center information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize St. Joseph Medical Center to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)	Date	Witness	Date
Signature (Spouse)	Date	Witness	Date

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1: Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.

2: Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.

3: Complete the guarantor's address, home telephone number and length of residence at this address.

4: Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-" in the dependent field.

5: List the names and ages of dependents.

6: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.

7: Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A".

8: Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A".

9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.

10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.

11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.

12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".

13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.

15: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other

loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this section.

DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing St. Joseph Medical Center to obtain credit information and perform a credit check.

PLEASE RETURN THE FOLLOWING INFORMATION:

_____ Completed and signed application form
_____ Proof of income for all household members
_____ Bank statements showing interest
_____ Award or denial letters from Social Services or Social Security
_____ W-2 form from most recent tax year
_____ Tax return from most recent tax year
_____ Denial letter from Maryland Medical Assistance Program

EXHIBIT 2

**Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 3: Uninsured/Underinsured Patient Discounts (Charity Care)**

Charity Care/Extended Monthly Payment Checklist (Page 1 of 2)

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION
	1—The demographic information is completed for patient <u>and</u> guarantor (i.e., address, telephone number, etc.).
	2—The dependent information is completed (i.e., number in household, names, ages, etc.).
	3—The employment and income information is completed for patient/guarantor and spouse.
	4—A copy of most recent year's IRS Tax Return is attached.
	5—A copy of most current pay stub is attached.
	6—A copy of medical savings account balance (if any) is attached.
	7—If no income is documented, attach an explanation for how expenses are being met.
	8—If the patient/guarantor has filed bankruptcy, all questions are answered.
	9—If the patient/guarantor is a homeowner, all questions are answered.
	10—Information is completed for banking information (i.e., checking and savings accounts).
	11—Information is completed for automobile.
	12—Information is completed for other assets.
	13—The expense/monthly payment information is completed.
	14—Does all information look reasonable?
	15—Are there any luxury items listed that might prevent patient/guarantor from paying the bill (e.g., country club dues, maid or lawn service, boat, high cable bills, etc.)?
	16—Has the patient/guarantor and spouse signed and dated the form?
	17—Has the witness signed and dated the form?
	18—Compare the <i>Total Family Monthly Income</i> to the <i>Total Monthly Expenses</i> . Can the patient/guarantor afford to make monthly payments? If so, contact the patient/guarantor to establish payment arrangements. STOP.
	19—If the patient/guarantor <u>cannot</u> afford monthly payments, use the Poverty Guidelines Matrix to determine if the patient/guarantor qualifies for Charity Care.
	20—If the patient qualifies for Charity Care and the total discount is less than \$2000, log on Charity Log, process discount and send acceptance for Charity Care letter to patient.
	21—If the patient qualifies for Charity Care and the total discount is over \$2000, log on Charity Log and forward all information to Director of Revenue Cycle to review and approve.
	22—If the patient does not qualify for Charity Care, send denial for Charity Care letter to patient/guarantor.
	23—If the application is incomplete, return application and all supporting documentation to patient with a letter indicating what is required and that it needs to be returned.
	24—The Director of Revenue Cycle (see policy for approval levels) needs to approve for Charity Care discounts.

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION	
	25—The Director of Revenue Cycle will return the Charity Log and all supporting documentation to the Patient Financial Eligibility Representative to send acceptance for a Charity Care letter to the patient.	
	26—The Patient Financial Eligibility Representative will send an acceptance for the Charity Care letter to the patient and return all information to the Central File for Charity Care.	
	27—The Director of Revenue selects this chart for Quality Review.	
Signature – Patient Financial Eligibility Representative		Date
Signature – Director of Revenue Cycle		Date

EXHIBIT 3

**Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 3: Uninsured/Underinsured Patient Discounts (Charity Care)**

My name is (please print): _____
LAST FIRST MI

I am: _____ The Patient _____ The Patient's Guarantor

_____ Neither (Please state your relationship to the Patient: _____)

Instructions:

- 1. Please indicate that the Patient is eligible for charity care discount because the Patient is in one or more of the following categories.***
- 2. More than one copy of this form may be required if it is to be completed by more than one individual (e.g., Patient, Guarantor, etc.).***

Please initial if category is applicable	#	Is relevant document attached?		Category
		Yes	No	
	1			Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
	2			Patient is homeless and/or has received care from a homeless clinic.
	3			Patient is eligible for and is receiving food stamps.
	4			Patient's family is eligible for and is participating in subsidized school lunch programs.
	5			Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
	6			Family or friends of a patient have provided information establishing the patient's inability to pay.
	7			The patient's street address is in an affordable or subsidized housing development.
	8			Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
	9			Patient is deceased, with no known estate.
	10			Other – <u>Provide explanation:</u>

Signature _____ Date _____

Authorized by: _____ Date _____

Title: _____



Appendix 3

Describe the hospitals mission, vision and value statements.

Mission

The mission of St. Joseph Medical Center and Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.

Vision

Our Vision is to live up to our name as one CHI:

Catholic: Living our Mission and Core Values.

Health: Improving the health of the people and communities we serve.

Initiatives: Pioneering models and systems of care to enhance care delivery.

Catholic Health Initiatives thrives on its vision of Catholic health care as a vibrant ministry, ready to provide compassionate care of the body, mind and spirit through the 21st century and beyond.

The same pioneer spirit that first led congregations of women religious to carry out the healing ministry of Jesus hundreds of years ago now guides Catholic Health Initiatives. The organization is committed to:

- Creating new ministries that build healthy communities.
- Reaching new milestones of clinical quality.
- Pursuing an agenda of social justice.

At St. Joseph Medical Center and Catholic Health Initiatives, we reach beyond the walls of our facilities to build healthy communities. In collaboration with individual citizens, community organizations and other providers of health and human services, Catholic Health Initiatives creates values-based, forward-looking models of community health.

St. Joseph Medical Center

7601 Osler Drive Towson, MD 21204 410-337-1000

Mission Statement

The mission of St. Joseph Medical Center and Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, energy, and vitality in the 21st century.

Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.

Vision Statement

St. Joseph sets a standard for excellence in Christ's healing ministry, offering a blend of community-based hospital services and regional centers of excellence preferred by patients, payers, employees and physicians. St. Joseph Medical Center will be recognized as the leading regional destination hospital by providing superior clinical expertise and quality combined with the most compassionate health care. Patient safety and operational excellence will be hallmarks of St. Joseph's reputation and culture. We will advance healthier and more productive lives in the community by building collaborative and mutually beneficial relationships with physicians, employees and other local resources. By living our core values we will be a voice and advocate for the poor, underserved and most vulnerable. The leadership of St. Joseph will be recognized for creating a high performance organization with a culture of trust, exceeding the expectations of all stakeholders and fostering growth through, people, information, quality and performance.

1. What is the licensed bed designation and number of inpatient admission for this fiscal year at your facility?

In fiscal year 2009, St. Mary's Hospital's licensed bed designation was as follows:

Medical/Surgical Acute	66
Pediatric Acute	6
Acute Psychiatric – Adult	12
Obstetric	12
Intensive Care	<u>12</u>
Total Acute Care Bed Capacity	108
 Newborn Nursery Bassinets	 16

Total admissions in fiscal year 2009 was 9,861. The number of deliveries for the fiscal year was 1,093.

2. Describe the community your organization serves.

St. Mary's Hospital is located in Leonardtown, Maryland and is part of St. Mary's County, which has the second fastest growth rate in Maryland.

Contributing to the growth in St. Mary's County is the Patuxent River Naval Air Station. Base Realignment and Closure has created significant expansion at the Naval Air Station. Defense contractor presence equates for 10,697 civilian contractors. Each direct Navy job equates to 1.5 – 2 additional local jobs.

Members of the community are scaling back on medical care due to unemployment as well as being underinsured or uninsured. These people are skipping doctor appointments, going without necessary prescription medications, and postponing or entirely skipping diagnostic testing to prevent any incurred cost(s) to themselves. St. Mary's Hospital is the only acute care hospital in the County thus playing a vital role in the healthcare of the community members and visitors to the area.

In addition to our charity care policy which will be described in Appendix 1, St. Mary's Hospital partners with physicians in St. Mary's County, the St. Mary's County Health Department and the St. Mary's County Department of Social Services in a program called Health Share of St. Mary's.

Health Share of St. Mary's was developed to serve those who cannot afford the full cost of medical services, but do not qualify for Medical Assistance. The goal of the program is to service those above the Medical Assistance level but below the Federal Poverty Level. The non-profit program provides physician care, subsidized prescriptions, diagnostic services, hospital sliding scale payments and advocacy for those who qualify. The cost of services provided to patients is tailored to the individual circumstances of each patient.

3. Identification of Community Needs.

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

St. Mary's Hospital identifies community needs by reviewing information provided thru several different sources. These sources include the following:

Maryland Rural Health Plan

The most recent year of the Maryland Rural Health Plan, dated June 2007.

Community Advisory Committees

Members of St. Mary's Hospital's staff regularly participate in the following community advisory committees. Healthcare needs of the community and answers on how the needs will be addressed are discussed at each committee's meetings.

- St. Mary's County Health Advisory Council (staffed by St. Mary's Hospital and the St. Mary's County Health Department)
- Human Services Council
- Tri-County Council VA Subcommittee

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

In addition to collaborating on the Health Share of St. Mary's program and the St. Mary's County Health Advisory Council, St. Mary's Hospital and the St. Mary's County Department of Health continually work together to address the needs of those in the community. The hospital and the Department of Health work together to provide diagnostic testing and various community outreach classes and workshops.

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

- Low cost primary care service
- Diabetes Education and Self-Management
- Living with Heart Failure
- Dealing with Cancer

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

In addition to St. Mary's Hospital's Board of Directors, associates in the following areas participate in various community and hospital committees which identify the areas that will best benefit from community benefits activities:

- Administrative Team
- Health Connections (Coordinates St. Mary's Hospital's community outreach programs)
- Performance Measurement/Clinical Resource Management

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

Low Cost Primary Care Service

St. Mary's Hospital's Health Connections department sponsors a program called Get Connected to Health. The program was developed in the fall of 2008 and utilizes the hospital's Mobile Outreach Center. The Mobile Outreach center is equipped with two exam rooms, a wheelchair lift and a cardiac monitor. Traveling care providers include a registered nurse, a volunteer physician and other St. Mary's Hospital associates.

In addition to primary care services, the following are also offered thru the Get Connected to Health program:

- Flu shots for patients over the age of 18 when vaccines are available
- Laboratory testing for the following
 - Urine
 - Rapid Strep
 - Occult Blood
 - Whole Blood Glucose
 - Pregnancy
 - Blood Sugar Testing

Diabetes Education and Self Management

St. Mary's Hospital's diabetes education program is recognized by the American Diabetes Associates and covers the following areas for individuals diagnosed with the disease:

- Treatment options
- Meal planning
- Activity and exercise
- Medications
- Monitoring

- High and low blood sugar
- Chronic complications, detection, treatment and prevention
- Goal setting and problem solving for daily living
- Coping and resources
- Insulin pump use education

Heart Failure

St. Mary's Hospital's heart failure program is staffed by a registered nurse who meets with patients while they are admitted to the hospital. After a patient is discharged, the nurse contacts him/her on a periodic basis in order to provide education and advice. Patients, their family members and caregivers are invited to attend quarterly meetings sponsored by the hospital called Living Well with Heart Failure.

Dealing with Cancer

St. Mary's Hospital teams together with the American Cancer Society and the National Cosmetology Association to host a Look Good, Feel Better program which provides support to cancer patients in all stages of diagnosis or treatment of the disease.

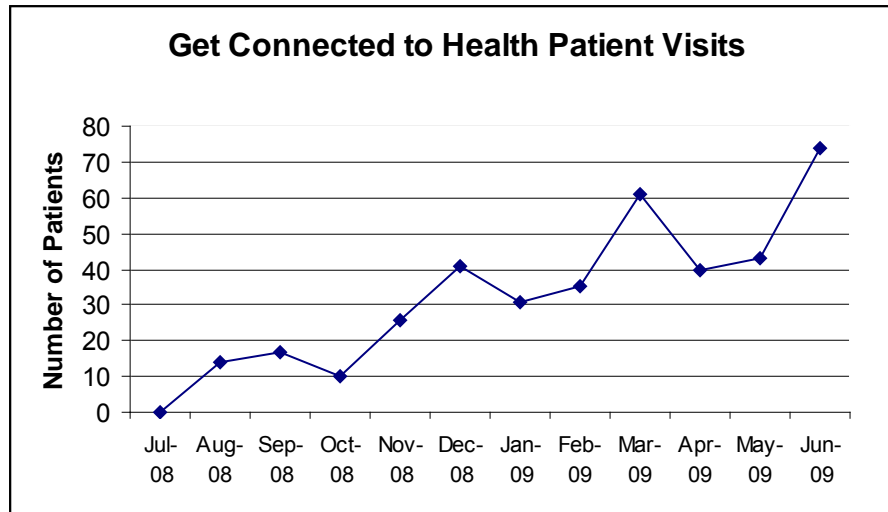
Female patients learn to improve their physical appearance and self-image via hands on beauty techniques. The goal of this hands on program is to help women deal with the side effects they may get from chemotherapy and/or radiation treatments.

St. Mary's Hospital also sponsors a free Cancer Support Group which is open to all cancer patients as well as their families and friends.

Patients of St. Mary's Hospital's Cancer Care and Infusion Services Department are offered free services from our Patient Navigator Program. Through this program, patients are navigated through all phases of diagnosis and treatment.

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

- a. **Name of initiative:** Get Connected to Health
- b. **Year of evaluation:** FY 2009
- c. **Nature of the evaluation:** (i.e., what output or outcome measures were used):
Increase participation: Average # patients seen: 1st quarter -10, 2nd quarter 26, 3rd quarter 42, and 4th quarter 52



- d. **Result of the evaluation (was the program changed, discontinued, etc)**
Program continued and plans to investigate a community health center planned for FY 2010
 - e. **If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?** N/A
-
- a. **Name of initiative:** Congestive Heart Failure (CHF) Team (Living with Heart Failure)
 - b. **Year of evaluation:** FY 2009
 - c. **Nature of the evaluation: (i.e., what output or outcome measures were used):**
Inpatient re-admissions rate for Heart Failure patients met MHA benchmark within 31 days for Heart failure (HF) patients for three quarters.
 - d. **Result of the evaluation (was the program changed, discontinued, etc):**
Goal not met. Continue to implement improvements in inpatient care, education, and discharge instructions. Continue outpatient follow up and quarterly education programs. Continue to work with Home Health Agencies. Include local nursing homes on the HF team to increase awareness & care of heart failure patients.
 - e. **If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?** N/A
-
- a. **Name of initiative:** Outpatient Diabetes Education
 - b. **Year of evaluation:** FY 2009
 - c. **Nature of the evaluation: (i.e., what output or outcome measures were used):**
Outcome: Average reduction of A1c value three months post Diabetes Education. Goal > 1.0 percentage point reduction.
 - d. **Result of the evaluation (was the program changed, discontinued, etc);**
FY 2009 average A1c reduction 2.28 percentage points
 - e. **If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?** N/A

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

The State of Maryland has a growing shortage of physicians in clinical practice. Recruiting specialist in the Southern Maryland region has proven to be quite a challenging task, however, St. Mary's Hospital continues in its efforts to recruit specialists in the following much needed areas:

- Endocrinology
- General Surgery
- Gastroenterology
- Orthopaedic Surgery
- Ophthalmology
- Hospitalists
- Intensivists

Additionally, primary care physicians are also needed.

Due to the small number of specialists on staff at St. Mary's Hospital, physicians are required to provide an exorbitant amount of emergency call coverage to the hospital's Emergency Department.

1. Describe your Charity Care policy (taken from IRS Schedule H, Part V, Question 3:

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.

St. Mary's Hospital offers a payment assistance program to patients who are deemed eligible upon completion of a Payment Assistance/Reduced Charges application form. The application forms help to determine a patient's eligibility based on income, amount of the bill and the ability to pay. The Reduced Charges Program is for patients whose religious beliefs prohibit them from participation in any type of payment assistance programs and/or insurance coverage. The Payment Assistance Program applies to all other applicants.

Information on the hospital's Payment Assistance Program is posted at every point of service for patients. Point of service areas includes all registration/admission areas, Emergency Department, and all other inpatient and outpatient service areas. Informational cards are available for patients in English and Spanish.

Patient Registrars as well as nursing and other staff involved in patient care will refer patients to the hospital's Financial Assistance Counselor when they are made aware of a patient's inability to pay for medical care. The Financial Assistance Counselor will visit the patient in his/her patient care area in order to inform them of available options for payment assistance. Patients who are being discharged or are leaving after receiving an outpatient service and have not met with the Financial Assistance Counselor are given contact information to call at a later time.

The Financial Assistance Counselor provides patients with information on the hospital's Financial Assistance and Reduced Charges programs. Additionally, the Financial Assistance Counselor, when necessary, refers patients to the St. Mary's County Department of Social Services for assistance in applying for Medical Assistance and Health Share of St. Mary's. Health Share of St. Mary's is a non-profit program that assists individuals and families who cannot afford the cost of medical service but do not qualify for Medical Assistance. The goal of Health Share of St. Mary's is to serve people who are above the Medical Assistance Level but are below the Federal Poverty Level.



St. Mary's Hospital

Administrative Policy and Procedure Manual

SUBJECT: PAYMENT ASSISTANCE PROGRAM AND HEALTH SHARE;
MATCHING PROCESS FOR AFFILIATED PHYSICIAN GROUPS

DATE: July 2009

SUPERSEDES: November 2007

MANUAL CODE: 10-L

REFERENCE: LD.3.20, LD.3.90; RI.1.10

I. POLICY

St. Mary's Hospital (SMH) will provide financial aid for hospital care that is determined to be medically necessary by the Hospital. In determining eligibility for financial aid options, the Hospital will consider the patients' income, the size of the bill, and the ability to pay. The program will be known as "Reduced Charge Program" for those patients whose religious beliefs prohibit participation in such programs and as "Payment Assistance Program" for all others. The amount of financial aid provided will be within Hospital budgetary constraints. The purpose of this policy is to describe the St. Mary's Hospital Payment Assistance/Reduced Charge Program and establish criteria to determine those patients who would be eligible under the program.

II. PROCEDURE

A. Guidelines

Write-offs will be based on the guidelines for financial aid indicated in the "Payment Assistance Program," or "Reduced Charge Program". The Hospital may consider assets on a case-by-case basis.

B. Requests

Patient Accounting employees who staff the Credit Office will initiate the process for financial aid. The form entitled "Application for Reduced Charge Program" will be used for those patients whose religious beliefs prohibit participation in charity programs. Patient Accounting employees will have the patient complete an Application for Payment Assistance (or an Application for Reduced Charges, if applicable) and a Statement of Assets, and then request proof of income. All potential cases will be reviewed to determine if they are eligible to have payment made on their behalf by another source or program.

C. Payment Assistance Program ("Charity")

There is no funding for this charity service. The program is based upon the Federal Poverty Guidelines published in the Federal Register. Once it has been determined from the hospital-based Department of Social Services (DSS) Caseworker that a customer does not qualify for any State programs, they refer him/her to the SMH Financial Assistance Counselor. The customer is required to complete a payment assistance application, and include a copy of a Federal 1040 tax form, 3 current paychecks, or an SSDI/SSI letter showing annual or monthly income. If the customer is not currently working, we require a letter of circumstance. Once all is received, the documents are reviewed by the Financial Assistance Counselor, then it is given to the Patient Accounts Supervisor to determine final eligibility. Applications are good from July 1 thru June 30 of the following year, with reviews conducted every 3 months, depending on the customer's usage of the facility. All customer applications are reviewed with the DSS Caseworker at each review. Each customer is informed that they must contact the physician billing group for the service(s) he/she received and inform them that they are in the process of filing for Payment Assistance with SMH.

Once a customer is accepted in the Payment Assistance Program, the following steps are taken:

- a. Letter of Determination is sent to the customer.
- b. A form letter is sent to the appropriate physician billing company stating that the customer has been accepted in the Program. Every customer is informed that the affiliated physician billing groups are asked to match the write off for current charges. This is a professional courtesy. The hospital has no authority to require this decision.

There is no annual maximum allowance for this service.

D. Health Share

Health Share is a St. Mary's county-based charity program. Health Share is given to uninsured patients through the St. Mary's County DSS. There is no funding. Customers must apply at the main DSS office; they cannot apply through the hospital. Customers must present their Health Share eligibility letters at the time of registration. Each time a customer uses the facility, they must provide a copy of their letter. When a customer comes in for services and does not have his/her letter, they are classed as "Self Pay" until Health Share coverage is verified.

E. Reduction Program (Amish and Mennonite Community)

The Reduction Program services the Amish and Mennonite communities of St. Mary's County. There is no funding. The hospital has a Payment Reduction Program, and if applicants qualify, they receive a reduction for services provided by the hospital. The only requirement in addition to a completed application is a Federal 1040 form. Both the application form and the Federal 1040 form are submitted to the hospital's Financial Assistance Counselor. Upon approval, the

customer receives a determination letter from the hospital, and the appropriate affiliated physician group(s) are notified. The Financial Assistance Counselor will fax the reduction determination letter to the appropriate physician group(s).

F. Authorization of Payment

For those patients that meet the eligibility requirements established herein, the Director of Revenue Cycle Management or his/her designee will approve all write-offs.

G. Patient Registration and Patient Accounting

1. If at the time of admission, the registration clerk determines that the patient does not have insurance coverage, the patient will be directed to the Credit Office of the Patient Accounting Department.
2. Upon determination that the patient would not qualify for payment from other third party sources, and circumstances exist that make patient payment unrealistic; payment assistance/reduced charges may be considered.
3. The patient will be asked to complete an Application for the Payment Assistance (or an Application for Reduced Charges if applicable), an Asset Statement, and provide verification of household income.
4. Patient Accounting employees who staff the Credit Office will calculate income; and the amount of tentative write-off based on the payment assistance guidelines.
5. All documentation will be provided to the Credit Office/Patient Accounting Department Employee who will be responsible for review of the application, its approval or denial, and return of written determination of eligibility within two (5) working days of receiving the complete patient application. The Director of Revenue Cycle Management or their designee will credit the patient accounts for properly authorized charge write-offs under this program.
6. Patient Accounting employees who staff the Credit Office are responsible to set up a payment plan for any amount of disposable income, if applicable, to be applied to the hospital bill.

Christine R. Wray
President and Chief Executive Officer

Date

Original: 12/95
Revised: 03/98, 02/01, 02/04, 04/05, 11/07, 07/09

****PLEASE NOTE THAT A SIGNED COPY OF THIS POLICY IS ON FILE IN ST.
MARY'S HOSPITAL'S ADMINISTRATIVE OFFICE****

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

St. Mary's Hospital's mission, vision and value statements reflect our commitment to providing patients with quality healthcare. Our associates provide our patients with outstanding medical care, rehabilitative therapy, community screenings and educational sessions. Meeting the growing needs of our community allow us to continue enhancing services that we provide.



St. Mary's Hospital

Our Mission: St. Mary's Hospital is a community hospital that upholds its tradition of caring by continuously promoting, maintaining and improving health through education and services while insuring fiscal integrity.

Our Vision: St. Mary's Hospital is an integral partner in the Southern Maryland healthcare continuum.

- ♦ SMH is recognized as the leader in healthcare
- ♦ SMH is proactive in furthering the health of all in the community
- ♦ The hospital provides excellence in care, service and education
- ♦ Our future is built on welcoming positive change and innovation
- ♦ We are valued and recognized as the employer of choice

Our Values: St. Mary's has adopted CARE with RESPECT as a framework of essential values to carry out its mission and vision.

Customer Service Regardless

Actions Speak Louder than Words

Respect is the Golden Rule

Excellence in All We Do

Responsibility

Education/Information

Safety

Pride

Empathy

Courtesy

Teamwork

Shady Grove Adventist Hospital **FY2009 Community Benefit Report**

1. Shady Grove Adventist Hospital is a 320 licensed bed facility with 26,890 inpatient admissions between July 1, 2008 and June 30th, 2009.
2. The service area of Shady Grove Adventist Hospital covers a large portion of Montgomery County, with a population estimated at over 530,000 for 2009.

Zip Code(s)	City/Area
20850 – 20853	Rockville
20879 & 20886	Montgomery Village
20874 & 20876	Germantown
20877, 20878, 20882	Gaithersburg
20841	Boyd's
20871 & 20872	Clarksburg & Damascus
20855	Derwood
20837	Poolesville
20854	Potomac
20906	Silver Spring

-- Demographic characteristics of the service area include the following (2009 Estimates):

Population	533,063
Median Household Income	\$123,663
Life Expectancy (2006 estimate)	77.7

-- According to the US Census Bureau, the area has families below the poverty level ranging from 5.1% to 7.8%:

Montgomery County	5.1%
Gaithersburg	7.1%
Rockville	7.8%

-- Payor mix for Shady Grove Adventist Hospital's patients, including the uninsured & Medicaid patients is as follows:

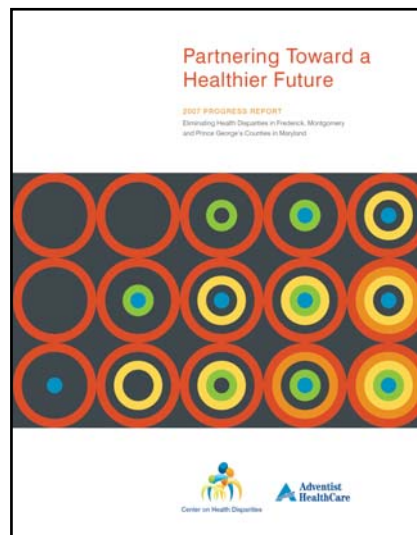
Medicare	32.8%
Medicaid	24.1%
HMO	17.3%
Self Pay	7.5%
Blue Cross	8.3%
Commercial Insurance	8.7%
All Other	1.3%
Total	100%

3. (Shady Grove Adventist Hospital ("SGAH") / Washington Adventist Hospital ("WAH")) has served the Greater Washington metropolitan community for more than (three decades / 100 years). Our mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing. Each year, SGAH / WAH, go through an extensive environmental scan using internal and publically available data sources, partnerships, and community organizations that better understands the needs within the community. Over the years, Adventist HealthCare, the parent corporate of (SGAH/WAH) has identified health care disparities in our region. As a result, AHC's pioneering Center for Health Disparities, assisted by its Blue Ribbon Advisory Panel of community leaders, has three areas of focus: increased services for underserved populations; a research program to identify and promote best practices of healthcare for the underserved; and an education initiative to improve the ability of caregivers to provide quality care to those populations. Progress continues on a number of the panel's recommendations including an annual health disparities report card, a Maternal Services Center, a Patient Advocacy Program/Linguistic Access and Disparities Awareness Program, and cultural training programs for physicians and staff.

Identification of Community Needs:

In 2007, The Center on Health Disparities at AHC, published "Partnering Toward a Healthier Future" Progress Report. The Report highlighted health disparities issues that exist in Montgomery, Prince Georges and Frederick Counties. The report proposed three recommendations:

1. Expansion of outreach and services for needs of racial and ethnic minorities is needed.
2. We need to pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers.
3. Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.



Many resources were utilized when compiling this report; U.S. Census Bureau, Maryland Department of Health and Mental Hygiene, Montgomery, Prince Georges and Frederick Counties Departments of Health and Human Services, Office of Minority Health, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Maryland Behavior Risk Factor Surveillance System, Maryland Healthcare Commission, Centers for Medicare and Medicaid Services, Kaiser Family Foundation State Health Facts, amongst others.

We conducted a 2008 progress report that highlighted our community partnerships and their accomplishments towards achieving equity. In 2009, our progress report focused on Adventist HealthCare initiatives and programs as a response to the 2007 report recommendations.



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

1. Expansion of outreach and services for needs of racial and ethnic minorities is needed.
 2. We need to pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers
 3. Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices
- 5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?**

In addition to AHC Leadership, The Center on Health Disparities has a Community Advisory Board that helped us guide and provided input into the programs that we have implemented to address the issues identified in the 2007 progress report (question 4)

- 6. Do any major community benefit program initiatives address the needs listed in #4 and if so, how?**

Yes, after discovering that 28% of Latinos and 40% of Asians are linguistically isolated in our county, we have implemented the Qualified Bilingual Staff program that trains and certifies our bilingual staff in proper interpreting skills in a medical encounter. So far we have trained over 230 individuals on our staff and also other community organizations.

We live in a very diverse community, close to 30% of Montgomery County Residents are foreign born. This statistics bring a set of opportunities when diverse individuals seek access to care. As a result we implemented the Culturally Competent Care training for health providers and staff. We have developed three modules:

Module 1	Educate participants on community/patient demographics, health disparities, Center programs and services, and cultural/linguistic competence and standards.
Module 2	Explore how personal values, biases and assumptions impact patient-provider relationships, adherence to treatment, and consequently health outcomes.
Module 3	Teach cross-cultural communication skills to facilitate communication, cultural beliefs and practices of diverse populations, and highlight implications for providers and staff.

We have established a relationship with the University of Maryland, School of Public Health, with the goal of developing a research agenda for our disparities initiatives.

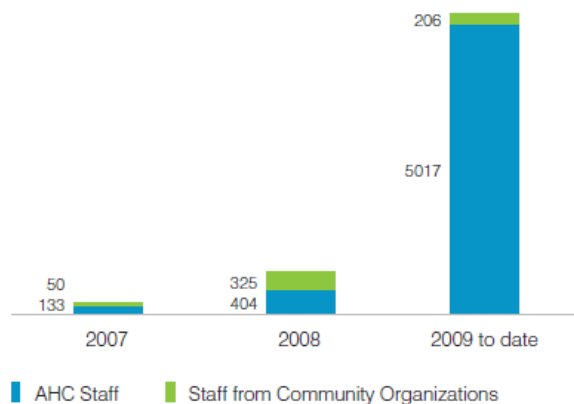
We partnered with the Brookings Institution in order to standardize demographic data collection and develop Quality Reports stratified by Race, Ethnicity and in the near future ad Language proficiency and country of origin.

Adventist HealthCare also established a partnership with Montgomery County to provide prenatal care to 1000 underserved women in the county. As well as partner with Mobile Med Clinics, Mercy Clinic and Mary Center for the provision of primary care to our most vulnerable and uninsured residents.

The Center on Health Disparities at AHC convened a conference with over 250 attendees form our community partners to highlight area accomplishments and provide a venue for transferring of best practices when implementing Health Disparities Programs.

7. Please provide description of any efforts taken to evaluate or assess the effectiveness of major community benefit program initiatives.

Cultural Competency Training Participants*



* Participants defined as individual receiving some aspect of training.
Source: Center on Health Disparities staff.

Qualified Bilingual Staff Interpreters

232 participants
95 QBS certified
QBS certified interpreters in 10 languages

QBS Evaluation Process

<p>PHASE I</p> <p>Manager's survey: Assess effectiveness and impact of QBS protocol from managers' perspective</p> <p>QBS interpreter's survey: Assess impact on staff morale, usefulness of training to interpreter, and impact on patient population</p> <p>QBS interpreter's log: Collect data on frequency, type of interpretation, providers that utilize QBS services</p> <p>QBS focus groups</p>	<p>PHASE II</p> <p>Physician's survey: Assess utility of QBS staff to healthcare encounters, knowledge of QBS availability, quality of services</p> <p>Physician education: Educate physicians on QBS use and related cultural competency issues</p>	<p>PHASE III</p> <p>Patient's survey: Assess quality of interpreters encounters, impact on patients' view of AHC, identify areas for improvement</p>	<p>PHASE IV</p> <p>Quality Study: Assess quality of QBS encounters, health outcomes of patients, cultural/linguistic sensitivity on an organizational level</p>
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8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Shady Grove Adventist Hospital has determined that there are gaps in the availability of coverage in the following specialties for our uninsured and underserved population:

Critical Care
ENT
Neurology
Neurosurgery
Obstetrics & Gynecology
Pediatrics
Urology

9. If you list physician subsidies in your data, please provide detail.

Physician Category	Amount
Emergency Department On-Call	\$1,025,969
Non-Resident House Staff and Hospitalist	\$4,448,444
Sexual Support Center	\$199,265
Recruitment of Physicians to meet community need	\$475,056

Appendix 1

Shady Grove Adventist Hospital Community Benefits Report For the Year Ended June 30, 2009

Charity Care Policy

Shady Grove Adventist Hospital informs patients of their eligibility for financial assistance under its charity care policy at several intervals. The Hospital's charity policy is clearly posted in the emergency room and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy at either the time of admission or discharge a copy of the charity policy will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is told that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines that the patient may be eligible for Medicaid an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance a copy of the Hospital's charity application will be sent to them.

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

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Charity Care Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	1 of 14

SCOPE

This policy applies to all AHC-affiliated facilities, except for Hackettstown Regional Medical Center, which has its own financial assistance policy that is compliant with New Jersey regulations.

PURPOSE:

To provide a systematic and equitable way to provide medical services to those who have a need and lack adequate resources to pay for those services. To provide service while recognizing the need to preserve the dignity of individuals in need of this assistance.

BENEFITS:

Increase in uncompensated care for community residents, decrease in bad debt placement of accounts with collection agencies . Enhanced community service by providing quality medical services regardless of a patient's ability to pay.

POLICY:

All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance. Printed public notification regarding the program will be made annually.

Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's circumstances. Circumstances could include; the needs of the patient and/or family, available income and/or other financial resources. It is part of Adventist Healthcare's mission to provide necessary medical care to those who are unable to pay for that care. However, this policy encourages a patient or their representative to cooperate with, and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for the services related to the request for Financial Assistance.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
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SCOPE:

- A.** The Financial Assistance policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Potomac Ridge Behavioral Health, Hackettstown Community Hospital or Adventist Rehab Hospital of Maryland. A patient may apply for Financial Assistance at anytime. Services not covered by the Financial Assistance policy:
1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
 2. Cosmetic, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
 3. Patients who qualify for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Financial Assistance Program to the extent that services would be covered under those programs.
- B.** The patient would be required to complete an application for Financial Assistance and be approved using established guidelines, completion of the “Income” and “Family Size” portions of the State Medicaid Application could be considered as “an application for Financial Assistance”. An approved application for assistance will be valid for six months from the effective date and can be applied to any qualified services(see “A” above), rendered within the six month period . The patient or Family Representative may reapply for Financial Assistance if their situation continues to merit assistance.

This program provides for care to be, either free or rendered at a reduced charge to those most in need, based on limited income and family size, (i.e., individuals who have income that is less than or equal to 300% of the federal poverty level), and the absence of other available financial resources. See attached Sliding Scale Chart, attached.

- C.** Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Financial Assistance without having completed a formal application.

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This would occur after a determination that other family members have no legal obligation to provide financial assistance. After receiving appropriate authorization, adjust the account balance via the appropriate adjustment Codes 23001 – Account in active AR, 33001 – Account in Bad Debt.

- D.** Where a patient is from out of state with no means to pay, follow instructions for “C” above.
- E.** A Maryland Resident who has no assets or means to pay, follow instructions for “C” above..
- F.** A Patient who files for bankruptcy, and has no identifiable means to pay the claim, follow instructions for “C” above..
- G.** Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, follow instructions for “C” above..
- H.** A Patient is denied Medicaid but is not determined to be “over scale” follow instructions for “C” above.
- I.** A Patient is an approved participant in the Montgomery County Maternity Partnership Program, but requires services not covered under the program and, services are rendered prior to the birth of the child, approve 100% Financial Assistance. The patient has already met the qualifications for Financial Assistance using the Federal Poverty Guidelines in their MCMPP Application.
- J.** Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, will have their current balances adjusted using Financial Assistance Adjustment Codes. See “C” above.

PROCEDURE:

- A.** Financial Counselor(s), Registration, Collection and Patient Communication staff should be thoroughly familiar with the criteria and process for financial assistance..

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

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Effective Date	01/08	Policy No:	AHC 3.19
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- B.** An individual notice of Financial Assistance availability should be provided to each person who seeks services in the Hospital. The notice is presented at the time of preadmission or admission, or upon request.
- C.** Patients being admitted should be prescreened for potential Financial Assistance qualification, using the questions found in the Registration- Financial Assistance Pathway.
- D.** All inpatients without documented Insurance Coverage will be referred to the Government Services Vendor by the Admitting Office Staff to complete a Medicaid application.
- E.** All applications for Financial Assistance should be sent to the Patient Financial Services Office. The Application should include at a minimum, information regarding the patient's family size and income level. **Manager of Collections and Customer Service (or designee) will take the following actions:**
1. Review application to ensure that all remaining information is complete and if necessary, contact patient/guarantor specifying what information is still needed.
 2. Determine probable eligibility within two business days of the initial request.
 3. If the patient/guarantor is deemed over scale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are over scaled per the Federal Poverty Guidelines.
 4. If the patient/guarantor qualifies according to their income, the Customer Service Manager(or designee) will query the patient accounting system to identify all of the patient or guarantor's accounts, looking for patient responsibility balances.
 5. Accounts still outstanding with the patient/guarantor's insurance carrier for payment will be held until the insurance either makes or denies payment, it will then be processed according to policy for Financial Assistance.

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6. The Manager (or designee) will then complete an adjustment form, using the Financial Assistance adjustment code, 23001 or 33001. Also, if the account is in collections document the account using the following activity codes:

Financial approval follows the following guidelines:

- a. CHDN - Financial Assistance denied- require more information.
 - b. CHLT - Financial Assistance approval sent to patient.
 - c. CHWO - Financial Assistance write-off approved.
7. The Manager (or designee) will notify any agencies that hold accounts for the patient/guarantor that they have been given Financial Assistance, providing details if there is any patient/guarantor responsibility.
 8. The application will then be forwarded to imaging to be scanned into the patient folder.

AUTOMATED PROCESS - Accounts sent to outsourced agencies:

Outsourced agencies are using software to determine a patient or guarantor's Payment Predictability Score (PPS). Where the PPS meets criteria for Financial Assistance, an adjustment will be made to the Patient's Account, See "C" above.. Adjustments will be processed electronically via an electronic report sent to the PFS Regional Director for review and final approval. The approved accounts are automatically written off by PFS per the amount of Financial Assistance applied to each account. Supporting Documents for the write-offs are kept in Electronic Files on the PFS – "N" Drive, by Vendor.

Appendix 2

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

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SAMPLE NOTICE TO BE POSTED IN ALL DESIGNATED AREAS ACCESSABLE TO THE PUBLIC

ADVENTIST HEALTHCARE NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE

Shady Grove Adventist, Potomac Ridge Behavioral Health System, Washington Adventist Hospital, Hackettstown Community Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Financial Assistance is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than twice these amounts, you may qualify for Financial Assistance.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

2008 Poverty Guidelines

<u>Size of Family Unit</u>	<u>Guideline</u>
1 _____	\$10,400
2 _____	\$14,000
3 _____	\$17,600
4 _____	\$21,200
5 _____	\$24,800
6 _____	\$28,400
7 _____	\$32,000
8 _____	\$35,600

Note: The guidelines increase **\$3,600** for each additional family member.

If you feel you may be eligible for Financial Assistance and wish to apply, please obtain an application for Community Financial Assistance from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made within thirty working days of your request.

Appendix 2

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

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ADVENTIST HEALTHCARE

Patient Financial Services, 1801 Research Blvd, Suite 300, Rockville, MD 20850

- ☐ Washington Adventist ☐ Potomac Ridge ☐ Shady Grove Adventist
☐ Adventist Rehab Hospital of Maryland ☐ Hackettstown Community Hospital

COMMUNITY FINANCIAL APPLICATION- DEMOGRAPHICS

Date: _____ Account Number(s) _____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____

Social Security #: _____ US Citizen: _____ No Residence: _____

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application _____

Dependents Listed on Tax Form:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Employment: Patient employer

Spouse employer

Name: _____ Name: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

Social Security #: _____ Social Security #: _____

How long employed: _____ How long employed: _____

TOTAL FAMILY INCOME \$ _____

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months worth of pay-stubs, or a statement from your employer and also include your 2007 taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses.

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COMMUNITY FINANCIAL APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _____
Food _____
Transportation _____
Utilities _____
Health Insurance premiums _____
Medical expenses not covered by insurance _____
 Doctor: _____

 Hospital: _____

TOTAL: _____

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

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

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

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Applicant Signature: _____ **Date:** _____

**Return Application To: Adventist HealthCare
Patient Financial Services
Attn: Customer Service Manager**

ADVENTIST HEALTH CARE, INC.

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1801 Research Blvd, Suite 300
Rockville, MD 20850

COMMUNITY FINANCIAL ASSISTANCE APPLICATION- OFFICIAL DETERMINATION ONLY

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

The reason for Denial:

What additional information is needed:

Approval Details:

Patient approved for _____ %
\$_____ will be a Financial Assistance Adjustment
\$_____ will be the patient's responsibility

Approval Letter was sent on _____

AUTHORIZED SIGNATURES:

CS/COLLECTION MANAGER
UP TO \$1500.00

Sr. ASSISTANT DIRECTOR
UP TO \$2500.00

REGIONAL DIRECTOR
UP TO \$25,000.00

HOSPITAL CFO
OVER \$25,000.00

Revised October 2008

ADVENTIST HEALTH CARE, INC.

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2008 Poverty Guideline

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	\$10,400	100% ALLOWANCE	0%
2	100%	\$14,000	100% ALLOWANCE	0%
3	100%	\$17,600	100% ALLOWANCE	0%
4	100%	\$21,200	100% ALLOWANCE	0%
5	100%	\$24,800	100% ALLOWANCE	0%
6	100%	\$28,400	100% ALLOWANCE	0%
7	100%	\$32,000	100% ALLOWANCE	0%
8	100%	\$35,600	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	125%	\$13,000	100% ALLOWANCE	0%
2	125%	\$17,500	100% ALLOWANCE	0%
3	125%	\$22,000	100% ALLOWANCE	0%
4	125%	\$26,500	100% ALLOWANCE	0%
5	125%	\$31,000	100% ALLOWANCE	0%
6	125%	\$35,500	100% ALLOWANCE	0%
7	125%	\$40,000	100% ALLOWANCE	0%
8	125%	\$44,500	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	150%	\$15,600	100% ALLOWANCE	0%
2	150%	\$21,000	100% ALLOWANCE	0%
3	150%	\$26,400	100% ALLOWANCE	0%
4	150%	\$31,800	100% ALLOWANCE	0%
5	150%	\$37,200	100% ALLOWANCE	0%
6	150%	\$42,000	100% ALLOWANCE	0%
7	150%	\$48,000	100% ALLOWANCE	0%
8	150%	\$53,400	100% ALLOWANCE	0%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	\$18,000	100% ALLOWANCE	0%
2	175%	\$24,500	100% ALLOWANCE	0%
3	175%	\$30,800	100% ALLOWANCE	0%
4	175%	\$37,100	100% ALLOWANCE	0%
5	175%	\$43,400	100% ALLOWANCE	0%
6	175%	\$49,700	100% ALLOWANCE	0%
7	175%	\$56,000	100% ALLOWANCE	0%
8	175%	\$62,000	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	200%	\$20,800	60% ALLOWANCE	0%
2	200%	\$28,000	60% ALLOWANCE	0%
3	200%	\$35,200	60% ALLOWANCE	0%
4	200%	\$42,000	60% ALLOWANCE	0%
5	200%	\$49,600	60% ALLOWANCE	0%
6	200%	\$56,800	60% ALLOWANCE	0%
7	200%	\$64,000	60% ALLOWANCE	0%
8	200%	\$71,200	60% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	225%	\$23,400	50% ALLOWANCE	50%
2	225%	\$31,500	50% ALLOWANCE	50%
3	225%	\$39,600	50% ALLOWANCE	50%
4	225%	\$47,700	50% ALLOWANCE	50%
5	225%	\$55,800	50% ALLOWANCE	50%
6	225%	\$63,900	50% ALLOWANCE	50%
7	225%	\$72,000	50% ALLOWANCE	50%
8	225%	\$80,100	50% ALLOWANCE	50%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	\$26,000	40% ALLOWANCE	60%
2	250%	\$35,000	40% ALLOWANCE	60%
3	250%	\$44,000	40% ALLOWANCE	60%
4	250%	\$53,000	40% ALLOWANCE	60%
5	250%	\$62,000	40% ALLOWANCE	60%
6	250%	\$71,000	40% ALLOWANCE	60%
7	250%	\$80,000	40% ALLOWANCE	60%
8	250%	\$89,000	40% ALLOWANCE	60%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	275%	\$28,600	30% ALLOWANCE	70%
2	275%	\$38,500	30% ALLOWANCE	70%
3	275%	\$48,400	30% ALLOWANCE	70%
4	275%	\$58,300	30% ALLOWANCE	70%
5	275%	\$68,200	30% ALLOWANCE	70%
6	275%	\$78,100	30% ALLOWANCE	70%
7	275%	\$88,000	30% ALLOWANCE	70%
8	275%	\$97,900	30% ALLOWANCE	70%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	300%	\$31,200	20% ALLOWANCE	80%
2	300%	\$42,000	20% ALLOWANCE	80%
3	300%	\$52,800	20% ALLOWANCE	80%
4	300%	\$63,600	20% ALLOWANCE	80%
5	300%	\$74,400	20% ALLOWANCE	80%
6	300%	\$85,200	20% ALLOWANCE	80%
7	300%	\$96,000	20% ALLOWANCE	80%
8	300%	\$106,800	20% ALLOWANCE	80%

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

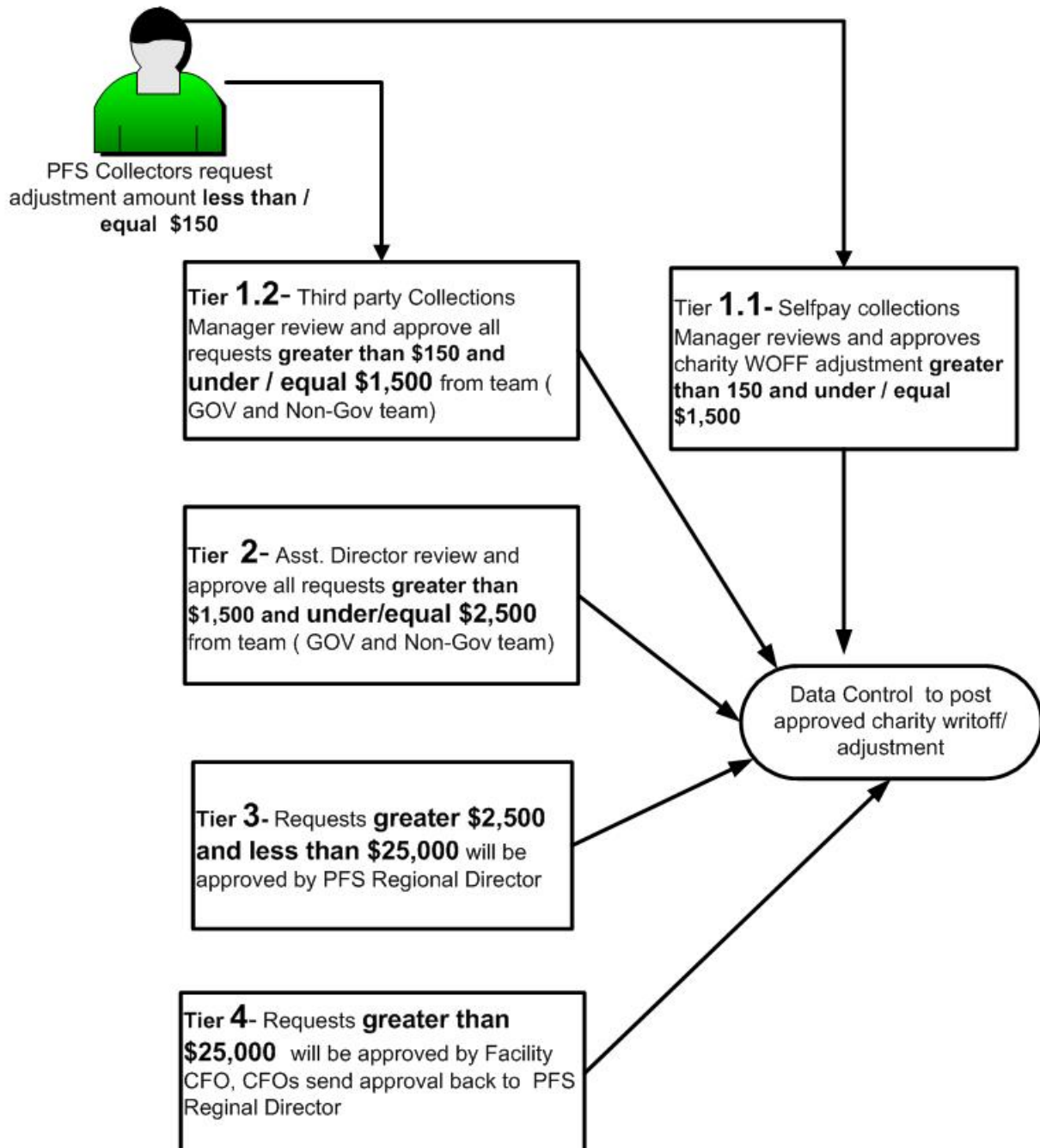
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PFS Current Manual Writeoff and Adjustment > \$100 Process
Tuesday, November 25, 2008



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



**Shady Grove Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2009**

Appendix 3 & 4 – Description of Hospital's Missions, Vision, and Value statement

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

Shady Grove Adventist Hospital's Missions, Vision, and Value statement was developed based on the following five concepts:

1. Respect: Recognize the infinite worth of each individual and care for each individual as a whole person.
2. Integrity- Be above reproach in all that we do.
3. Service: Provide compassionate and attentive care in a manner that inspires confidence.
4. Excellence: Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.
5. Stewardship: Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.

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

Narrative

Community Benefits Report For Fiscal Year 2009

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

Shore Health System, an affiliate of the University of Maryland Medical System, is currently licensed to operate 192 beds combined. Inpatient admissions for fiscal year 2009 was 15,044.

2. Description of the community Shore Health System serves:

The Memorial Hospital at Easton and Dorchester General Hospital in Cambridge are private, not for profit hospitals offering a complete range of inpatient and outpatient services to over 150,000 people throughout the Mid-Shore of Maryland. Situated on Maryland's Eastern Shore, Shore Health System services a four county area, covering Caroline, Dorchester, Queen Anne, and Talbot counties.

Talbot County Statistics from Talbot County Health Plan

Population 36,062

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

Median Household Income, 2005 \$51,637 2008 estimate **\$54,550***

Persons Below Poverty, 2006 8.5%

High School Graduate, 2006 85%

Proportion without health insurance 11%

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

Caroline County Statistics from Caroline County Health Needs Assessment

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

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

Median Household Income, 2004 \$41,432 2008 estimate **\$47,920***

Persons Below Poverty, 2004 10.5%

High School Graduate, 2000 75%

Bachelor's Degree or higher, 2000 12.1%

Proportion without health insurance 16%
(less than 65)

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

Leading Causes

1. Heart Disease 200.8

- | | |
|-----------|-------|
| 2. Cancer | 222.4 |
| 3. Stroke | 52.4 |

Dorchester County Statistics from Dorchester County Health Department

Population 31,631

Racial mixture 69.4% white, 28.4% black, 2.2% Other (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2005 \$38,347

2008 estimate **\$47,920***

Persons Below Poverty, 2005 14.4%

High School Graduate, 2006 75%

Proportion without health insurance 15.1%

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **870.3****

Queen Anne's County

Population 46,241

Racial mixture 91% white, 8% black, 1%, Other (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2005 \$65,980

2008 estimate **\$70,816***

Persons Below Poverty, 2005 6.3%

High School Graduate, 2006 84%

Proportion without health insurance 14%

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **757.2****

* Source: U.S. Census Bureau, 1989&1999, and the Maryland Department of Planning, Planning Data Services, June 2008

** Source: Maryland Vital Statistics, Annual Report 2006 Table 50.

3. Identification of Community Needs:

Shore Health identifies community needs through analysis of the current needs assessments and health plans developed by the local health departments. The needs assessments include data compiled by county, state, and federal government.

An additional source reviewed to identify community needs, is the *Healthy People 2010* guidelines established by the Maryland DHHS. The comprehensive set of health objectives set in *Healthy People 2010* serves as the framework to develop community health initiatives and activities that address major public health concerns.

4. Major Needs Identified:

The top ten areas/needs that have the greatest impact on overall health in our communities are:

- Access to quality health services
- Cancer
- Heart Disease and Stroke
- Physical Activity and Fitness
- Educational & Community-based Programs

- Diabetes
- Maternal, Infant and Child Health
- Nutrition and Obesity
- Mental Health and Mental Disorders
- Environmental Health

5. Description of the decision making process for community benefits activities:

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

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

Access to quality health services

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

Cancer

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

Stroke Prevention and Awareness

Shore Health System hosted community outreach activities including screenings and education on stroke prevention and treatment. Attendees received a free blood pressure screening and information on a variety of health topics, such as diabetes, nutrition, exercise and fitness. The Power to End Stroke Campaign, an initiative to reduce the risk of stroke among African Americans is ongoing.

Diabetes

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

Maternal, Infant and Child Health

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

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

Educational and Community-based Programs

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

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

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

SHS is continuing to work towards the incorporation of a data collection process to improve tracking effectiveness of activities.

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

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

Appendices:

Appendix 1: Describe your charity care policy

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

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

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

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

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

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

Shore Health System has a strategic plan and mission statement, which are tied to community benefits. The 2009 strategic plan is developed involving physicians, board members, Senior Leadership staff, management staff and other SHS employees.

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

Mission, Values, and Strategic Principle of Shore Health System

Mission: “To excel in quality care and patient satisfaction”

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

Strategic Principle: “Exceptional Care, Everyday”

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

SHORE HEALTH SYSTEM

Administrative Policy and Procedure

TITLE OF POLICY: PATIENT FINANCIAL SERVICES - FINANCIAL ASSISTANCE PROGRAM

PURPOSE

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

1.0 POLICY

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

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

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

2.0 PROCEDURE

2.1 Application

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

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

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

2.2.2 Income Determination

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

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

- 2.2.2.2.1 Money, wages and salaries before any deductions.
- 2.2.2.2.2 Net receipts from non-farm self employment (receipts from a person's own incorporated business, professional enterprise, or partnership, after deductions for business expenses).
- 2.2.2.2.3 Net receipts from farm self-employment (receipts from a farm that one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses).
- 2.2.2.2.4 Regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veteran's payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, and non-Federally funded General Assistance or General Relief money payments), and training stipends.
- 2.2.2.2.5 Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household.
- 2.2.2.2.6 Private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments.
- 2.2.2.2.7 College or university scholarships, grants, fellowships, and assistantships.
- 2.2.2.2.8 Dividend, interest, rental income, net royalties, periodic receipts from estates or trusts.
- 2.2.2.2.9 Net gambling and lottery winnings.

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

2.2.2.3.1 Capital gains.

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

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

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

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

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

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

2.3 Denials

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

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

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

2.4 Pending

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

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

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

2.6 Appeal Process

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

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

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

2.7 File retention

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

2.7.2 Separate files will be maintained for each Hospital.


Gerard M. Walsh, Chief Operating Officer

Effective: 10/05

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

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

Sinai Hospital of Baltimore, Inc.

FY 2009 Community Benefit Narrative Report

1. The **licensed bed designation** at Sinai Hospital of Baltimore (SHOB) is 528. **Inpatient admissions** for FY 09 were 28,410.

2. **Community Description:** Sinai Hospital of Baltimore (SHOB) is located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others from throughout the Baltimore City and County region. The neighborhoods surrounding Sinai are identified by the Baltimore Neighborhood Indicators Alliance (BNIA) as Southern Park Heights (SPH) and Pimlico/Arlington/Hilltop (PAH). Together they constitute an area that is predominately African American with a below average median family income, but above average rates for unemployment, and other social determinants of poor health.

In data from the 2000 census, BNIA's statistical information for Baltimore City and its neighborhoods indicates SPHs' median household income was \$21,218 and PAH's median household income was \$26,012. This is compared to Baltimore City's median household income of \$30,078. The percent of families earning less than the federal self-sufficiency standard in SPH was 56% for married couples with 1-5 children and 85% for "other" families with 1-5 children; in PAH these indicators were 59% for married couples and 83% for "other" families. The unemployment rate for Baltimore City was 10.9 % while SPH had an unemployment rate of 15.5% and PAH 13.8%.

The five zip codes that represent the largest number of admissions to the hospital or Emergency Room in 2009 are, in descending order of admissions 21215, 21207, 21216, 21208, 21209. The Baltimore City Health Department uses Community Statistical Areas (CSA) when analyzing health outcomes and risk factors. The CSAs are based on census tract data and do not follow zip code boundaries. In the chart below we have identified the CSAs that are contained within the zip codes of the primary service area for Sinai Hospital. Two of the zip codes (21207 and 21208) span city/county lines (see footnotes below chart). Baltimore County does not provide CSA's.

The data provided in the chart below for the primary racial composition, median income and households below poverty level was obtained from the US Census Bureau, based on census data from 2000. The life expectancy data, unless otherwise noted, was obtained from the Baltimore City Health Department's 2008 CSA health profiles.

Zip Code	21215	21207	21216	21208*	21209
Community Statistical Area	Southern Park Heights (SPH) and Pimlico/ Arlington/ Hilltop (PAH)	Howard Park/ W. Arlington	Greater Modawin (GM) and Dorchester/ Ashburton (DA)	NA (Baltimore County does not designate CSA)	Mt. Washington/ Coldspring
Total admission %	27.35%	8.11%	5.45%	5.11%	4.66%
ER %	38.5%	10.48%	7.52%	4.1%	3.86%
Primary racial Composition	80.9% African American	80% African American	97.4% African American	64.2% White	83.2% White
Median income	\$28,687	\$41,375	\$26,946	\$56,671	\$51,531
% households below poverty level	19.5%	8%	21.4%	2.2%	3.6%
Life Expectancy in years	PAH 65.6 SPH 67.1	70.8*	GM – 69.5 DA- 70.2	78.1**	76.5

*The life expectancy provided for the 21207 zip code is not for the entire zip code, but for the CSA Howard Park/W. Arlington, the city segment of that zip code. Life expectancy is not available at the zip code level in Baltimore County.

** 21208 spans city/county lines but a majority (over 90%) of the zip code is within Baltimore County. The city CSA that contains the small portion of this zip code is not representative of the zip code. The life expectancy provided for 21208 is the life expectancy for all of Baltimore County, since county zip code specific data is not available.

The racial composition and income distribution of these zip codes reflect the segregation and income disparity characteristic of the Baltimore metropolitan region. As indicated above, those zip codes that have a predominantly African American population, including 21215, in which the hospital is located, reflect the racial segregation and poverty representative of Baltimore City. This is in contrast to neighboring Baltimore County zip codes (21208 & 21209) in which the median household income is much higher, and in which the population is predominantly white. Notable is the high proportion of ER use by those in the 3 city zip codes, reflecting the use of the ER for primary medical care. Of the hospital's 74,249 ER visits 50%, or 37,434, were Medical Assistance or self pay.

3. Identification of Community Needs:

3a.) Hospitals process for identifying community needs:

Community needs assessments are done in a variety of ways, according to the hospital departments involved and the constituencies they serve. Below are several of the methods used by the hospital to identify community needs. Examples and application of the methods are described in further detail in questions 4, 5, and 6 below.

Method A: Clinical department recognition based on daily patient care.

For many of the clinical departments informal needs assessments are performed as a by-product of daily patient care, as staff encounter the needs of those who seek services. For example, when the Department of Psychiatry developed an Intensive Outpatient/Partial Hospitalization program, it identified needs beyond clinical treatment of mental illness for patients living in poverty.

Method B: Identification through participation in a community coalition.

Another way the hospital has identified community needs is through participating in or serving on community coalitions that perform a planning function. For example, the Director of Community Initiatives represented Sinai on the Baltimore City Babies Born Healthy Leadership in Action Program. This group performed a comprehensive needs assessment on the health needs of women of childbearing age to improve birth outcomes in Baltimore. The resulting recommendations of this group then became the basis for the Strategy to Improve Birth Outcomes adopted in 2009 by the Baltimore City Health Department.

Method C: Assessment by an external consultant.

An external consultant performed a needs assessment in FY 05. We used this means to conduct a needs assessment necessary to identify a priority community health need and develop an intervention in response, as charged by the health system's Board and President. As part of that assessment process, the consultant interviewed key informants including hospital staff and leadership, community service providers and other community representatives. The consultant also performed an extensive review of public health data from City, County, and State health departments. In addition, she interviewed the Health Commissioners of both Baltimore City and Baltimore County to determine their priorities, existing programs, and potential for partnerships.

Method D: Collaboration with the Health Department and/or other partners.

During FY 2009 Sinai representatives from both the Finance and Community Initiatives departments participated in a series of meetings for hospital representatives convened by the Baltimore City Health Commissioner to collaborate on the Community Benefit reporting process and possible collaborative community benefit activities. Since the conclusion of those meetings we have been holding discussions with representatives from the Health Department and another hospital to develop collaboration on two specific programs. We have also used the results of the latest formal needs assessment commissioned by the Baltimore City Health Department to guide our planning in our health equity initiatives.

3b) Consultation with local health department.

As mentioned above, in Method D, Sinai participated in a series of meetings with the Baltimore City Health Department. The health department has identified several community needs and Sinai Hospital is working in collaboration with the Health Department to address these. Additionally, as noted in Method C, when performing a formal needs assessment, we use publicly available health data compiled by local and State health departments.

4. Health needs identified by assessment processes: Using the methods described above the following major community needs were identified:

Method A: Clinical department recognition based on daily patient care.

As a result of recognizing that patients living in poverty have barriers to care beyond the identified mental illness, the Department of Psychiatry identified psychosocial issues that were affecting their patients, these include:

- 1) Transportation to access care
- 2) Nutritional deficits

Method B: Need identification through participation in a community coalition

The Babies Born Healthy Leadership in Action Program, the process identified the following needs:

- 1) Reducing unintended (unplanned and mistimed) pregnancy
- 2) Improving pregnancy outcomes among women with a previous adverse pregnancy outcome
- 3) Improving pregnancy outcomes among women who enter pregnancy with poor health, including mental health issues and/or substance abuse
- 4) Improving pregnancy outcomes among women who experience barriers to accessing prenatal care

- 5) Reducing sleep-related infant deaths

Method C: Assessment by an external consultant.

The consultant's formal needs assessment process identified:

- 1) Pediatric obesity leading to adult cardiovascular disease
- 2) Depression in the elderly

Method D: Collaboration with the Health Department and/or other partners. .

The Baltimore City Health Department identified priority needs and invited hospital collaboration on these issues:

- 1) Substance abuse
- 2) Cardiovascular disease
- 3) Violence

5. Those involved in decisions re: community needs addressed through community benefit activities: Decisions regarding the selection of community needs to address depend on the hospital departments involved and the constituencies they serve. Decisions may also involve how the community assessment was done, and for what purpose.

Method A - Clinical Department recognition based on daily patient care and professional experience.

In the process done on a regular basis by clinical departments as a by-product of daily patient care when staff encounter the needs of those who seek services, decisions are made within those departments by the caregivers and departmental administrators. If additional resources are required to support a new community benefit program, then ultimately those decisions must be made by executive management.

Method B - Participation in community coalitions.

In the second method of needs assessment, Sinai participates in community coalitions that provide a planning or program development function. If that participation reaps opportunities for program development in response to the needs identified in that process, then the hospital's representative to that group brings suggestions back to executive management for planning discussions. Once management determines that a community benefit program should be developed, then the specific clinical department that can appropriately provide the planned community benefit services will make decisions about the specific services, based on assessed needs and departmental resources.

For example, in the Baltimore Babies Born Healthy Leadership in Action process, home visiting was identified as a key intervention to improved birth outcomes for at-risk and

under-resourced pregnant women. Sinai's Department of Community Initiatives has had good experience providing such services since 1992 as a participant in a major federal infant mortality reduction initiative. We were able to further develop our capacity to provide home visiting services as a result of a partnership with the Baltimore Mayor's Office in which we were selected to be the home visiting services provider in the Park Heights Human Development Zone, our immediate community and an area of high rates of poverty and poor pregnancy outcomes.

Method C- Formal needs assessment conducted by an external consultant

When a formal needs assessment by a consultant is commissioned by the hospital, the intent is to respond to identified needs with a new community benefit program. For example the most recent consultant needs assessment (FY 05) discussed above, was a result of a charge by the health system's Board and President to identify a priority community health need and develop an intervention in response. In that case, the highest level of decision makers drove the process through their charge. However, the specific health problem selected to focus on was driven by the information the consultant gathered from key informant interviews and from public health data from City, County, and State health departments. The consultant then made recommendations of priority areas. Finally, the executive management and Community Mission Committee of the Board made the selection of the specific need to focus on and community benefit services to develop.

Method D: Collaboration with the Health Department and/or other partners

In this example, Sinai's representatives to the group convened by the Baltimore City Health Commissioner brought back ideas and the Health Department's priority needs to the hospital's president. After consultation with others in the hospital, the hospital president decided on which of the identified community needs the hospital would collaborate. Because the community in which Sinai is located has high levels of street violence resulting in its consequences being seen regularly in our Emergency Department, we have chosen to collaborate with the city on its violence intervention programs.

6. Community Benefit program initiatives to address needs in #4: As noted above, we develop community benefit programming based on identified needs and hospital resources available to address those needs.

Example A – With recognition of poor nutrition and accessibility to care for mentally ill patients living in poverty, Sinai's Department of Psychiatry now provides free hot lunches and transportation to patients enrolled in the Intensive Outpatient/Partial Hospitalization program. This community benefit is at a cost to the hospital of \$80,000 annually.

Example B – Sinai's Department of Community Initiatives has a long history of reaching out to women at risk for poor pregnancy outcomes using home visiting as a critical intervention. We have specifically focused some of our interventions on women who are

at risk due to poverty and conditions that often accompany it such as substance abuse, depression, and intimate partner violence. While these conditions may be the initial focus of selection for service eligibility, our home visitors then provide education and interventions surrounding other identified risk factors such as unintended pregnancy or infant sleep-related deaths. This program, home visiting to improve birth outcomes and health care access for at-risk and under-resourced pregnant women and new mothers, has been one of our largest and longest standing community benefit programs.

Example C - The consultant identified a major need in Sinai's community, high rates of cardiovascular disease. Because Sinai has a strong Department of Pediatrics and a pediatric outpatient service that serves a large Medicaid patient group, we decided to approach the cardiovascular health needs from a prevention perspective, targeting pediatric obesity as a precursor and cause of later cardiovascular disease. For three years (FY05-08) we provided an obesity reduction initiative in three community locations, two schools and a JCC. However, we found that we were not able to achieve the outcomes we anticipated because of the nature of the program, operating in a host setting and not able to provide the intensity and duration of services needed, so we terminated that intervention in FY08.

Example D - our collaboration with the Baltimore City Health Department and other hospital partners has resulted in several community benefit activities. The programs that the Baltimore City Health Commissioner proposed as having potential for hospitals to participate in were the Baltimore Buprenorphine Initiative, a home visiting program for patients with heart disease, and the Violence Intervention Program developed at the University of Maryland's Shock Trauma. Sinai Hospital's Addictions Recovery Program had already begun the process of becoming a provider for the Baltimore Buprenorphine Initiative, so we decided to focus on the violence intervention initiative. We have held several discussions with the staff at the Violence Intervention Program about extension of that program into the Park Heights community and the Sinai emergency department, a designated trauma center. We are currently planning a joint proposal to the Robert Wood Johnson Foundation to fund this expansion.

7. Evaluation efforts: We have used various measures to evaluate community benefit programs over the years. When funds are available through grant funding, we have hired outside program evaluation consultants from local universities or private practice. For example, in the mid 1990's we hired the evaluation team from the Johns Hopkins School of Public Health & Hygiene that was evaluating the Baltimore Healthy Start initiative to also evaluate our home visiting initiative, New Bridges to Improved Child Health. That evaluation measured rates of compliance with prenatal care visits, preterm birth, and improvement in social or behavioral determinants of health among our home visiting clients. The positive outcomes this evaluation found in over 140 women enabled us to receive subsequent funding from multiple funders to continue the program until the present. This program was also evaluated by another Johns Hopkins evaluation team when it became a component of the Baltimore Success by Six Partnership in 2001-4.

Another of our community benefit programs, our domestic violence intervention program, has had regular evaluations by domestic violence experts from the Johns Hopkins University

School of Nursing. We no longer have funds available to contract with an evaluator, but we continue to gather data on changes in attitudes, knowledge and behavior in the relationship violence prevention and treatment groups that we provide in the community and in the hospital. The previous evaluator set the evaluation up to gather such data so that we could continue to evaluate our community benefit efforts in this area after her contract terminated.

When we do not have funds to hire a consultant evaluator, the department that provides the community benefit services does its own measurement of performance and outcomes for the program. As a rule we measure outcomes for success using a Results Accountability framework.¹ The Results Accountability framework asks three questions: 1).How much work did we do? 2). How well did we do that work? 3). What effect did we make (ie how are our clients better off for our service?) We then answer each question with a performance measurement. For example:

1. How much work did we do? For example: number of clients served, assessments and service plans done, referrals made, or group sessions provided. Indicates volume of work and demand for services.
2. How well did we do that work? For example: percent of service goals met, referrals and follow-up completed, improvement in group participants' knowledge on post-tests over pre-tests. Indicates how well the staff is performing in terms of facilitating access to and utilizing services, or in educating group members. Participant reaction to staff's performance is also measured by a Participant Satisfaction survey.
3. What effect did we make? For example the measurement is the percent of clients accessing and receiving services, changes in attitudes of group participants, and life changes such as obtaining employment, leaving an abuser, or attaining sobriety. These measurements indicate the effect the program is having on the lives of those served.

8. Gaps in availability of specialty providers: As a teaching hospital with its own accredited, non-university-affiliated residency training programs, Sinai Hospital employs a faculty of 140 physicians in several specialties including Ophthalmology, Cardiac Surgery, Obstetrics and Gynecology, Pediatrics, and so forth. Faculty physicians provide services to patients through a faculty practice plan. When patients request appointments in the faculty practice offices, they are not screened on their ability to pay for services. Physician fees for uninsured patients are determined on a sliding scale based on income. Fees may be waived if a patient has no financial resources nor health insurance.

Additionally, in those specialties in which the hospital does not have a faculty, such as Dentistry, Otolaryngology, Vascular and Neuro-surgery, we employ specialists in order to provide continuous care for patients admitted to the hospital through the Emergency Department. In these cases the hospital covers these specialists' consultation fees and fees for procedures for all indigent patients. Because of these two arrangements for providing specialty care for uninsured patients, we are not able to document gaps in specialist care for uninsured patients.

However, we find gaps in the availability of specialty providers to serve those who are

uninsured or who have Medicaid from several sources. The first source of such information is those persons who use our Emergency Department for all of their medical needs. We find that uninsured persons and often also those who have Medicaid will seek care, both for primary and specialty care needs, in the Emergency Department because they do not have a medical home and they cannot afford specialty care, or physicians they seek help from are not Medicaid providers. Often those who use the Emergency Department for their sole source of care are too ill for primary care and are in need of specialty care because they have delayed care for so long.

Another reason we see the gaps in specialty services is due to our partnership with a Federally Qualified Health Center to provide primary care services to the uninsured and Medicaid recipients. Park West Health Systems, an FQHC, provides primary care on the Sinai campus, with physician services provided by Sinai faculty members. Thus, Park West's patients requiring specialty care are referred to Sinai specialists. Not all such services are readily available for these patients.

Finally, we do health promotion activities as a community benefit. When we do screening programs we must have a physician to whom we can refer those who demonstrate risk factors upon screening. However, specialists are often reluctant to participate in those screenings because they fear that they will discover conditions that require specialty care, but will not be paid for because of lack of or under-insurance. For example, urologists are reluctant to participate in prostate screenings because they do not want to be responsible for potential surgery that will be uncompensated.

9. Physician subsidies:

The OB/GYN, Internal Medicine, House Staff and Department of Medicine's Hospitalists are employed physicians, who provide 24/7 services in the hospital. The hospitalists and house staff attend to unassigned admissions through the ED many of whom are uninsured. Thus they are providing 24/7 coverage and their patients are often uninsured or underinsured, this service results in a negative profit margin.

The services provided to our uninsured patients who come to the ED result in a negative profit margin. The hospital subsidizes payments to an external physician group to provide 24/7 coverage in the ER. Without this subsidy, these physician would not be able to cover the cost of providing services to the uninsured and underinsured patients in the community.

¹ Friedman, M. (2005). Trying Hard is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities. Victoria, BC: Trafford Publishing.

Sinai Hospital of Baltimore
Financial Assistance Procedures

The following describes means used at Sinai Hospital to inform and assist patients regarding eligibility for financial assistance under governmental programs and the hospital's charity care program.

- Financial Assistance notices, including contact information, are posted in the Business Office and Admitting, as well as at points of entry and registration throughout the Hospital.
- Patient Financial Services Brochure '*Freedom to Care*' is available to all inpatients; brochures are available in all outpatient registration and service areas.
- Sinai Hospital employs one FTE Financial Assistance Liaison who is available to answer questions and to assist patients and family members with the process of applying for Financial Assistance.
- A Patient Information Sheet is given to all inpatients prior to discharge.
- A Patient Information Sheet is mailed to all inpatients with the Maryland Summary Statement.
- Sinai Hospital's uninsured (self-pay) and under-insured (Medicare beneficiary with no secondary) Medical Assistance Eligibility Program screens, assists with the application process and ultimately converts patients to various Medical Assistance coverages and includes eligibility screening and assistance with completing the Financial Assistance application as part of that process.
- Sinai Hospital participates with local Associated Jewish Charities to provide Financial Assistance eligibility for qualifying patients.
- All Hospital statements and active A/R outsource vendors include a message referencing the availability of Financial Assistance for those who are experiencing financial difficulty and provides contact information to discuss Sinai's Financial Assistance Program.
- Collection agencies initial statement references the availability of Financial Assistance for those who are experiencing financial difficulty and provides contact information to discuss Sinai's Financial Assistance Program.
- All Hospital Patient Financial Services staff, active A/R outsource vendors, collection agencies and Medicaid Eligibility vendors are trained to identify potential Financial Assistance eligibility and assist patients with the Financial Assistance application process.
- Financial Assistance application and instruction cover sheet is available in Russian; translation to Spanish is in process with an expected completion date of September 30, 2009.
- Sinai Hospital hosts and participates in various Department of Health and Mental Hygiene and Maryland Hospital Association sponsored campaigns like 'Cover the Uninsured Week'.

SINAI HOSPITAL OF BALTIMORE

HOSPITAL ADMINISTRATIVE POLICY

Financial Assistance

PURPOSE: To assist patients who do not qualify for Financial Assistance from State, County or Federal Agencies, but may qualify for uncompensated care under Federal Poverty Guidelines.

POLICY: To provide Financial Assistance applications to patients experiencing financial difficulty paying for their hospital bill(s). Eligibility is based on gross income and family size according to current Federal Poverty Guidelines.

Financial Assistance information is made available to the public through multiple sources including: 1) the admission packet, 2) signage and pamphlets located in Admitting, the Emergency Room, Patient Accounting, as well as other patient access points throughout the hospital, and 3) registration and Patient Accounting staff.

Financial Assistance eligibility determinations cover facility/hospital patient charges only. Physicians and ancillary service providers outside of Sinai Hospital of Baltimore are not covered by this policy.

Original Date: 7/92

Review Date: 6/96

Revised Date: 9/96, 5/98, 9/01, 12/02, 8/04, 2/05, 3/05, 6/08, 10/08, 01/09

Approvals:

Name:	Title:	Date:
Neil M. Meltzer	President/COO	03/01/2005
Charles Orlando	Senior Vice President/CFO	03/01/2005

Neil M. Meltzer

President/COO

Anthony K. Morris

Vice President/Revenue Cycle

SINAI HOSPITAL OF BALTIMORE

HOSPITAL ADMINISTRATIVE POLICY**Financial Assistance**

IMPLEMENTATION/PROCEDURE: Implementation procedures are different for non-emergent and emergent services.

A. Unplanned, Emergent Services and Continuing Care Admissions

1. Unplanned and Emergent services are defined as admissions through the Emergency Department. Continuing care admissions are defined as admissions related to the same diagnosis/treatment as a prior admission for the patient.
2. Patients who believe they will not be able to meet their financial responsibility for services received at Sinai Hospital will be referred to a Patient Financial Advisor or Customer Service Technician in Patient Financial Services.
3. For inpatient visits the Patient Financial Advisor or Customer Service Technician will work with the Medical Assistance Liaison to determine if the patient is eligible for Maryland Medical Assistance. The patient will provide information to make this determination. The Patient Financial Advisor or Medical Assistance Liaison will determine probable Medicaid eligibility within two (2) business days of initial application.
4. If the patient does not qualify for Maryland Medical Assistance the Patient Financial Advisor or Customer Service Technician will determine if the patient has financial resources to pay for services rendered based on Federal Poverty Guidelines.
5. If the patient does have the financial resources according to the Guidelines, the Patient Financial Advisor or Customer Service Technician will arrange for payment from the patient following Sinai's payment arrangement guidelines.
6. If the patient does not have the financial resources according to the Guidelines, the Patient Financial Advisor or Customer Service Technician will assist the patient with the Financial Assistance application process.
7. Patients may request Financial Assistance prior to treatment or after billing.
8. Patients must complete the Financial Assistance application and provide the Patient Financial Advisor or the Customer Service Technician documented proof of income for consideration. At least one of the following items is required:
 - a. Patient's recent paycheck stub
 - b. Copy of the prior year's tax statement and/or W-2 form
 - c. Verification of income with employer via telephone

SINAI HOSPITAL OF BALTIMORE

HOSPITAL ADMINISTRATIVE POLICY

Financial Assistance

- d. Verification of other household income, i.e. Social Security Award Letter, retirement/pension payment, etc
- 9. Financial Assistance Eligibility:
 - a. Approved Medicare inpatients and outpatients are certified for one year from approval date. Medicare patients are required to provide a copy of their Social Security Award Letter on a yearly basis.
 - b. Non-Medicare inpatients and outpatients are certified for six months from approval date, with the exception of outpatient psychiatry services, which are certified for one year from approval date. However, if it is determined during the course of that period that the patient meets Maryland Medical Assistance eligibility requirements, we will assist the patient with this process while still considering requests for Financial Assistance.
 - c. Outpatient surgical procedures, including multiple procedures as part of a treatment plan, may be certified for one time only. Additional surgical procedures would require a new application.
 - d. Dates of service outside the Financial Assistance consideration period, prior to the approval date, will be considered on a case-by-case basis.

At time of application, all open accounts are eligible for consideration including accounts previously written-off to bad debt, which are reviewed on a case-by-case basis.

- 10. Financial Assistance is based upon the Federal Poverty Guidelines published in the Federal Register. The poverty level guidelines are revised annually. Patients with an annual income up to 200% of the Federal Poverty Level may have 100% of their hospital bill(s) covered by Financial Assistance.
- 11. Patients slightly above 200% annual income may have a portion of their medical bill covered by Financial Assistance based on a sliding scale. The Financial Assistance amount is calculated as follows:
 - Identify the annual income based on the income tax form or W-2 (A)
 - Identify 200% of the Federal Poverty Level for the patient based on household size (B).
 - Subtract B from A. This is the maximum amount for which the patient would be responsible (C). Failure to pay the patient responsibility will result in a reversal of the Financial Assistance adjustment resulting in the patient being responsible for total charges.
 - Subtract C from the patient liability on the hospital bill(s). This is the approved Financial Assistance amount.

SINAI HOSPITAL OF BALTIMORE

HOSPITAL ADMINISTRATIVE POLICY**Financial Assistance**

12. The Director of Patient Financial Services or his/her designee approves or denies the application.
13. Patients will receive determination of probable eligibility of Financial Assistance within two (2) business days from application receipt date.

B. Planned, Non-Emergent Services

1. Prior to an admission, the physician's office or hospital scheduler will determine if a patient has medical insurance. If the patient does not have medical insurance, the physician's office or hospital scheduler will call a Patient Financial Advisor in Admitting. The Patient Financial Advisor will work with the Medical Assistance Liaison to screen the patient for Maryland Medical Assistance eligibility. The Patient Financial Advisor will determine probable eligibility within two (2) business days from initial application.
2. The Patient Financial Advisor will obtain information from the patient to determine Maryland Medical Assistance eligibility. If the patient qualifies, the appointment is confirmed and the patient will receive service as scheduled.
3. If the patient is scheduled for service prior to Maryland Medical Assistance probable eligibility determination, the Patient Financial Advisor will contact the physician's office to postpone the service. If the physician does not want to postpone the service, the Patient Financial Advisor will inform the physician that the Vice President of Revenue Cycle and/or Vice President of Finance will review and determine whether the case will be postponed, provided, or denied. The Vice President of Revenue Cycle and/or Vice President of Finance will contact the physician regarding the case. The Vice President of Revenue Cycle and/or Vice President of Finance will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether Financial Assistance should be provided. Final determination will be made on a case-by-case basis.
4. If the patient does not qualify for Maryland Medical Assistance, the Patient Financial Advisor will determine an estimate of charges for services to be provided. The Patient Financial Advisor will contact the patient for payment.
5. For planned, non-emergent services, Self Pay patients who are United States citizens must pay at least 50% of estimated charges prior to service, with an agreement to pay the remaining 50% not to exceed two (2) years. For patients who are not United States citizens, 100% of the estimated charges must be paid prior to date of service. Financial Assistance eligibility may be considered on a case-by-case basis for non-emergent, yet

SINAI HOSPITAL OF BALTIMORE

HOSPITAL ADMINISTRATIVE POLICY

Financial Assistance

medically necessary services, based on the policies documented herein. Vice President of Revenue Cycle and/or Vice President of Finance approval are required.

6. If an agreement is made, the patient must provide payment at least three (3) business days prior to service, and sign the LifeBridge Health Installment Agreement Form. If the patient has the financial resources according to the Federal Poverty Guidelines, but fails to pay prior to service or sign the Self Pay Agreement Form, the Patient Financial Advisor will contact the physician's office to request that the planned service be cancelled due to non- payment.
7. If there are extenuating circumstances regarding the patient, the patient's clinical condition, or the patient's financial condition, the patient or the physician may seek an exception from the Vice President of Revenue Cycle and/or the Vice President of Finance. If an exception is requested, the Patient Financial Advisor will gather documented proof of income as stated in the emergent section of this procedure. The Vice President of Revenue Cycle and/or the Vice President of Finance will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether Financial Assistance should be provided. Final determination will be made on a case-by-case basis.

Sinai Hospital of Baltimore
Mission Statement

Sinai Hospital of Baltimore provides a broad array of high quality, cost effective health and health related services to the people of Greater Baltimore. Central to its role is the provision of undergraduate and graduate medical education and educational programs to other health professionals, employees, and the community at large.

As an organization founded and supported by the Jewish community, it carries out its mission with sensitivity to the needs of Jewish patients and staff, and asserts traditional Jewish values of excellence, compassion and community concern for all.

October, 1992



SOUTHERN MARYLAND HOSPITAL CENTER

7503 SURRATTS ROAD • CLINTON, MARYLAND 20735 • (301) 868-8000

December 11, 2009

Mr. Robert Murray, Executive Director
Health Systems Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Community Benefit Report

Dear Mr. Murray:

Attached is the community benefit report for Southern Maryland Hospital Center ("SMHC"). While the hospital is the only taxable hospital in the state and therefore exempt from this reporting requirement, we choose to file this report in order to show the community benefits we provide in addition to the various Federal, State, and local taxes paid.

SMHC is committed to the health and wellness of our community. As such, we dedicate ourselves to providing quality health care that is accessible to all constituencies, and moreover remain focused on the core mission of the hospital with the investment in time, talent and resources necessary to achieve goals and sustain programs and services through systematic change in strategic planning. To enhance the wellness of our community (as highlighted later in this report) we commit ourselves, and our resources to a diverse array of education, health screenings, and community outreach programs.

Southern Maryland Hospital is currently licensed for 255 beds under the Maryland regulatory system and the total physical capacity is 350 beds. For the Fiscal Year ending June 30, 2009 there have been 19,089 admissions to the facility and well over 100,000 outpatient visits such as emergency room visits, outpatient surgeries, and other types of scheduled services.

Southern Maryland Hospital Center is located in Clinton, Maryland within the epicenter of southern Prince George's County and nearby Charles County, Maryland. The region has pressing community development and community health care needs that are complicated by a set of unique geographic and socioeconomic factors. A detailed set of maps and charts in Appendix A graphically depict characteristics of the population served by the Hospital accompanied by projected growth estimates by the year 2011 within the Hospital's primary service area based on zip code assessment, and summarized as follows:

- Based on 2006 resource data, the estimated population within the Hospital's service area is 351,638 and is expected to increase 6% by 2011. As reported by the Prince George's

County government, in the estimated overall census for 2005, there were 846,123 people, 286,610 households, and 198,047 families residing in the county.

- ❑ Among the highest growing segments within this population, it is estimated females aged 35+ will represent 11% growth, adults age 65+ will grow 32%, and those in the age category 45 – 65 (a.k.a. the so called “baby boomer” generation) will grow 14%.
- ❑ With respect to the demographic make-up of the Hospital’s service area, 97% is non-Hispanic and 3% Hispanic. Segments within the non-Hispanic population are African-American 73%, Caucasian 21%, Asian 3%, and other 3%.
- ❑ Prince George’s County statistics reveal the median income for a household in the county was \$55,256, and the median income for a family was \$62,467. Males had a median income of \$38,904 versus \$35,718 for females. The per capita income for the county was \$23,360. About 5.3% of families and 7.7% of the population were below the poverty line including 9.2% of those under age 18 and 6.9% of those ages 65 or over. Southern Maryland Hospital Center has rendered services to slightly less than **9% of patients with no insurance** and just **over 14% with Medicaid**.

In response to the HSCRC request for a written description of gaps in availability of specialist providers to serve the uninsured in the community, the following perspective is provided:

Over a period of several years, various medical specialty practitioners as well as primary care physicians on the active medical staff within our service areas gradually began to notify the hospital that they would no longer be able to participate in emergency room call coverage for their specialty or continue to directly admit patients to the hospital. Researching the dynamics of this experience with other hospitals in our region, we found our situation was clearly not unique with respect to gaps in coverage from the available pool of providers that could potentially be drawn upon to serve the uninsured and underinsured in the community.

It also became apparent that the solution other facilities gravitated to out of necessity, was to essentially “underwrite” the cost for these provider services, that would in effect subsidize the medical specialist for attending to “no pay,” or “limited pay,” patients. The medical specialists we are reporting are also those in which, by virtue of their area of specialization, there tends to be a higher incidence of “no pay,” or “limited pay” patient encounters.

For the specialties of Obstetrics and Gynecology, Pediatrics and Neonatology, Gastroenterology, Otolaryngology, Orthopedics, Neurosurgery, and Primary Care, the hospital found that these independent medical groups encountered the most consistent trend in which their patient encounters had the potential of leading to no reimbursement or minimal reimbursement for services provided. The hospital quickly came to the realization that these specialty services were critical to the continued operation of this facility as an acute care hospital offering immediate access to the full range of acute care services responsive to the needs of all segments of the patient population we serve.

Measured steps have been undertaken by the hospital to mitigate gaps in provider coverage:

1. Hospitalist physicians: the hospital was proactive years ago in responding to a recognized need for attending to unassigned Emergency Room admissions many of whom were among the uninsured within the community. Staff physicians employed by the hospital within this group are available 24 hours per day and 7 days per week basis (24/7) fulfilling a pivotal role in providing coverage for primary care.
2. Anesthesia: Likewise, an internal staffing model was created for anesthesia to assure optimal 24/7 obstetrical coverage.
3. Emergency Medicine: The hospital established an Emergency Medical Group three years ago where the physicians are employed and managed by the hospital.
4. Obstetrics, pediatrics and neonatology: The hospital employs and manages a group of house-based obstetrical practitioners, pediatricians and neonatologists.
5. The hospital underwrites specialty coverage for *Orthopedics, Neurosurgery, Gastroenterology, Urology, and Otolaryngology* from local providers on a 24/7 basis.

As a provider of services to those suffering from the effects of chronic illness, SMHC is acutely aware of the benefits that prevention and early detection of disease provide to the community. The hospital and its staff have consistently focused over the years on educating the community about various resources available to them. It is thus that SMHC offers a variety of free educational outreach programs and resources (delineated in Appendix E) designed to promote community wellness.

1. “Ask the Doctor” Free Community Seminars – SMHC physicians and professional staff give presentations on a variety of health topics in a relaxed, welcoming environment. After the presentation, an open discussion and question and answer session takes place. By way of example, seminars have focused on Parkinson’s disease, arthritis, coronary artery disease, childhood & adolescent obesity, and chronic lung diseases.
2. Community Education Classes – SMHC offers classes on a variety of subjects, including heart failure management, cardiac risk reduction, freedom from smoking, total joint replacement, CPR and a range of maternal child health classes covering topics such as childbirth, breastfeeding, and the first year of life. Knowledge, to us, is the key to helping individuals and families stay healthy, make positive lifestyle changes or manage a chronic condition. It is a vital resource to the community.
3. Support Groups – Sometimes it helps people in our community to know they’re not alone with respect to health care concerns. As a professional courtesy to our community, SMHC hosts an array of support groups for a range of health issues such as Alzheimer’s

disease, stroke, prostate cancer, breast cancer, mental health & emotional well-being and perinatal loss.

4. Health and Fitness programs for Body and Mind -- community members are encouraged to take a positive step toward a healthy future by partaking of programs structured with practical application and educational components such as adult weight reduction, swimming lessons, exercise for arthritic patients or help individuals understand and manage diabetes or heart disease. One important ongoing program is the daily, "Mall Walkers" group that engages in a popular indoor cardiovascular fitness regime.
5. Several staff members including a nurse are dispatched each week to participate in health fairs, county fairs, local churches and community centers, where basic health screening exams such as blood pressure, prostate screening, cholesterol, blood glucose level and other lab tests are offered. Influenza vaccinations are also facilitated at these events during the flu season.

Our Chaplaincy Department provides pastoral care and support for staff and patients, and also assists community spiritual leaders and clergy who visit the hospital in matters of health, grief counseling, end-of-life concerns, and advance directives.

In addition to normal duties, the Patient Relations staff provides resources to patients and their families. They conduct patient interviews and proactively visit patients throughout their hospital stay. In the primary role of a patient advocate, they document and track patient concerns and communicate issues or trends directly to senior management in nursing and hospital administration.

Also attached is a description of our Financial Assistance Policy (Appendix B), a copy of the Financial Assistance Policy (Appendix C), Southern Maryland Hospital Center's Mission and Vision statements (Appendix D) and Community Benefits Report Stats for the period 07/01/08 – 06/31/09 (Appendix E).

If you need any additional information, please contact me at 301-877-5527.

Sincerely,

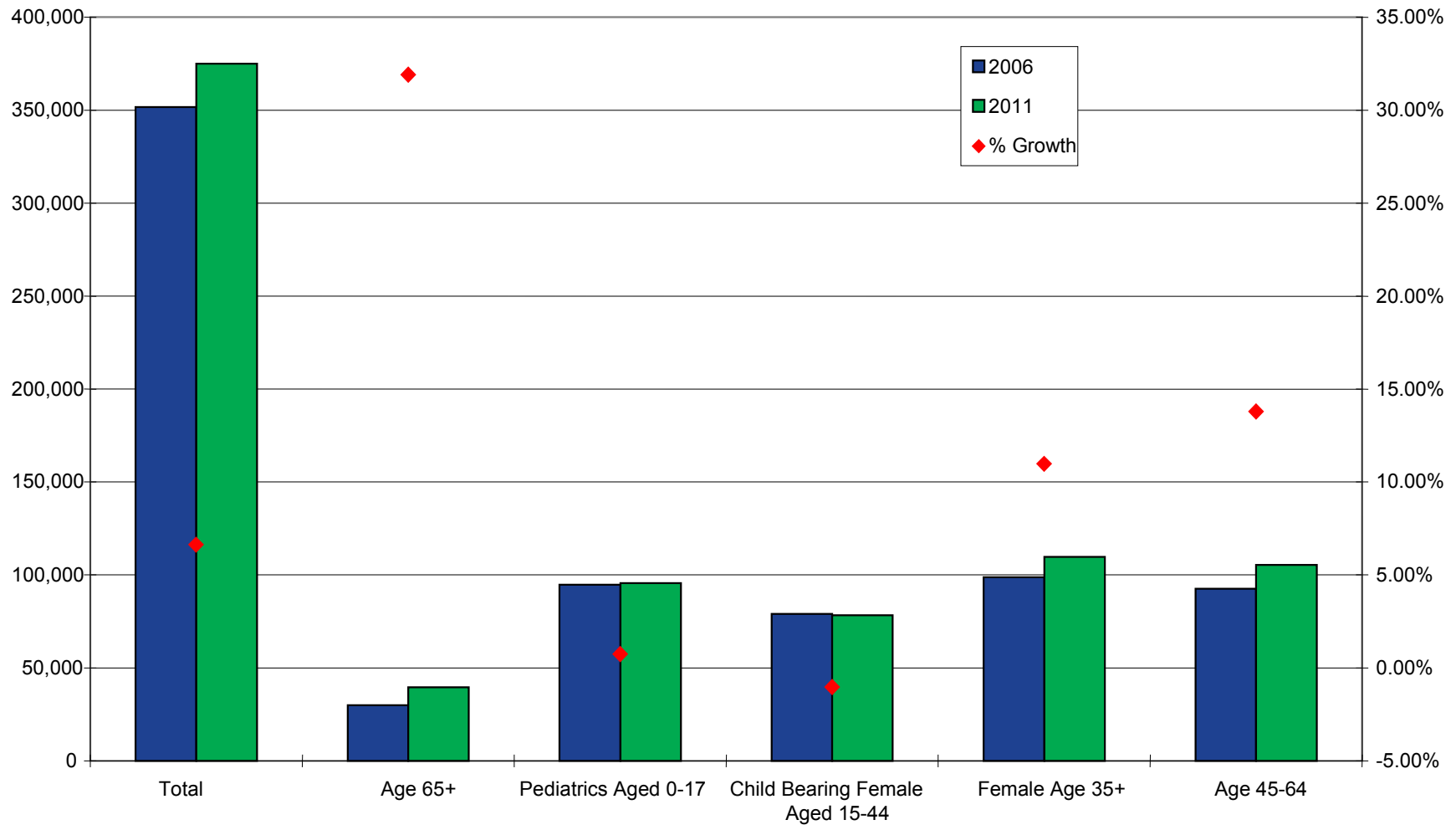


Charles R. Stewart

Vice President of Business, Finance, and Corporate Compliance

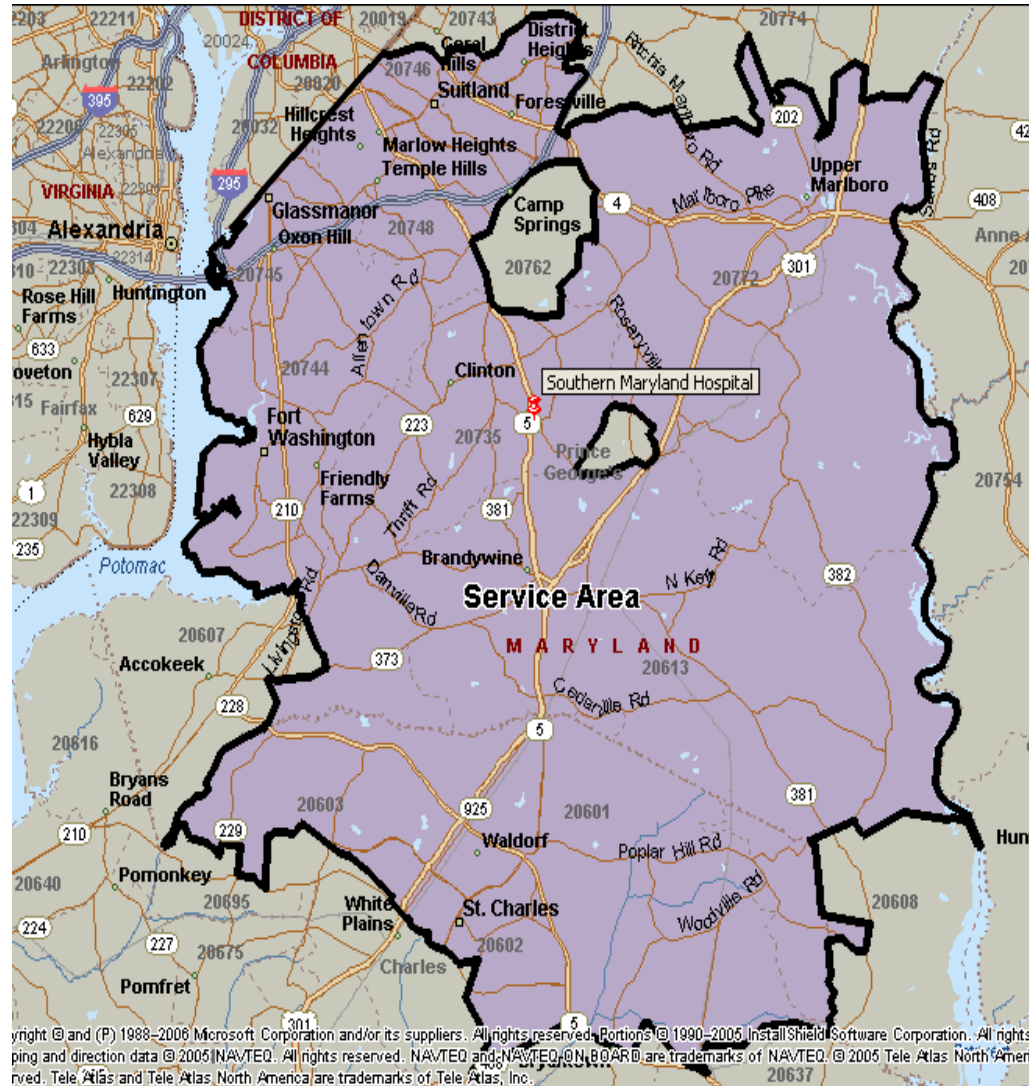
Attachments

Southern Maryland Hospital Center Service Area Demographics—Population



Southern Maryland Hospital Center

Primary Service Area by Zip Code

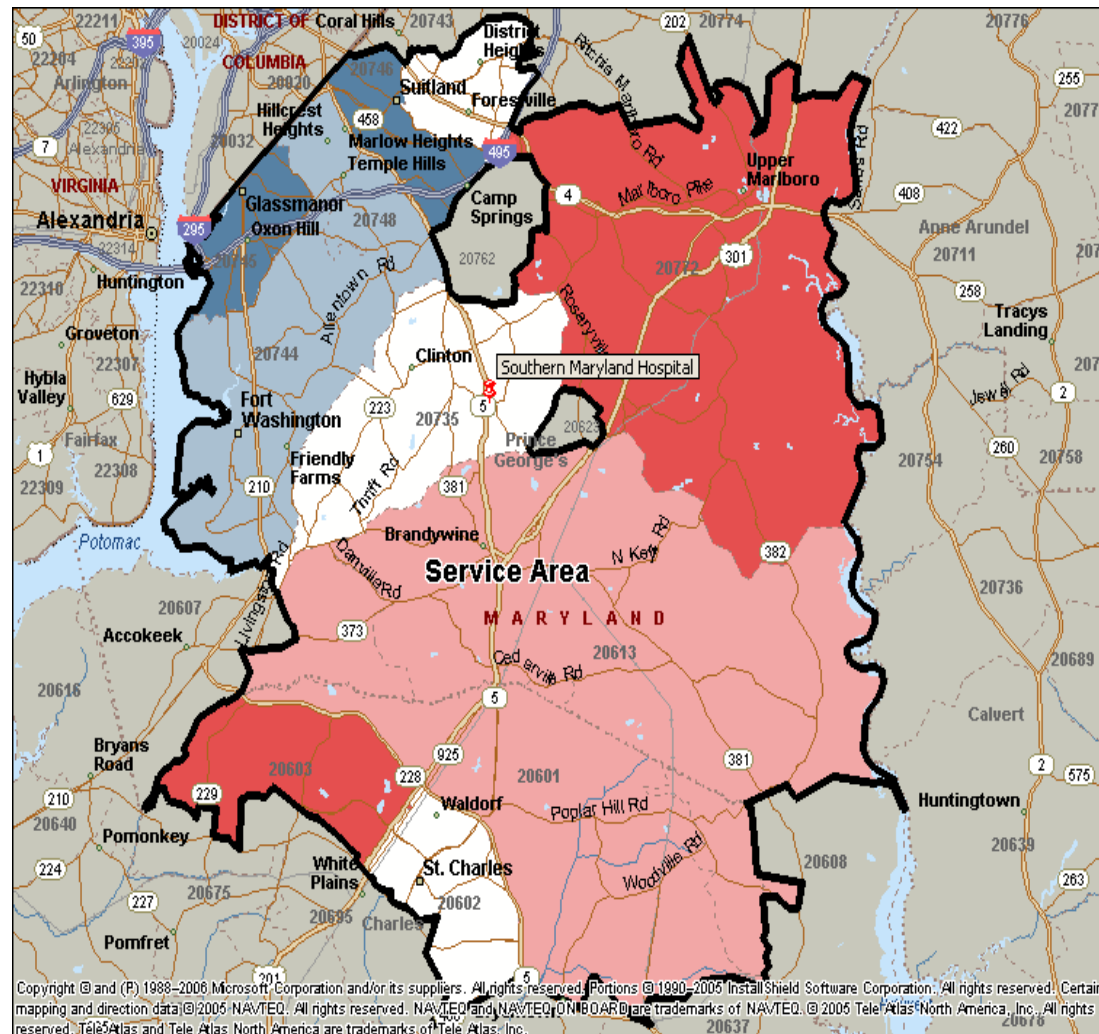


ZIP CODE	CITY	COUNTY	STATE
20601	Waldorf	Charles	MD
20602	Waldorf	Charles	MD
20603	Waldorf	Charles	MD
20613	Brandywine	Prince George's	MD
20735	Clinton	Prince George's	MD
20744	Fort Washington	Prince George's	MD
20745	Oxon Hill	Prince George's	MD
20746	Suitland	Prince George's	MD
20747	District Heights	Prince George's	MD
20748	Temple Hills	Prince George's	MD
20772	Upper Marlboro	Prince George's	MD

Southern Maryland Hospital Center Primary Service Area by Demographics

Population	2006	2011	% Growth
Total	351,638	374,943	6.63%
Age 65+	29,928	39,475	31.90%
Pediatrics Aged 0-17	94,848	95,558	0.75%
Female Aged 15-44	79,053	78,238	-1.03%
Female Pop 35+	98,768	109,607	10.97%
Male/Female Aged 45-64	92,604	105,379	13.80%

Southern Maryland Hospital Center Demographics (Zip Code Detail)



ZIP CODE	2006	2011	5-Yr % Growth
20603	26,166	30,582	16.9%
20772	41,587	47,048	13.1%
20601	25,159	27,680	10.0%
20613	9,423	10,206	8.3%
20735	35,819	38,136	6.5%
20747	41,543	43,563	4.9%
20602	22,538	23,618	4.8%
20744	50,793	53,047	4.4%
20748	41,458	42,773	3.2%
20746	29,138	29,875	2.5%
20745	28,014	28,415	1.4%
Totals	351,638	374,943	6.6%

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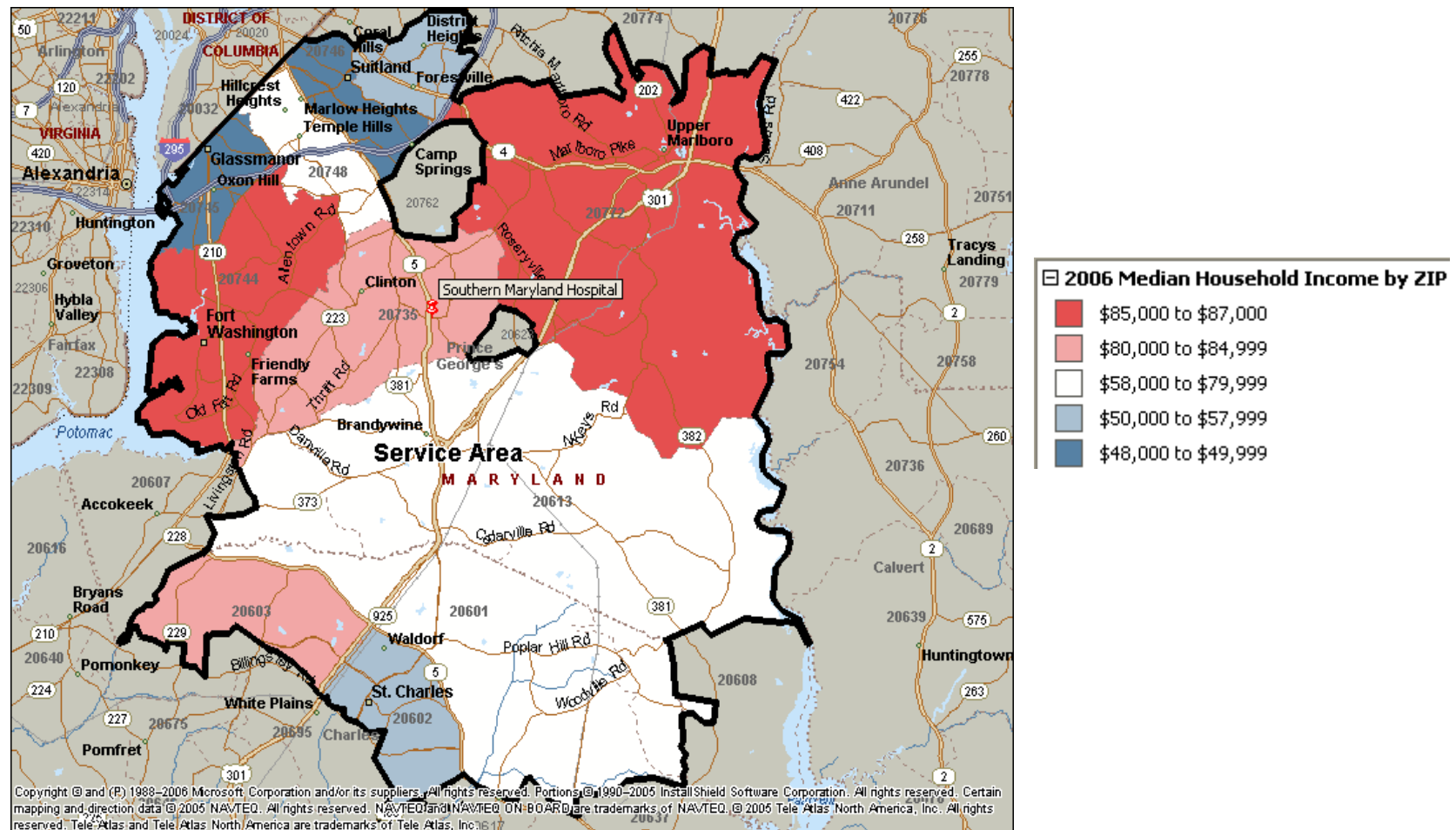
Southern Maryland Hospital Center Population by Zip Code – Chart A

Service Area	Total			Age 65+			Age 0-17		
	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth
20601	25,159	27,680	10.02%	1,620	2,375	46.60%	6,863	6,921	0.85%
20602	22,538	23,618	4.79%	1,561	2,012	28.89%	6,415	6,264	-2.35%
20603	26,166	30,582	16.88%	1,215	1,893	55.80%	7,928	8,594	8.40%
20613	9,423	10,206	8.31%	1,152	1,438	24.83%	2,413	2,477	2.65%
20735	35,819	38,136	6.47%	3,616	4,788	32.41%	9,211	9,120	-0.99%
20744	50,793	53,047	4.44%	5,266	6,926	31.52%	12,126	11,810	-2.61%
20745	28,014	28,415	1.43%	2,276	2,877	26.41%	8,006	7,805	-2.51%
20746	29,138	29,875	2.53%	2,270	2,823	24.36%	8,556	8,443	-1.32%
20747	41,543	43,563	4.86%	3,119	4,094	31.26%	11,980	11,860	-1.00%
20748	41,458	42,773	3.17%	4,495	5,413	20.42%	10,538	10,442	-0.91%
20772	41,587	47,048	13.13%	3,338	4,836	44.88%	10,812	11,822	9.34%
Totals	351,638	374,943	6.63%	29,928	39,475	31.90%	94,848	95,558	0.75%

Southern Maryland Hospital Center Population by Zip Code – Chart B

Service Area	Age 15-44 Female Child Bearing Years			Age 35+ Female			Age 45-64 Baby Boomers"		
	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth
20601	6,034	6,174	2.32%	6,418	7,505	16.94%	6,258	7,661	22.42%
20602	5,458	5,338	-2.20%	5,674	6,304	11.10%	5,144	6,055	17.71%
20603	6,446	6,958	7.94%	6,441	8,005	24.28%	6,015	8,283	37.71%
20613	1,730	1,735	0.29%	2,791	3,030	8.56%	2,777	3,181	14.55%
20735	7,442	7,311	-1.76%	10,894	11,778	8.11%	10,487	11,699	11.56%
20744	10,205	9,975	-2.25%	15,485	16,544	6.84%	16,161	17,050	5.50%
20745	6,503	6,166	-5.18%	7,551	8,083	7.05%	6,885	7,300	6.03%
20746	7,043	6,719	-4.60%	7,910	8,646	9.30%	6,669	7,345	10.14%
20747	10,064	9,721	-3.41%	11,520	12,677	10.04%	10,012	11,433	14.19%
20748	9,035	8,717	-3.52%	12,478	13,421	7.56%	11,020	11,818	7.24%
20772	9,093	9,424	3.64%	11,606	13,614	17.30%	11,176	13,554	21.28%
Totals	79,053	78,238	-1.03%	98,768	109,607	10.97%	92,604	105,379	13.80%

Southern Maryland Hospital Center Service Area Median Household Income



The Financial Assistance Policy for Southern Maryland Hospital Center is attached as Appendix C. This policy is posted in all the admission areas of the hospital as well as in of the emergency room. While a copy the policy is not routinely provided to the patient at registration, at any point in the patient process, from registration to final payment of the bill, a patient may indicate a need for financial assistance. At that point in the process the patient or guarantor is given a copy of our financial assistance policy and the application for financial assistance. Upon completion of the application and submission of the requested information, a determination of the amount of assistance is made according to the attached policy. During the registration process, depending on the type of services to be provided, a hospital representative may speak with the patient or guarantor about other state or federal programs to assist with payment.

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 1 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			
<p><u>Purpose:</u> To help facilitate medical care to persons regardless of their age, sex, race, color, national origin, creed, religion, sexual orientation, physical handicap or financial ability to pay for services.</p> <p><u>Procedure:</u> If a patient/guarantor expresses the inability to pay for services based on lack of income or resources, the patient/guarantor may be offered consideration for a financial adjustment.</p> <p>An application for financial assistance must be completed and the appropriate documentation (as defined on the application) attached to be considered for a financial adjustment. The director of Collections must approve any exception to this requirement.</p> <p>One of the following conditions must be met or exist to be eligible to apply for financial assistance:</p> <ul style="list-style-type: none"> ➤ Patient/Guarantor whose income level is at or below the current Federal Poverty Guidelines as published in the Federal Register; ➤ Patient/Guarantor whose income level is above the current Federal Poverty Guidelines as published in the Federal Register, but whose financial profile indicates that expense related to the necessities of life (food, housing, utilities and medications) consume most or all of their income; ➤ No ownerships of real estate, other than primary residence; no ownership of stocks, bonds, and other assets that affects the net worth of patient/guarantor; ➤ Fixed income such as Social Security, retirement, or disability with no other sources of income; ➤ Medical expenses which exceed 50% of monthly income; ➤ Patient is homeless, whereby a Medical Assistance application cannot be completed; ➤ Patient is deceased with no estate on file. 			

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 2 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			
<p>A. Patient Registering In Admitting Office</p> <ol style="list-style-type: none"> 1. Admitting Office representatives will refer any self-pay patient or responsible party, who demonstrates need, or has requested financial assistance, to the Medicaid facilitator. The Medicaid facilitator will then complete a medical assistance profile application and determine if the patient or responsible party may qualify for Medicaid. 2. Should the patient or responsible party be determined ineligible for Medicaid, the Medicaid facilitator will notify the Admitting Office and Collection Department. 3. Should the patient or responsible party demonstrate financial inability, a Financial Assistance Application can be completed and returned along with supporting documentation to apply for Financial Assistance through Southern Maryland Hospital Center. <p>B. Patients Registering In Out-Patient Services</p> <ol style="list-style-type: none"> 1. Out-Patient Services representatives will refer any self-pay patients or responsible parties, who demonstrate need or have requested financial assistance to the Collections Department. The Collections Department representative will perform financial counseling to include providing a Financial Assistance Application. The patients will be informed that the application must be returned within thirty (30) days along with all required documents. 			

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 3 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			

C. Patients Registering In the Emergency Room

- Emergency Room representatives must ensure that the patient or responsible party receives a copy of the Financial Assistance brochure and/or read the displayed signs. If the patient or responsible party does not have: Medicare, Medical Assistance benefits, commercial insurance, Workman's Comp, or any other insurance information at the time of registration, the Emergency Room representative will provide a Financial Assistance Application. If patient/responsible party requests it.

- All Financial Assistance Applications and supporting documentation are then forwarded to the Collections Department Administrative Assistant or Supervisor to determine eligibility, after which they are directed to the Department Head for signature of approval or denial.
- The applicant is advised via letter or telephone call of approval or denial within two business days of review and any patient responsible portion of the bill.

The following formula is to be used to calculate the patient's responsibility:

Less Monthly HHS Poverty Guidelines (most current)	<_____>
Gross Monthly Income Available	_____
Multiply by 0.92935	_____
Less Patient Monthly Expenses	<_____>
**Patient Responsibility per Month	_____

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Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 4 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			
<p>Total Amount of Patient's Bill _____ Divide by a maximum of 18 monthly payments, if needed _____</p> <p>**If the patient responsibility is equal to or less than zero, then 100% of the balance is adjusted. If the patient's responsibility is less than the medical bill, the patient is only responsible for "Patient Responsibility" amount. The remaining balance of the bill should be adjusted. **</p> <p>The Department of Health and Human Services poverty guidelines represents the minimal income for the number of person's dependant on the income per Exhibit A, attached.</p> <p>3. All Financial Assistance write-offs under this policy shall be adjusted using the adjustment code "991-1001".</p> <p>4. Any patient responsibility will be due to Southern Maryland Hospital Center and paid no later than 18 months from the date of Financial Assistance approval. All eligible Financial Assistance applicants must have a signed contract on file with Southern Maryland Hospital Center for any balance due.</p> <p>NOTE: Non-U.S. citizens who travel to the U.S. primarily for the purpose of receiving medical services are not eligible for Financial Assistance.</p>			

Southern Maryland Hospital Center

Mission

Southern Maryland Hospital Center is a full-service, regional health care facility founded in 1977 to provide a complete range of inpatient, outpatient and community services for the residents of Southern Maryland. At SMHC, highly skilled health professionals efficiently deliver respectful and compassionate care using the most advanced medical technology.

Southern Maryland Hospital Center is a resource center seeking to prevent illness and promote health through education and screening. Our goal is to assist the residents of Southern Maryland in achieving the highest possible level of physical and mental health, and thereby improve the quality of life in our community.

Southern Maryland Hospital Center continuously evaluates all services and seeks to improve the delivery of care. Each SMHC employee, medical staff member and volunteer is motivated by an uncompromising commitment to quality as measured by the satisfaction of our patients and their families.

Values

The employees, medical staff and volunteers of Southern Maryland Hospital Center hold in common these values with respect to our patients and our professional relationships.

Quality - We perform each task to the best of our abilities and never cease to try to do better.

Respect - We acknowledge the dignity of every individual and appreciate the differences and uniqueness of each.

Integrity - We are forthright with our patients and each other and fulfill our tasks promptly, accurately, and completely.

Safety - We are committed to improving patient safety and reducing risks in the care environment for patients and others, including health care providers.

Flexibility - We continually adjust our methods to better serve our patients and we readily embrace change and new technology.

Efficiency - We manage our work so as to conserve resources and hold down the costs of health care without compromising patient care.

Confidentiality - We protect the rights of our patients and their families and safeguard their privacy.

Accountability - We accept responsibility for the results of our work and set aside personal interests for the good of our patients.

Community Benefit Summary Report

07/01/08 – 06/31/09

- **Health Express Van** (encounters)
 - Flu Shots – (347)
 - Lab Draws – (484)
 - Blood Pressure Checks (exclusive to HEV) – (2,052)
 - Other services – (772)

- **Mall Walkers** (encounters)
 - Blood Pressure Checks – (14,260)
 - Other services – (5,513)

- **Special Events** (encounters)
 - Diabetes Expo – (217)
 - Cardiac and Wellness Expo – (975)

- **Ask the Doctor Programs** (encounters)
 - Five Programs multiple times per year – (67 average per event)
 - Program details attached

- **Support Groups/Classes:** (encounters)
 - Seven Programs multiple times per year – (639)

<u>Ask The Doctor Topic</u>	<u>Date</u>	<u>Location</u>	<u>Responsible Department</u>	<u># of Attendees</u>
HPV & Cervical Cancer	10/08	Colony South	Marketing	55
Hip & Knee Replacement	11/08	Colony South	Marketing	75
Hip & Knee Replacement	02/09	Regency Furniture Stadium	Marketing	45
Parkinson's Disease	04/09	Colony South	Marketing	60
Chronic Back Pain	06/09	Colony South	Marketing	100

<u>Support Group</u>	<u>Responsible Department</u>	<u>Meets/Held</u>	<u>Location</u>	<u>Average # of participants</u>
Alzheimer's Support Group	Marketing	12/yr.	SMHC Library	4-7
Mental Health Support Group	4 West	12/yr.	Colony South Hotel	6-8
Stroke Support Group	Stroke Center	11/yr. *Does not met in December	SMHC Library	10
Prostate Cancer Support Group	Marketing	12/yr.	Colony South Hotel	15
Weight Management Support Group	Dietary	24/yr.	SMHC 4 TH Floor Lobby	2-5
C.A.R.E./A.W.A.K.E. Support Group	Cardiopulmonary	4/yr.	Cardiac Rehab	5-6
Breast Cancer Support Group	Marketing	12/yr.	SMHC Library	



SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Community Benefit Narrative

1. Quick Stats:

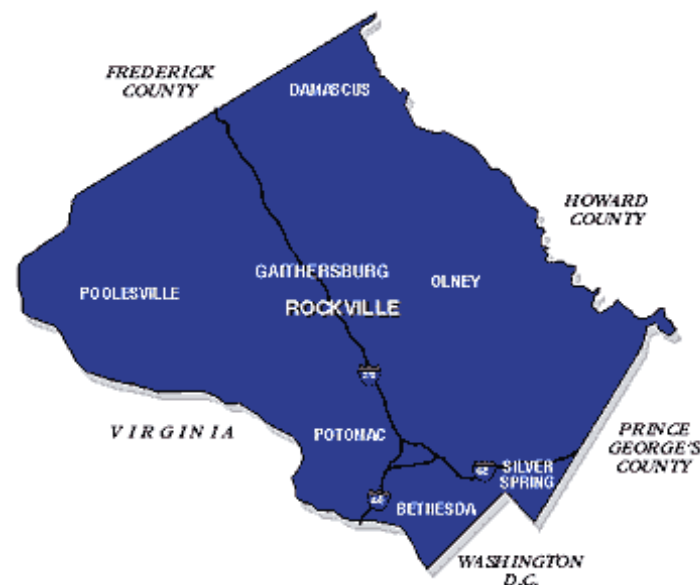
The licensed bed designation for Suburban Hospital is 238 beds. In fiscal year 2009, there were 14,610 inpatients admitted to Suburban Hospital. An additional 9,633 patients had outpatient surgery at the main hospital.

2. Our Community:

Suburban Hospital is a community owned, not-for-profit hospital serving Montgomery County, MD, and the greater Washington, DC, region since 1943. As a healthcare provider, we are guided by the needs of our patients and community. On June 30, 2009 Suburban Hospital became a member of Johns Hopkins Medicine. We distinguish ourselves through service and clinical excellence, affiliations with the National Institutes of Health (NIH) and other regional healthcare providers, and state-of-the-art technology and facilities.

Suburban serves patients from rural, suburban and urban populations, from all socioeconomic levels, and from all racial and ethnic groups. Suburban's community outreach programs extend well beyond the hospital's inpatient service area to the region. Suburban Hospital is committed to promoting wellness, encouraging prevention and empowering individuals to maintain healthier lifestyles.

Suburban Hospital collaborates with health professionals in Montgomery and Prince George's County to provide free health screenings and health information for vision, hearing, diabetes, colorectal cancer, oral cancer, cholesterol, breast health, blood pressure and smoking cessation at county community centers. To reach minority and indigent populations, Suburban Hospital collaborates with organizations that have recognized relationships in these communities.



Suburban Hospital's Primary Service Area (PSA) accounts for approximately 58% of the hospital's total inpatient discharges and 64% of emergency/trauma visits. The PSA includes areas predominantly in southern Montgomery County: Bethesda, Rockville and Potomac.

Suburban Hospital's Secondary Service Area (SSA) accounts for approximately 20% of its inpatient discharges and 17% of emergency/trauma visits. This area extends slightly northward

into upper Montgomery County and southward into Northwest Washington, DC. Cities and towns within the hospital's secondary service area include: Gaithersburg, Germantown, Montgomery Village, Wheaton, Silver Spring, and Northwest Washington, DC. Underserved areas of Southern Maryland in Prince George's, Calvert, Charles and St. Mary's Counties are a specific focus for the department of Community Health and Wellness.



**In FY 09, Suburban Hospital supported
2,612 events reaching 123,474 individuals
in Montgomery, Prince George's, Calvert,
Charles, and St. Mary's Counties.**

Like the rest of the country, Maryland, in particular Montgomery County, is experiencing dramatic growth in the proportion of residents belonging to racial and ethnic minority groups. Given the racial and ethnic transformation, there are increasing challenges in addressing the health disparities that tend to affect these rapidly growing populations. Racial subgroups include Latino, Asian American and African American residents which evolve from varied backgrounds. For example, most Latino residents are from Central America, specifically El Salvador and Mexico. Chinese residents represent the most populous Asian group, followed by Korean,

Asian Indians and Vietnamese residents. While most African American community members were not born in the United States, many originated from the Caribbean and African countries. In 2008, of the estimated 950,680 residents living in Montgomery County, 14.80% are Hispanic, 16.10% are African American, and 13.30 % are Asian.

In Montgomery County, the median household income for Asian Americans is \$78,000, for Latinos \$57,000, for African Americans \$58,000 and \$94,500 for Caucasians. In addition, 9.5% of Montgomery County residents live below the federal poverty guidelines. In fiscal year 2009, there were 7,001 uninsured cases recorded at Suburban Hospital. The charge to provide services to these residents was just under \$15 million.



---In FY09 Suburban Hospital contributed a total of \$15,783,345 in Community Benefit services and programs to improve the health, well being and quality of life for its surrounding community----

3. Community Needs:

Suburban Hospital's Community Benefit plan targets very specific areas of community need. For example, a Community Advisory Board was established in 1998 composed of several public and private health officials along with other outside organization leaders. The Community Advisory and Visioning team identified four specific target areas of need: A focus on health access of minority populations, underserved seniors, at-risk youth, and management of chronic diseases like Diabetes for the under/uninsured. Healthy People 2010 guidelines established by the Maryland DHHS are among vital information sources used to identify community needs. Additional tools used to identify specific health challenges include the use of focus groups. In the past, the department of Community Health and Wellness conducted several focus groups with members of the Hispanic community. Results from these studies have been incorporated to strengthen and customize our Latino Diabetes education and outreach programs.

In addition, graduate students from the American University in 2008 conducted health surveys with the Scotland teen community to identify which at-risk teen behaviors were most prevalent in the target population. The result of these surveys has enabled the Department of Community Health and Wellness to design future teen health programs for this unique neighborhood.



In 2007, American University graduate students were also involved in compiling a physical fitness assessment for Senior Shape participants at Cora B. Woods Senior Center in Prince George's County. The data compiled from the fitness assessment enabled Suburban staff to measure and track health improvements that can be realized with minimum resources and materials.

Suburban Hospital continues to engage community involvement and feedback through the hospital's efforts to organize ongoing *Community Panel for a Healthy Future*. This is a community panel which includes a variety of hospital leadership and is composed of several community representatives from the hospital's neighborhoods and businesses that share a common goal to work collaboratively on health advocacy, enhancement of services, and other community initiatives.

Last year, an article in *CNN Money* magazine highlighted Montgomery County as the place where one can expect the longest lifespan in the United States. However, there are still

serious health issues that face Montgomery County residents. The most common diagnoses for Suburban Hospital inpatients are the same as those for all Montgomery County hospitals, except obstetrics, and reflect the health issues in the population.

Chart 1. Inpatient Discharges by Top Primary Diagnosis for Suburban Hospital and Montgomery County over the past two years

	Total Suburban	Montgomery County Patients *
Diseases of the Circulatory System	19%	12%
Injury and Poisoning	16%	7%
Diseases of the Musculoskeletal System and Connective Tissue	10%	5%
Mental Disorders	10%	5%
Diseases of the Digestive System	8%	8%
Diseases of the Respiratory System	7%	6%

Source: Maryland Vital Statistics Administration - <http://vsa.maryland.gov/deaths/Montgomery.pdf>

Chart 1 demonstrates the distribution of Suburban Hospital inpatients by primary diagnosis and contrasts that distribution with the County overall.

Chart 2. Montgomery County, Maryland – Leading Causes of Death, 2007

MONTGOMERY COUNTY									
CAUSE OF DEATH (TENTH REVISION INTERNATIONAL CLASSIFICATION OF DISEASES, 1992)	ALL RACES ¹			WHITE		BLACK		ASIAN OR PACIFIC ISLANDER	
	BOTH SEXES	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
ALL CAUSES	5,452	2,531	2,921	1,996	2,336	359	418	166	154
DISEASES OF THE HEART	1,369	663	706	539	578	89	97	35	29
MALIGNANT NEOPLASMS	1,296	615	681	483	516	76	113	54	46
CEREBROVASCULAR DISEASES	278	118	160	90	129	19	23	9	8
CHRONIC LOWER RESPIRATORY DISEASE	220	84	136	74	130	*	5	6	*
INFLUENZA AND PNEUMONIA	190	81	109	71	96	7	7	*	6
ACCIDENTS	162	86	76	63	59	14	8	8	8
DIABETES MELLITUS	150	73	77	52	50	17	21	*	6
ALZHEIMER'S DISEASE	148	44	104	37	95	6	6	*	*
SEPTICEMIA	115	61	54	49	42	6	8	5	*
NEPHRITIS, NEPHROTIC SYNDROME, AND NEPHROSIS	85	39	46	30	33	6	11	*	*
PARKINSON'S DISEASE	71	42	29	40	29	*	*	*	*
INTENTIONAL SELF-HARM (SUICIDE)	64	43	21	35	15	*	*	*	*
PNEUMONITIS DUE TO SOLIDS AND LIQUIDS	58	26	32	24	29	*	*	*	*
ESSENTIAL (PRIMARY) HYPERTENSION AND HYPERTENSIVE RENAL DISEASE	57	14	43	11	27	*	12	*	*
CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD ..	48	27	21	6	7	17	12	*	*
CHRONIC LIVER DISEASE AND CIRRHOSIS	42	28	14	24	10	*	*	*	*
ASSAULT (HOMICIDE)	26	20	6	9	*	10	*	*	*
AORTIC ANEURYSM AND DISSECTION	24	14	10	10	10	*	*	*	*
HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE	19	13	6	*	*	12	6	*	*

¹ Includes races categorized as 'other'.

* Deaths under 5 not reported.

Source: Maryland Vital Statistics Administration - <http://www.vsa.state.md.us/deaths/Montgomery.pdf>

In reference to Chart 2, the leading causes of death in Montgomery County for both men and women were heart disease and cancer. The incidence of cancer rates is not captured by the hospital's inpatient discharge figures because most cancer treatment, such as radiation therapy or chemotherapy, is delivered in outpatient settings.

Suburban Hospital works closely with the Montgomery County Department of Health and Human Services, health officers and community health coalitions to identify community health needs and set community benefit strategic programs and activities. Two examples include Suburban Hospital's participation in the Montgomery County Cancer Crusade and the hospital's recent appointment in serving on the Montgomery County Health and Human Services Community Improvement Process Advisory Board.

4) Strengthening our Focus

As explained above, many Maryland residents are affected by chronic illness like heart disease, stroke, diabetes and development of several cancers including breast, colorectal, prostate and skin. Access to primary and specialty care for under and uninsured community members is another identified health need based on the growing number of individuals served through our partnership safety net clinics.



5) Living the Vision

Suburban Hospital's Board of Trustees is actively engaged in an ongoing dialogue of how the organization broadly serves its community. Equally supportive is the Organization's President and CEO, who leads a motivating role in the System's planning of Community Benefit initiatives. Other hospital clinical operations, finance, and nursing leadership along with all levels of hospital staff are equally involved in developing a community benefit plan and have historically embraced the opportunity and responsibility of reaching out to serve the community.



In addition, a Community Advisory Board was established in 1998 composed of several public and private health officials along with other community organization leaders. The Community Advisory and Visioning team identified four specific target areas of need: A focus on health access of minority populations, underserved seniors, at-risk youth, and management of chronic diseases like Diabetes for the under/uninsured.

6) Addressing the needs

A. Cardiovascular Disease:



MobileMed/NIH Heart Clinic at Suburban

Hospital: For more than a decade, Suburban Hospital has provided free cardiovascular diagnostics, interventional and diagnostic radiology,

laboratory, and inpatient services to MobileMedical Care, Inc., a clinic that provides free or low-cost medical care for the uninsured. Suburban's partnership with MobileMedical has expanded over the years. The most recent collaborative has been the opening of the MobileMed/NIH Heart Clinic at Suburban Hospital. Since October 2007, MobileMed patients who require expert cardiac evaluation, imaging and testing are

able to receive these services through the Heart Clinic.

The Heart Clinic provides patients access to the very best cardiac care, from diagnostic tests to surgery to rehabilitation, all at little or no cost. One night per week, physicians, nurses and administrators from Suburban Hospital, the National Heart, Lung and Blood Institute (NHLBI) and MobileMed, volunteer their time to staff the cardiac clinic, located at the NIH Heart Center at Suburban Hospital. The hospital donates the space for the clinic along with the use of diagnostic equipment.

Due to the clinic's success and the raising need for specialty care, in 2008, the Heart Clinic opened its doors to patients from other safety-net clinics.

HeartWell: Providing cardiac care through one of the county's safety net organizations is a natural extension of the hospital's existing efforts to ensure equal access to primary and specialty care. Another example of these efforts is the hospital's Heart Well program, which offers free cardiovascular health education, disease management, and exercise and nutrition classes at five senior centers throughout the county. The program is designed to keep area seniors out of the hospital and as functional as possible, and data shows that those county residents who have participated in the HeartWell program have experienced positive clinical outcomes.

Senior Shape: Suburban Hospital funded over 360 free *Senior Shape* strengthening and flexibility classes and 240 mall walking programs reaching regular program participants over 30,000 times! In addition to encouraging active lifestyles, Suburban's Community Health and Wellness department conducts monthly blood pressure screenings at 12 local senior

living and community centers each month. Consistent health screenings with each individual affords the opportunity for individual monitoring, education, and prevention counseling, which empowers older adults to be more proactive in self care and encourages healthy lifestyles.

Cardiovascular Outreach in Southern Maryland: In addition to reaching out to Montgomery County residents, Suburban Hospital has expanded its cardiovascular outreach to residents of surrounding communities as well. Over the past three years, more than 35,000 people from Prince George's, St. Mary's, Calvert and Charles counties in southern Maryland have taken advantage of free cardiovascular health education, screenings and classes.

G.O.S.P.E.L: Glorifying Our Spiritual & Physical Existence for Life (G.O.S.P.E.L) is a county program that Suburban Hospital has partnered with for the past 5 years. In fiscal year 2009, Suburban hosted their annual G.O.S.P.E.L Healthy Heart

symposium in which individuals participated in a heart healthy lunch, lecture and screening day that highlighted the benefits of cardiovascular health, stress management and smoking cessation to members of the African American community. This well received symposium attracted participants from across the Metropolitan Washington area. Free cholesterol, blood pressure, body fat analysis, oral cancer screenings and the opportunity to speak one-on-one with a variety of healthcare professionals were provided to attendees.

Montgomery Cares: A public/private partnership, Montgomery Cares provides health services to low income uninsured Montgomery County adult residents administered by the Primary Care Coalition (PCC). In June 2008, in support of Montgomery Cares, a formal agreement was signed to enable Suburban Hospital to support *Clinica Proyecto Salud* in achieving Montgomery Cares' goal of increasing uninsured adult patients' access to primary care. Specifically, Suburban Hospital's financial support will enable the Clinic to employ additional healthcare providers, extend their hours, and provide approximately 1,680 additional patient appointments.

B. Cancer Care:

Research suggests that only five percent of cancers are hereditary. That means the non-inherited causes of cancer, the lifestyle choices we make, the foods we eat, and our physical activity levels have a direct impact on our overall cancer risk. The American Cancer Society reports that half of all men and one-third of all women will develop cancer in their lifetimes. To fight against these statistics in our community, Suburban Hospital focuses on breast, prostate, skin, colorectal and testicular cancer prevention and education programs through lifestyle changes or early detection and treatment.

Check It Out (CIO) is a community-based program that provides breast cancer education and early detection information to young women in the 11th and 12th grades. Since 1993, the program has been offered by Suburban Hospital and

the Greater Washington Chapter of Hadassah in partnership with Montgomery County public and private high schools. *Check It Out* is held every two years in the spring.

Colorectal Cancer Education and Screening: Suburban Hospital's *Get a Check Up* program, which is made possible by the Tobacco Restitution Fund, has been able to reach more than 70,000 Montgomery County residents to date in an effort to communicate the importance of cancer screening. FY09 marked the 7th year of partnership between Suburban Hospital and the Montgomery County Cancer Crusade (MCCC). As the partnership between Suburban Hospital and the MCCC has grown over the years, we have been able to expand our education, outreach and navigation program from colorectal cancer to various target cancers, such as, prostate, breast, and skin.

Prostate Cancer Screenings: Volunteer urologists, nurses and hospital staff conduct free PSA and DRE screenings for nearly 100 men in Montgomery County. Follow-up and case management is provided by the Cancer Program's patient navigator.

Skin Cancer Screenings: Volunteer dermatologists, clinical and other hospital staff conduct free full-body checks to over 200 community members per year.

C. Stroke

As a designated Stroke Center, Suburban Hospital hosts not only monthly stroke support groups but also the regular board meetings of the Montgomery County Stroke Association. Every May, in recognition of Stroke Awareness Month, Suburban Hospital conducts a variety of community education seminars throughout the County to educate those at high risk about prevention, warning signs and the treatment of stroke. In partnership with the Circle of Rights, Stroke prevention and education programs are presented within the Latino/Hispanic community in Spanish.

D. Diabetes

Suburban Hospital hosts a diabetes education class for community members who want to learn about practical ways to manage their diabetes. In addition, the department of Community Health and Wellness provides a bilingual patient navigator to facilitate diabetes school at *Clinica Proyecto Salud* in Wheaton, MD which has enrolled over 600 participants to date.

7. Evaluating Our Progress

Many of Suburban Hospital's community benefit initiatives are performance-based and include process and outcome measures. An example is outlined below.

Initiative	Year evaluated	Measure	Results	Future Evaluation options
Senior Shape	2008	Health Status Improvement Quality of life improvement Monthly BP screening for Class participants	Two additional Senior Shape classes have been established in Prince George's County. Class size continues to grow from 30 to over 300 individuals. Blood pressure results fall into normal range and under control/monitored	Physical Assessments of Senior Shape participants Focus Groups
MobileMed/NIH Heart Center at SH	Quarterly	# of clinical providers, # of patients served, health outcomes	Best practice model for specialty clinic & increased access to care	Establish Diabetes clinic under the same model
Check It Out	2008	Pre/post test results	In 2009, reached nearly 5,000 young women on breast cancer education.	Continue model
G.O.S.P.E.L.	2009	Focus on Chronic Disease. Self health assessment. Clinical screenings results, participant surveys	Narrowed focus to cardiovascular health	Continue model
Safety Net Clinic Partnerships: Montgomery Cares	2008-2009	Review of data/financials to measure if partnership/program goals were achieved	SH representation on clinic board/advisory council with ongoing oversight of meeting community health improvement goals	Present template for quarterly reporting

8. Filling the Gap

Suburban Hospital is concerned about patient access to care which is endangered by an identified shortage of physicians in Montgomery County practicing in primary care and in several specialties including, anesthesiology, psychiatry, diagnostic radiology, hematology/oncology, general surgery, pathology, and neurosurgery. A recent study of the physician workforce in Maryland predicts that these shortages are expected to grow over the next ten years.

For example, to expand access to care and alleviate the gap in specialty providers, Suburban Hospital operates one specialty cardiac clinic on-site on Thursday evenings with our partners MobileMedical Care, Inc. and the National Heart, Lung and Blood Institute of the NIH.

The MobileMed/NIH Heart Clinic at Suburban Hospital welcomed our first patient in October 2007. Patients are

referred from safety net clinics in the County operated by MobileMed, *Clinica Proyecto Salud* and the Holy Cross Hospital Health Clinic. Each patient is seen by a Suburban cardiologist and the clinical staff at NIH. In addition to coordinating the cardiologists who volunteer at the clinic, Suburban provides a variety of free cardiovascular specialty diagnostic screenings, and open heart surgery for patients that require advanced



care. The MobileMed/NIH Heart Clinic has provided care to close to 1,000 patients to date and has conducted multiple open heart surgeries at no cost to the patient.

Another significant partnership is with the *Clinica Proyecto Salud*. Since 2004, Suburban Hospital has supported numerous initiatives targeted at *Clinica Proyecto Salud* patients, including diabetes education and prostate cancer screenings. In addition, Suburban Hospital has provided a bilingual patient navigator to facilitate routine health screenings for Clinic patients. The diabetes school has enrolled over 600 participants and we have screened close to 100 clinic patients for prostate cancer. In June 2008, a formal agreement was signed to enable Suburban Hospital to support *Clinica Proyecto Salud* in achieving Montgomery Cares' goal of increasing uninsured adult patients' access to primary care.

Specifically, Suburban Hospital's financial support will enable the Clinic to employ additional healthcare providers, extend their hours, and provide approximately 1,680 additional patient appointments. Uninsured adult patients who come to Suburban Hospital's Emergency Department will be referred to the Clinic for primary care and follow up. *Clinica Proyecto Salud's* established patient population will benefit from the expansion of services at the Clinic's existing site in Wheaton, MD given its convenient location and access to public transportation. The partnership also provides *Clinica Proyecto Salud's* patients with access to needed cardiac specialty care through the MobileMed/NIH Heart Clinic at Suburban Hospital. To strengthen the collaboration, Dr. Robert Rothstein, Chair of Suburban Hospital's Department of Emergency Medicine, is an acting member of the *Clinica Proyecto Salud's* Board of Directors.

9. Supplemental Support

Suburban Hospital provides subsidy to physicians for Trauma On-Call services that they would otherwise not provide to the hospital. In FY09 Suburban Hospital paid a total of **\$1,767,391** in subsidies to physicians for the following patient services for On-Call coverage in the emergency department.

Trauma Call	ENT Call
Behavioral Health Call	OB/GYN Call





Suburban Hospital Charity Care and Financial Assistance

Suburban Hospital provides quality care to all patients regardless of their ability to pay. Free care, sliding fee scales and extended payment plans are offered to eligible patients. Approval for charity care, sliding fee scales or payment plans are based on submission of a financial assistance application available upon request at each of our registration points of entry and our website, suburbanhospital.org.

Suburban Hospital provides each patient registered for emergency care, same day care, or inpatient care a copy of our Financial Assistance Information Sheet. Signs are also posted in English and Spanish explaining the availability of financial assistance and contact information in the Emergency Department Lobby, inside the Emergency Department, both ED Registration Bays, the Front Registration Desk, Cath Lab, Financial Counseling Department and Patient Accounting Department (Montrose Road office). The financial assistance application is given to every self pay patient with instructions on how to apply and contact information. The same information is provided to all other patients upon request. This information is also available in Spanish.

In addition, our Financial Counselors and Social Workers are trained through staff meetings on how to answer patient questions regarding financial assistance and linkage to other community assistance resources prior to discharge. Registration staff is trained to answer questions regarding financial assistance and who to contact with billing questions or other financial questions. Patient Accounting staff is also trained to answer questions and provide information to patients regarding financial assistance and billing. Suburban Hospital uses a contractor from Financial Health Services who assists patients in applying for Maryland Medical Assistance. The Financial Health Services contractor interviews all self pay patients upon admission and provides them with information and referral for financial assistance.

This past March, Suburban Hospital published information in New Directions, Suburban Hospital's Community Newsletter mailed to 250,000 residents as well as a broadcast on a local radio station, inviting uninsured citizens to participate in a one day financial assistance informational event. The event was held at Suburban Hospital where financial assistance consultation was done including dissemination of information on our financial assistance eligibility criteria, Medicaid and other community resources. This event will be held annually in March.

SUBURBAN HOSPITAL**Patient Financial Services Policy and Procedure Manual****FINANCIAL ASSISTANCE POLICY**

Policy No. 3

POLICY:

It is the policy of Suburban Hospital to responsibly and fairly collect all amounts due that arise from providing patient care. Guidelines will be utilized to accurately and fairly assess the patient's/guarantor's/household's ability to pay. *These guidelines will differentiate between a patient's/guarantor's/household's inability to pay versus their unwillingness to pay.*

Suburban Hospital offers full and partial levels of financial assistance and extended payment arrangements for eligible patients/guarantors/households. Eligibility is established on the basis of the financial status of the patient/guarantor, regardless of their age, sex, race, sexual orientation, handicap, religion, or national origin.

PROCEDURE:**FINANCIAL ASSISTANCE**

- 1) The patient/guarantor/household shall have the option to request consideration for or be offered financial assistance. A Financial Assistance application (attachment 2) is available to anyone who requests one. All inpatients shall receive a Financial Assistance Information Sheet (attachment 1) during registration or upon request which includes a description of the financial assistance policy, billing and financial assistance contact information, as well as contact information for Medical Assistance.
- 2) If the patient/guarantor/household is unable to pay the account balance, he/she shall contact the Patient Financial Services Office at 301-896-6088 to make payment arrangements and, if necessary, apply for financial assistance.
- 3) An application for financial assistance (see attached) shall be completed and the appropriate documentation (as defined on the application) attached to be considered for a financial assistance adjustment. The Corporate Director of Patient Financial Services is required to approve any exception to this requirement.
- 4) The following conditions shall be met to be eligible for financial assistance:
 - The patient care service must be/ have been for a medical necessity; and,
 - Patient/Guarantor/Household income level which is 150% of the current Federal Poverty Level (FPL) or below as published in the Federal Register with net assets of \$10,000 or less qualifies for a full account balance adjustment (free care).
 - Patient/Guarantor/Household income level up to at least 200% of the current Federal Poverty Level as published in the Federal Register with net assets of \$20,000 or less for households of 2 persons or net assets of \$25,000 or less for households of 3 or more persons qualify for a sliding fee partial account balance adjustment.
 - A financial assistance application indicating expenses related to the necessities of life (food, housing, utilities, medications, etc.) consume most or all of the patient/guarantor/household income qualifies for a partial account balance adjustment. In addition, the

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patient/guarantor/household shall not have ownership of real estate, other than primary residence, no available equity in the primary residence, and/or no ownership of stocks, bonds, and other assets that affect the net worth of the patient/guarantor/household. Furthermore, consideration shall be given to whether the patient/guarantor/household; 1) is on a fixed income such as Social Security, retirement, or disability with no other sources of income; or 2) has medical expenses which exceed 50% of monthly income; or,

- The patient is homeless, whereby a Financial Assistance or Medical Assistance application cannot be completed;
- The patient is deceased with no person designated as Executor, or no estate on file with the appropriate agency in the appropriate jurisdiction;
- A balance on account remains after the Medical Assistance program has adjudicated the claim. The remaining balance shall receive full adjustment.

Individuals may have presumptive eligibility for financial assistance if they meet presumptive eligibility guidelines (see Patient Financial Services Policy #4) or meet the criteria for catastrophic financial assistance as outlined in Appendix B. All inpatient self pay patients are screened for potential eligibility for financial assistance using the Patient Profile Questionnaire.

- 5) Patients/Families/Households eligible for a sliding fee partial adjustment shall have income or assets consistent with the following table:

Size of Family Unit	Federal Poverty Level (FPL)	FPL + 150%	FPL + 167%	FPL + 183%	FPL + 200%
1	\$ 10,830	\$ 16,245	\$ 18,086	\$ 19,819	\$ 21,660
2	14,570	21,855	24,332	26,663	29,140
3	18,310	27,465	30,578	33,507	36,620
4	22,050	33,075	36,824	40,352	44,100
5	25,790	38,685	43,069	47,196	51,580
6	29,530	44,295	49,315	54,040	59,060
7	33,270	49,905	55,561	60,884	66,540
8	37,010	55,515	61,807	67,728	74,020
For each additional person, add	3,740	3,740	3,740	3,740	3,740
% Adjustment to Account =		100%	75%	50%	25%
Individuals must not have assets that exceed \$10,000. Households of 2 persons must not have assets that exceed \$20,000. Households of 3 or more persons must not have assets that exceed \$25,000.					

- 6) Any deviation from the above sliding fee partial adjustment scale shall be approved by the Corporate Director, Patient Financial Services.
- 7) Approvals for financial assistance adjustments shall be made by the appropriate individuals as defined below:
- Adjustments below \$5,000 Vendor Liaison or Manager, Patient Accounts;
 - Adjustments between \$5,000 - \$25,000 Corporate Director, Patient Financial Services;
 - Adjustments over \$25,000 Senior Vice President, Finance & Treasurer

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Financial Assistance Policy

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- 8) All financial assistance adjustments under this policy shall be recorded using a specified adjustment code.
- 9) The Hospital shall request a copy of the financial assistance applicant's credit report in connection with an extension of credit for services rendered for the purpose of verifying information the individual has provided on the application and his/her inability to pay. The patient shall be notified in writing of any adverse action against the patient based on the credit report including denial of full or partial account balance adjustment or extended payment plans. This notice will include the decision made by the hospital, the credit agency used with contact information, specific reason for the adverse action, and the patient's rights under the *Fair Credit Reporting Act*.
- 10) Notice of availability of the JHHS Financial Assistance Program will be posted at patient registration sites, Admissions/Financial Counseling Offices, and at the Emergency Department and presented to patients upon request.
- 11) Each person requesting Financial Assistance must complete a JHM/Financial Assistance application. Exception: when there is Presumptive Financial Assistance Eligibility (See Patient Financial Services Policy #4).
- 12) A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
- 13) Approval or denial of financial assistance will be made within 10 business days of a returned completed application. Patients who have been screened for Medical Assistance by Suburban Hospital's Financial Counseling Department and deemed appropriate based on eligibility criteria will need to submit a completed Medicaid application with the Financial Assistance application. These patients will also receive a decision regarding financial assistance approval within 10 business days of a returned completed application.

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SUBURBAN HOSPITAL**Patient Financial Services Policy and Procedure Manual****Appendix A****2009 HHS Poverty Guidelines**

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 10,830	\$ 13,530	\$ 12,460
2	14,570	18,210	16,760
3	18,310	22,890	21,060
4	22,050	27,570	25,360
5	25,790	32,250	29,660
6	29,530	36,930	33,960
7	33,270	41,610	38,260
8	37,010	46,290	42,560
For each additional person, add	3,740	4,680	4,300

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the “OMB” (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).”

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non Federal organizations that use the poverty guidelines under their own authority in non-Federally funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two person units.)

Note that this notice does not provide definitions of such terms as “income” or “family.” This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (for example, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program;

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that organization has the responsibility for making decisions about definitions of such terms as "income" or "family" (to the extent that the definition is not already contained in legislation or regulations)

The computations for the 2009 poverty guidelines are available. The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Appendix B

CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.

General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The JHM Financial Assistance Program
 - Other forms of assistance available through JHM affiliates
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$5,000)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

Definitions

<i>Approved: 11/96</i>	<i>Date Issued: 11/96</i>	<i>Date Revised: 10/09</i>	<i>Date Reviewed: 04/2012</i>
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Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash.
Living Expenses	Per-person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e., drugs, co-pays, deductibles and durable medical equipment.)
Take-Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest dividends, corporate distributions, net rental income before depreciation, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports.

Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notifications and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

Final Approval Signature: (President/Appropriate Sr. Vice President)

SUBURBAN HOSPITAL**Patient Financial Services Policy and Procedure Manual****Attachment 1****SUBURBAN HOSPITAL**

JOHNS HOPKINS MEDICINE

Financial Assistance Information Sheet**Our Philosophy**

- *Suburban Hospital is committed to the fair and equitable treatment of patients who seek medically necessary care regardless of their ability to pay. We provide patient friendly billing services and offer full or partial adjustments to account balances for all who qualify. Extended payment plans are made available to any patient who requires flexibility in paying for care received. We treat patients with dignity and respect during all financial interactions.*
- *Suburban Hospital balances the need for patient financial assistance with the financial needs of the Hospital in order to remain a viable healthcare facility for all who seek care in our community. We make concentrated efforts to reach out to patients who require assistance with their medical bills and inform them of all community assistance programs, financial assistance and payment options.*

Patient Rights

- Patients that meet the financial assistance eligibility described below may receive assistance from the hospital in paying their bill.
- Patients shall be given a bill for services at the end of each regular billing period. The bill shall cover substantially all care rendered. A patient has the right to request and receive an itemized bill with explanation for all hospital services.
- If you feel you have been wrongly referred to a collection agency, you have the right to contact the hospital to request assistance at 301-896-6000.
- You may be eligible for Maryland Medical Assistance. Medical Assistance is a state and federally funded program that pays the full cost of health coverage for low-income individuals who meet certain criteria (see contact below).

Patient Obligations

- Patients with the ability to pay their bill have the obligation to pay the hospital in a timely manner.
- Patients must provide correct insurance information.
- If you are unable to pay your bill or believe that you may be eligible under the hospital's financial assistance policy you should contact Financial Counseling promptly at 301-896-2222 or Financial Assistance Coordinator at 301-896-6088.
- Patient accounts are subject to collections procedures under the Fair Debt Collections Practices Act if not resolved through payment, payment plan, or financial assistance. In determining whether a patient is eligible for free, reduced cost care, or payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial situation changes, you have an obligation to promptly contact Patient Accounting at 301-896-6000 to provide updated/corrected information.

How to Apply for Financial Assistance

Approvals for full or partial adjustments to account balances or flexible payment plans are based on evaluation of the financial status of the patient/guarantor regardless of age, sex, race, religion, or national origin. If you would like to apply for financial assistance, please complete the attached application or download the application from our website at www.suburbanhospital.org. Please be sure to complete the entire application and provide all of the substantiating documentation needed to process the application. Failure to fully complete the application and/or send in complete substantiating documentation will delay the processing of your application. Once the Financial Assistance Coordinator receives a completed application, it will be processed and a written decision will be mailed to you within 10 business days. **Please note: Physician charges are not included in the hospital bill and are billed separately.** Suburban Hospital's financial assistance policy only applies to hospital charges. You must contact your physician's office directly to inquire about assistance. **If you have a question regarding your bill or the status of your application, please call our Financial Assistance Coordinator at 301-896-6088.**

Eligibility Criteria

- The service must be medically necessary.
- Patient/Guarantor/Household income level must be 150% of the current Federal Poverty Level or below with net assets of \$10,000 or less for individuals to receive a full account balance adjustment (free care).
- Patient/Guarantor/Household income level up to at least 200% of the current Federal Poverty Level or below with net assets of \$20,000 or less for households of 2 persons, or \$25,000 or less for households of 3 persons or more are eligible for a sliding fee partial account balance adjustment.
- A financial assistance application indicating expenses related to the necessities of life (food, housing, utilities, medications, etc.) consume most or all of the patient/guarantor/household income may receive partial account balance adjustments. In addition, the patient/guarantor/household must not have ownership of real estate, other than primary residence, no available equity in such real estate, and/or no ownership of stocks, bonds, and other assets that affect the net worth of the patient/guarantor/household. Consideration will be given to whether the patient/guarantor/household (1) is on a fixed income

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such as Social Security, retirement, or disability with no other sources of income; or (2) has medical expenses which exceed 50% of monthly income.

- Patient is homeless, whereby a Financial Assistance or Medical Assistance application cannot be completed.
- Patient is deceased with no person designated as Executor, or no estate on file with the appropriate agency in the appropriate jurisdiction.
- A balance on the account remains after the Medical Assistance program has adjudicated the claim. The remaining balance will receive full adjustment.

****Please note: If you would like to apply for Medical Assistance (Medicaid) benefits or other programs that may help pay the hospital bill, contact Suburban Hospital's Financial Counseling Department at 301-896-2222 or your Local Department of Social Services (LDSS). To find your LDSS, please call 1-800-332-6347.**



**Suburban Hospital
Mission, Vision and Value Statement**

Suburban Hospital is a community-based hospital serving Montgomery County and the surrounding area since 1943. We are a not-for-profit healthcare provider guided by the needs of our patients and community. On June 30, 2009, Suburban Hospital became a member of Johns Hopkins Medicine. The designated trauma center for Montgomery County, Suburban Hospital is affiliated with many local healthcare organizations, including the National Institutes of Health. It is committed to continuous improvement and appropriate use of resources, and creates an environment that encourages the success and fulfillment of our physicians, staff, and volunteers.

Suburban Hospital will set the standard for excellence in healthcare in the Washington metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.



Vision

Suburban Hospital will set the standard for excellence in healthcare in the Washington Metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.

Mission

Improving health with skill and compassion

Values

- Compassion
- Excellence
- Integrity
- Teamwork
- Accountability

Annual Nonprofit Hospital Community Benefit Report:

Community Benefit Narrative

FY2009

Union Hospital of Cecil County

**106 Bow Street
Elkton, MD 21921**

Overview

For 100 years, Union Hospital of Cecil County has been dedicated to continually improving the health and wellness of the people in the communities we serve. Situated conveniently in Elkton, Maryland, Union Hospital is a licensed 116-bed, not-for-profit, full-service community hospital that provides comprehensive care to Cecil County and the surrounding areas of Western New Castle County, Delaware, and Southern Chester County, Pennsylvania. During FY 2009, Union Hospital serviced 8,521 admissions, 117,164 outpatient referrals and 45,105 emergency department visits.

Community and Population Served

Union Hospital's primary service area include the towns of Elkton, Elk Mills, Childs, Chesapeake City, Earleville, Warwick, Cecilton, North East, Charlestown, and Rising Sun in Cecil County. The Hospital's secondary service area includes the towns in Western Cecil County of Conowingo, Colora, Port Deposit, Perryville, and Perry Point; in Delaware Bear, Middletown, and Townsend; and Southern Chester County, Pennsylvania.

Cecil County, one of Maryland's fastest growing counties, has an annual growth rate of approximately 2.2%. In 2008, the total population of Cecil County was estimated at 102,380, there were 36,576 households, and 26,314 families residing in the county. An average of 51.6% of the population in our service area is female. Approximately 11.1% of the population is 65+. The population density was 269 people per square mile. The racial makeup of the county was 93.2% White and 6.8% Non-White. The median age is 36 years. The median income for a household in the county was \$61,226, and the median income for a family was \$70,120. About 5.40% of families and 7.20% of the population were below the poverty line, including 9.20% of those under age 18 and 7.70% of those ages 65 and over. In fiscal year 2009, 7% of the hospital's patients were uninsured and 17.3% were Medicaid recipients.

Community Needs Assessment

Improving the health of our community requires collaboration among community members and active participation in the planning and implementation of health programs. To identify community need, Union Hospital works with community leaders from local service providers such as the Cecil County Health Department and the Cecil County Department of Social Services. One tool Union Hospital utilized to determine community need is the Cecil County Health Department's Health Profile 2005 Report. This health profile is based on information from several sources, including the Cecil County Community Health Survey, which gives important health information including self-reported health behaviors.

The major health needs of the community identified in the 2004 Community Health survey are: Coronary Heart Disease, Cancer, Stroke, Chronic Lower Respiratory Disease, Accidents, Diabetes, Pneumonia and Influenza, Suicide, Chronic Liver Disease, and Septicemia.

Governed by a Board of Directors, made up of community leaders, Union Hospital's strategic initiatives are evaluated and with the assistance of Executive Management, determinations are made as to the primary program focus. Each year, Union Hospital fulfills our commitment to improve the health of our community and meet the identified needs by sponsoring community-based clinical services (such as free screenings and clinics), offering health education programs, support groups and self-help programs, providing needed treatments to the underserved and training the future leaders of health care. Our employees also are dedicated to supporting area organizations that serve our community.

The impact of Union Hospital's community benefit activities on the health of area residents over the past five years should be identified in the 2009 Cecil County Community Health Survey which Cecil County Health Department conducted in partnership with Union Hospital in the summer of 2009. Determination of future programs will be identified in part through this survey as well.

Gaps In Availability of Specialist Providers

Union Hospital of Cecil County ("UHCC"), established in 1909, is a full-service community hospital located in Elkton, Maryland. Our 149-bed, not-for-profit hospital is dedicated to providing superior, personalized, quality health care to our neighbors, families and friends. We are the safety-net provider for the county, offering care to those without the ability or means to afford the highly specialized treatments provided by specialists. Our mission is to enhance the health and well-being of residents in Cecil County and neighboring communities, by giving those without means the access to this care. In the past fiscal year, we provided for over 56,567 patient encounters, which amounted to a net health care benefit of \$3,778,089 to Cecil County and the surrounding communities. Of that amount, UHCC provided \$1,270,050 in free health care through our charity care program, as well as free and discounted services to over 158,982 patients through our Community Health Services programs. In Cecil County and Elkton, we have a high percentage of minority residents, approximately 15% in Elkton, and nearly 12% of those living in Elkton live below the poverty line, all of whom rely on the services provided by UHCC for their on-going treatment. Cecil is a rural, overlooked county nestled between Baltimore and the Eastern Shore, and it is difficult to attract physicians to this poor, rural area.

UHCC provides free and reduced cost access to critically needed services, such as intricate specialties for which there are far too few practitioners and even fewer who are willing to forgo a lucrative private practice to be employed at a rural, community hospital. UHCC currently has few to no physicians on the medical staff that specializes in certain services or their associated illnesses and oftentimes, only by traveling are the patients in the Cecil County community able to obtain care in these specialties. Cecil County has a great unmet need for certain medical services when compared to the state and to the nation as a whole. This is due largely in part to our rural, remote location, as well as the high degree of specialization required for the practice of medicine.

Of the specialties on our medical staff, the following offer the greatest challenges with limited to no providers available:

Dermatology – 0 providers

Endocrinology – 1 provider

Internal Medicine – 1 provider

Neurosurgery - .5 providers

Oral Maxillofacial Surgeons – 0 providers

Psychiatry – 0 providers

Rheumatology – 1 provider (*beginning November 9, 2009*)

Urology – .75 providers

Vascular Surgery - .75 providers

Physician Subsidies

In order to better serve the residents of Cecil County and provide them with access to needed medical services, Union Hospital offers income guarantees to attract physicians to the community. The income guarantee is more like a loan, or an advance, that is forgiven over time, to help a physician establish his or her own private practice. The physician has the flexibility to build the practice as they wish and the hospital fills a vacancy in a much needed specialty

Appendix 1:

Description of Charity Care Policy

The purpose of Union Hospital's Financial Assistance (Charity Care) policy is to ensure that hospital staff follows a consistent and equitable process in granting charity/financial assistance to appropriate patients while respecting the individual's dignity and that the hospital's policy is in agreement with the established Maryland State Financial Assistance Guidelines regarding charity care.

This policy describes the application process for the Financial Assistance Program, the information required to verify income and assets, the timeline for application review, and the tiered adjustments based on the Federal Poverty Guidelines.

The application for Financial Assistance is available to all underinsured and uninsured patients of Union Hospital. Applications are located throughout the hospital, emergency room, and outpatient areas. In addition, the Financial Assistance application and brochure are available on the hospital's website. All inpatient, self pay patients are visited by finance staff and screened for the Financial Assistance program as well as for Medicaid and other state and county programs. Following discharge from the hospital, each patient receives a summary of charges which includes notice of the Financial Assistance program and a designated contact telephone number

Appendix 2:

Charity Care Policy

UNION HOSPITAL Elkton, Maryland		Policy Number:	F-415
		Effective Date:	3/2009
Hospital Policies and Procedures			
Financial Assistance Policy and Procedure			
Developed / Edited By:	Charles A. Poggioli, Dir., Revenue Cycle	Date:	3/2009
Reviewed By:	Laurie Beyer, S.V.P. & CFO	Date:	3/2009
Approved By:	Laurie Beyer, S.V.P. & CFO	Date:	3/2009
		Established Date:	03/2004
Departments Affected:	Patient Financial Services		
Reviewed Dates:	03/2004, 6/2004, 9/2004, 3/2006, 12/2008; 2/2009; 3/2009		
Revised Dates:	03/2004 (replaces Charity Care Policy and Procedure), 6/2004; 9/2004; 3/2006; 12/2008; 2/2009; 3/2009		
JCAHO Standard(s):	N/A		
HIPAA Standard(s):			

POLICY:

It is the policy of Union Hospital of Cecil County to assist underinsured or uninsured patients by offering services to patients at a reduced cost based on demonstrated inability to pay. Determination shall be based on the patient's income, assets, expenses, and the current Federal Poverty Guidelines.

PURPOSE:

To ensure that hospital staff follows a consistent and equitable process in granting charity/financial assistance to appropriate patients while respecting the individual's dignity and that the hospital's policy is in agreement with the established Maryland State Financial Assistance guidelines regarding charity care.

PROCEDURE:

General Procedure

Patient shall make application for UHCC's Financial Assistance Program using the Maryland State approved hospital form. The form must be accompanied by verification of income and assets (if requested). Applications returned without requested information may be denied pending receipt.

Appropriate verification may include:

- a. Pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony or child support checks
- b. Federal and/or state tax returns

- c. Bank statements or financial records
- d. If the patient resides at a shelter, written verification of active residence and the provision of room and board must be obtained from the shelter Administrator/Director.
- e. Medical Assistance Denial Letter (if requested)
- f. MA denial may not be required if the hospital representative determines that the patient will not qualify based on an initial interview.
- g. Proof of U.S. citizenship or permanent residency (if requested)

Items needed for approval are also listed on the Financial Assistance Application. If the patient does not provide complete verification of income and assets within 30 days of the application, the request for aid through the Community Assistance Program may be rejected. Additionally, the patient may be required to apply for Medicaid prior to the hospital accepting the patient's application for services at a reduced cost. If approved for Medicaid, the patient will qualify for financial aid for any spend-down amount determined by the State.

Within two (2) business days following a patient's request for charity care services, application for Medical Assistance (Medicaid), or both, the hospital will make a conditional determination of probable eligibility.

Once appropriate verification of income has been provided, the patient's income shall be compared to the current published Federal Poverty Guidelines based on specific family size. If the patient's income is at/or below the appropriate amount on the table, financial assistance will be granted and tiered up to a 100% adjustment for the services rendered. Final determination of eligibility will be made based upon a complete and accurate application. Should insufficient information be provided, the Financial Counselor will contact the patient to obtain additional documentation. All applications will be acknowledged; patients will be contacted by telephone, if possible, and a follow up letter will be sent indicating the level at which the application was approved or the reason for denial.

Tiered adjustments based on the Federal Poverty Guidelines are as follows:

- Up to 200% of the Poverty Level = 100% Adjustment
- 201% to 250% above Poverty Level = 50% Adjustment
- 251% to 300% above Poverty Level = 25% Adjustment

The Federal Poverty Guidelines will be updated annually based on changes by the Department of Health and Human Services.

Once eligibility for financial aid has been established the period of eligibility shall include medical care for three months prior to and continue for up to six months

following the date of application. If a patient returns to UHCC for treatment during the six month eligibility period he/she may be asked to provide additional information to ensure that all eligibility criteria continue to be met.

Balances Eligible for Financial Assistance

All self pay balances, including self pay balances after insurance payments, are eligible for consideration for Financial Assistance with the following exceptions:

- Balances covered by health insurance
- Balances covered by a government or private program other than health insurance
- Balances for patients that would qualify for Medical Assistance but who do not apply
- Balances for patients who are not U.S. residents may be allowed after administrative review on a case-by-case basis.
- Balances on cosmetic surgery and other procedures that are considered elective and without which the patient's general health would not be adversely affected
- Balances for patients who falsify information on, or related to, the application

Public Notice

Information regarding the UHCC Financial Assistance Program will be made available to patients in the following ways:

- Brochures will be available at all registration points, financial counseling areas and outpatient areas
- Information will be posted on the hospital's web site
- Signs will be posted in visible areas at each registration site, including the E D
- A notice of availability of the program will be sent to each patient that receives a self-pay statement from UHCC.

Appendix 3:

Description of Hospital's Mission, Vision, and Value Statement(s)

The Union Hospital mission, vision, and values statement identifies the importance of providing safe, high-quality, personalized services conducted by professional, trained staff while demonstrating collaboration among all providers and prudent management of our resources.

It is the vision of Union hospital that the provision of services in this manner will result in our being the first choice for health care by community residents seeking superior quality services and personalized care in a convenient, cost-effective community setting.

Appendix 4:

Hospital's Mission, Vision, and Value Statement(s)

HOSPITAL MISSION

Our mission is to provide safe, high-quality health and wellness services to the residents of Cecil County and neighboring communities.

VISION

Residents throughout our market will turn first to Affinity Health Alliance for health care because we provide superior quality services and personalized care in a convenient, cost-effective community setting.

VALUES

- We will maintain operational excellence in the provision of high **quality** care in a safe environment.
- We are committed to providing **personalized service** treating patients and their families with compassion and superb care.
- We support the **personal and professional development** of our workforce.
- We seek **collaboration** with our staff, physicians, management, trustees, volunteers, partners, and the communities we serve.
- We **prudently manage our resources** to ensure the continuity of our services to the community.

UNION MEMORIAL HOSPITAL COMMUNITY BENEFIT REPORTING EVALUATION FOR FY 2009

I. Summary

Union Memorial Hospital, a member of MedStar Health, is one of the top specialty hospitals in Baltimore and a valued member of the communities it serves. For more than 155 years it has provided exceptional health service to the local community and beyond. The affiliation with MedStar Health assures top quality medical services are provided in the community, within an integrated health care system offering advanced care, medical research, education and community outreach.

Definition of community and population served

The hospital is currently licensed to operate 301 beds and is accredited by The Joint Commission. For fiscal year 2009, patient volumes included more than 20,700 inpatient admissions and 50,000 emergency department visits. The largest concentration of patient visits and admissions come from eight zip codes in northern Baltimore City and southern Baltimore County. This includes communities of Arlington, Clifton-East End, Druid, Govans, Hamilton, Hampden, Northwood, Overlea and Waverly. In fiscal year 2009, 36 percent of admissions/visits from this area were self-pay and Medicaid recipients.

The median household income of Union Memorial's community is 40 percent lower than in overall Maryland, while 20 percent of households have an annual income of less than \$15,000, compared to 8.4 percent in all of Maryland. Sixty-eight percent of the population in Union Memorial's community is black non-Hispanic, compared to only 29 percent statewide and 12 percent nationally.

Identification of community needs

Union Memorial's community benefits plan regularly aligns with its strategic initiatives. The plan is developed with the guidance of key stakeholders and assessment of state reports and patient data. The individuals involved in the process range from hospital and board leadership to our own staff of community nurse educators. Priorities and programs are routinely reviewed and discussed, relative to Union Memorial's current efforts, to address health-related issues or the ability to initiate or enhance our support. This process also identifies capital-related needs, such as facility expansion, which are necessary for Union Memorial to continue to serve the health care needs of our service area.

We concentrate on residents who have a high prevalence of severity for a particular health concern, with multiple health problems and limited access to timely high quality health care. We focus on program activities that address the underlying causes of persistent health problems as part of a comprehensive strategy to improve health status and quality of life in local communities.

In identifying community needs, Union Memorial analyzed utilization patterns in the hospital, responded to incoming requests from the community, used data compiled by the state; and consulted with the local health department and non-profit organizations such as the American Heart Association, American Cancer Society, American Stroke Association, Baltimore City Cancer Commission and Maryland Department of Aging.

Identified priority areas included, but not limited to, access to health education and prevention services for cancer, heart and other chronic diseases; healthy living and fitness in older adults; and reducing youth sports injuries.

The evaluation process for the success of community benefit activities focuses mainly on gathering data and tracking activity on an ongoing basis. The key areas of interest include the total number of participants in health education programs, screenings and support services; total number of participants receiving follow-up care; and the hospital's communication process with state and local organizations in addressing community health priorities. Results of the data are used to evaluate existing programs and determine when or if changes are indicated.

Community benefit program initiatives

The following is a listing of some of the specific efforts in fiscal year 2009:

Lung cancer screening

Lung cancer continues to be the leading cause of cancer death among Americans. Thus, early detection offers great hope to people at risk, particularly individuals from diverse populations.

Union Memorial's cancer care program free or low-cost screenings for lung cancer to make it as convenient and accessible as possible for those who otherwise might not have access to health improvement services. The screening is designed to detect early stage lung cancer through a low-dose spiral CT (computerized tomography) scan. The hospital-based radiology practice provides diagnostic interpretation of services, and if additional specialty services are needed, the hospital arranges for care through referrals to Union Memorial specialists. Frequently, other diseases are found by way of the screening.

In fiscal year 2009, 493 lung cancer screenings were performed, with two cases of cancer confirmed. Benefit: \$30,731.

Senior programs

The risk for illness, injury and lack of independence naturally increases as we age. But exercise can slow the aging process and help older adults become stronger and gain optimum health. Through Union Memorial Hospital's senior programs, older adults age 55 and over may participate in safe exercise classes specifically designed for them and taught by certified

professionals. These classes help older adults build flexibility and strength, promote healthy living and ease pain due to chronic diseases such as arthritis.

Some of the classes offered include yoga for seniors and light weight lifting. Union Memorial hosts classes onsite and in partnership with the St. Mary's Outreach Center.

Over the years, the programs have grown steadily, and in fiscal year 2009 more than 190 seniors enrolled in the classes and participated more than 390 times. Benefit: \$14,324.

Preventing and treating youth sports injuries

Youth injuries from playing sports are on the rise. Each year, more than 3.5 million sports-related injuries requiring medical treatment occur in children under age 15. The certified athletic trainers and orthopedic physicians of Union Memorial Orthopedics and Sports Medicine are an integral part of minimizing the risk of injury for youth athletes, while also ensuring they receive proper sports care for their injuries. When a player goes down, they're the first on the scene, evaluating any injury as quickly and thoroughly as possible and determining whether the athlete can continue competing or needs further medical treatment.

Union Memorial has relationships with numerous high schools throughout central Maryland, with certified athletic trainers and physician specialists partnering to provide medical coverage at amateur sporting events. Among the organizations, events and schools benefitting from clinical services and physician coverage from Union Memorial in fiscal year 2009 included: Ripken Baseball, Under Armour High School All-America Lacrosse Showcase, Baltimore Sports and Social Club and Loyola high schools. Benefit: \$78,892.

Financial contributions

Union Memorial Hospital partners with organizations across its community to benefit those we serve. We appreciate these partnerships and recognize the positive impact they have in improving the education, health and well-being of our community. In fiscal year 2009, Union Memorial supported many activities within the community through monetary donations totaling more than \$100,500. Some of the organizations benefitting from our support included the Baltimore Zoo, Village Learning Place, Hampden Family Center, Greater Homewood, Big Brother, Big Sisters and United Way of Central Maryland.

Gaps in availability of specialist providers

This information has remained consistent with our fiscal year 2008 report. Physician leadership and case management staff consistently identified several areas of concern:

- Timely placement of patients in need of inpatient psychiatry services
- Limited availability of outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse treatment
- Medication assistance

Physician subsidies

Category 1:

The collections are not high enough in Psychiatry as a result of the uninsured patients and the fact that the 24/7 coverage requires a cost that is disproportionate to the numbers of patients seen in the off-hours.

Category 2:

Hospitalist subsidies ensure 24/7 services in the hospital and focus on preventive health measures and health status improvement for the community.

Category 3:

The subsidies are paid to make up for the shortfall in payments in relation to the cost of providing 24/7 coverage. The collections for these services are not high enough in the emergency department as a result of the large number of uninsured patients.

Other:

Outpatient renal reimbursement does not exceed the cost for providing the program, however, renal services are needed in the community and Union Memorial provides this service at a negative margin.

Category / Title / Department	Expenses	Offsets	Benefit
Subsidized Health Services (C)			
Psychiatry physician Subsidies	117,600	0	117,600
Hospitalists-Subsidies	2,440,350	631,146	1,809,204
ER Physician Subsidies	6,231,130	4,691,325	1,539,805
Pediatrics physician Subsidies	795,917	0	795,917
Renal Dialysis Subsidies	5,507,153	4,844,587	662,566
Subsidized Health Services	15,092,150	10,167,058	4,925,092

Appendix 1: Description of Charity Care Policy

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

Appendix 2: Charity Care Policy

See Corporate version.

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.
- Provide charity care and financial assistance according to applicable guidelines.

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

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

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

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

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

- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

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

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

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

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

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

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

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

Appendix 3: Description of Mission

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

The current mission statement was developed in 2002 as part of the FY03-05 strategic planning cycle. The mission states the organization's purpose and reason for existence, describes what the organization does and for whom, and forms the frame of reference for the vision. UMH is focused on providing comprehensive care to the immediate community in which it resides as well as advanced specialty care for a broad regional market. In addition to these clinical services, UMH is also committed to supporting teaching and research initiatives. The mission statement is reviewed every three years by the strategic planning committee which is comprised of board members, physicians, executive team members and corporate planning staff. The mission will stand in place until at least 2012.

Appendix 4: Mission, Vision, and Values

MedStar Health and each entity (hospital and diversified business) share a common vision and set of values. MedStar Health's common vision is to be the trusted leader, caring for people and advancing health. MedStar Health's common set of values are services, patient first, integrity, respect, innovation and teamwork. Each entity has a unique mission, or purpose for which it exists. MedStar Health's mission is to serve our patients, those who care for them and our communities. Union Memorial Hospital's mission is: Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

Below is an illustration of Union Memorial Hospital's mission, vision and values for reference.



Union Memorial
Hospital
MedStar Health

Vision

*The Trusted Leader
in Caring for People
and Advancing Health.*

Mission

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

Values

Service
We strive to anticipate and meet the needs of our patients, physicians and co-workers.

Patient first
We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.

Integrity
We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.

Respect
We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.

Innovation
We embrace change and work to improve all we do in a fiscally responsible manner.

Teamwork
System effectiveness is built on the collective strength and cultural diversity of everyone, working with open communication and mutual respect.

Union Memorial Hospital is a proud member of MedStar Health, a not-for-profit community-based healthcare organization serving the Baltimore-Washington region through patient care, research, and education

Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218 Phone: 410-554-2000 www.unionmemorial.org

UMMC FY09 COMMUNITY BENEFIT REPORT

1. University of Maryland Medical Center is a 731 licensed acute care bed facility with 36,744 inpatient admissions in FY09.
2. The University of Maryland Medical Center (UMMC) serves Baltimore City and the greater metropolitan region, including patients with in-state and out-of-state referrals for tertiary and quaternary care. UMMC is a private, non-profit acute care hospital and is affiliated with the University of Maryland School of Medicine, as well as the surrounding professional schools on campus. It is the second leading provider of healthcare in Baltimore City and the state of Maryland, and has served the state's and city's populations since 1823.ⁱ

According to U.S. Census Bureau 2007 population estimates, Baltimore City's population was at 637,455. Forty two percent of UMMC's patients reside in Baltimore City. While UMMC serves all of Baltimore City, many of the patients reside in West Baltimore City. According to the Baltimore City Health Status Report 2008, African Americans or Blacks make up 64% of Baltimore City's population. Whites comprise 32.5% of the population followed by Hispanic or Latino representing 2.5%. The remaining racial makeup is comprised of Asian, American Indian, Native Hawaiian/Pacific Islanders and other races. The total population is shown in the chart below.

Baltimore City Population by Race/Ethnicity, 2007		
<i>Total Population</i>	<i>637,455</i>	<i>Percent</i>
Black or African American alone	407,851	64.0%
White alone	206,921	32.5%
Asian alone	13,077	2.1%
American Indian and Alaska Native alone	2,176	0.3%
Native Hawaiian and Other Pacific Islander alone	295	0.0%
Two or more races	7,135	1.1%
Not Hispanic or Latino	621,602	97.5%
Hispanic or Latino	15,853	2.5%

Source: U.S. Census Bureau, 2007 Population Estimates

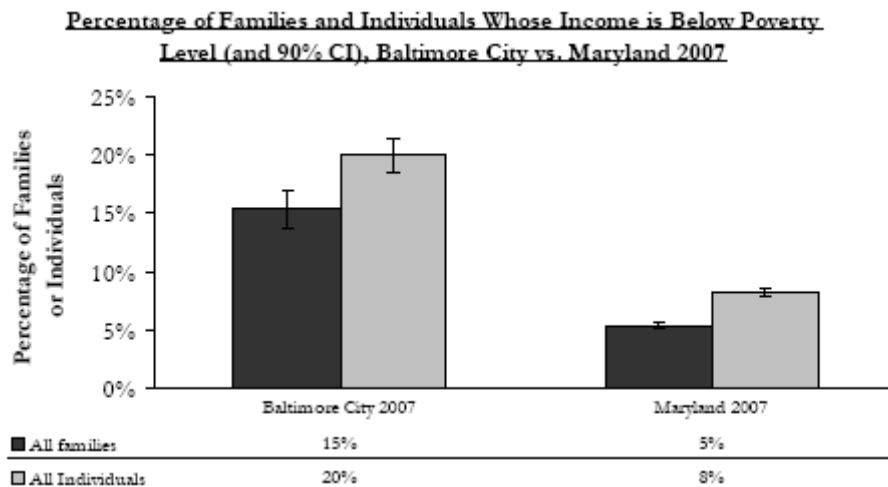
Source: Baltimore City Health Status Report 2008

Forty percent of Baltimore City households reported an income of less than \$30,000 in 2007. Statewide, 20% of households reported an income in this range. The 2007 median household income in Baltimore City for all races was \$36,949; approximately half of the statewide median income.

2007 Median Household Income in the Past 12 months (in 2007 Inflation Adjusted Dollars), Baltimore City	Estimate	Margin of Error*
All Households	36,949	+/-896
Black or African American Alone	32,023	+/-1,276
White Alone	51,584	+/-2,805
Asian Alone	48,689	+/-11,504
Native Hawaiian and Other Pacific Islander Alone	61,711	+/-1,486
Two or More Races	34,860	+/-6,279
Hispanic or Latino	33,890	+/-5,883
White Alone, Not Hispanic or Latino	52,638	+/-3,624

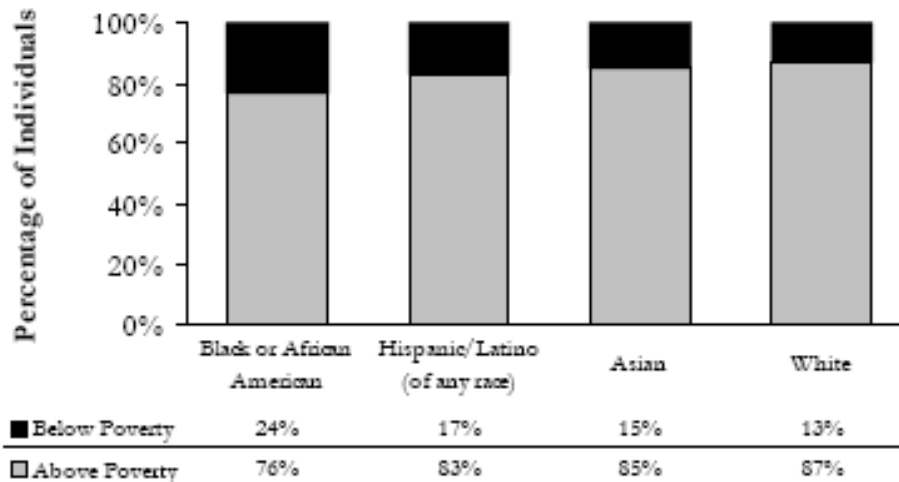
Source: Baltimore City Health Status Report 2008

In 2007, the U.S. Census Bureau Poverty Threshold stated a family of four with two adults and two children under 18 years would be considered “below poverty” if their annual income was less than \$21,027. Three times as many families living in Baltimore City had an income that was below the poverty level compared to Maryland families in 2007. More than three-quarters of Baltimore City residents of all races were above the poverty level, however, African American residents of Baltimore City were almost two times more likely than White residents to have a median income below the poverty level.



Source: Baltimore City Health Status Report 2008

**Percent of Individuals Above and Below Poverty by
Race/Ethnicity, Baltimore City, 2007**



Source: Baltimore City Health Status Report 2008

In FY2009, University of Maryland Medical Center had over 36,000 discharges. Approximately 20% of the hospital's discharges had Medicaid as a financial payor. Thirteen percent of the patients are considered uninsured.

In 2006, heart disease, cancer and cerebrovascular disease were the top three leading causes of death in Baltimore City and nationwide. There were 7,017 deaths among Baltimore City residents, resulting in an all-cause mortality rate of 1083.4 per 100,000. Among race/ethnic groups, African Americans had the highest mortality rate both in Baltimore and statewide.

3. UMMC uses a variety of credible sources to identify community needs. Local, state, and federal assessments and reports are utilized to address and prioritize community needs. The primary source of information for identifying the health needs of Baltimore city is the **2008 Baltimore City Health Status Report**, which is produced by the Baltimore City Health Department. This report outlines Baltimore's prevalence on eight major health categories as well as mortality and leading causes of death. While the focus of this report is on city-wide indicators, there are also numerous comparisons to state-wide prevalence rates as well. The national leading health indicators from **Healthy People 2010** have also recently been incorporated as a framework into community health programming for this year.

In 2008, the Maryland Hospital Association conducted a Maryland Public Opinion Survey on attitudes toward hospitals and health care. The public rated their top health care concerns as quality of care, cost and access, more nursing staff, and reducing infections as their top priorities. This type of survey gives an

initial insight into top-of-mind health concerns of the public, although they differ from the identified health needs.

In addition to these formal reports, UMMC has a long standing relationship with the Baltimore City Health Department. This promotes ongoing and real-time communication on a variety of health issues for the city. In particular, UMMC was awarded a grant for tobacco prevention education through the Baltimore City Tobacco Control Program. Quarterly reports and meetings are held between UMMC and the health department to report and evaluate program effectiveness. UMMC also participates in a variety of city-wide coalitions with the health department as the lead agency, such as the Tobacco Coalition, Cancer Coalition, and Flu Coalitions. This participation promotes a broader understanding of community needs with other community leaders, providers, and community organizations.

UMMC commissioned the Jackson Organization to conduct a telephone market research survey of consumers living in its service area. Interviews were conducted with the household's main healthcare decision maker from June 10 through July 1, 2005. These interviews were conducted with residents in a number of zip codes (see Chart 1 below). The survey was conducted to develop a profile of the health status, concerns, and needs of the community served by UMMC.

Chart 1 describes the geographic area under investigation.

Chart 1 Survey Area (n=300)			
Area	Zip Code	Sample Percent	Households In The Area
West Baltimore City	21207, 21211, 21215, 21216, 21217, 21223, 21225, 21229, 21230	48%	138,431
Other Baltimore City	21202, 21206, 21212, 21213, 21218, 21224, 21239	28	107,542
Surrounding	21045, 21093, 21117, 21144, 21208, 21227, 21228	24	100,635
		Total	346,608

Source: The Jackson Organization UMMC 2005 Needs Assessment

- Major identified health needs in Baltimore include the following health topics (in random order) obesity, tobacco prevention and cessation, cancer, low birth weight, sexually transmitted diseases, violence-related deaths and injuries, and substance abuse. Maryland's health needs are similar with less emphasis on low-

birth weight and substance abuse. Both obesity and smoking contribute substantially to the prevalence of chronic diseases such as diabetes, cardiovascular disease, cancer, and asthma. Therefore, much current UMMC community outreach programming is targeted to obesity and tobacco-related prevention and intervention.

UMMC commissioned the Jackson Organization to conduct a telephone market research. The issues identified that correlated most highly to consumers' health status were stroke, diabetes, high blood pressure and incontinence. These were considered services of importance to UMM in terms of increasing community awareness and access to care.

5. UMMS created the University of Maryland Community Outreach and Advocacy team that meets bi-monthly to address the health care needs of the West Baltimore community. The group is comprised of community outreach management and staff, social workers, directors, vice president's, and physicians from UMMS system hospitals. The group determines what needs are addressed as well as community involvement and activities each year.

6. ***From the Heart...An Afternoon of Heart Health and Education for the Entire Family***

The UMMS Community Outreach and Advocacy team, hosted "*From the Heart, An Afternoon of Heart Health Education for the Entire Family*," The event was held at the Reginald F. Lewis Museum of Maryland African American History and Culture in recognition of National Heart Month and drew hundreds of Baltimore City community members. We emphasized the importance of living a heart healthy lifestyle by offering heart-related health screenings and information, stroke and diabetes prevention, and fun heart-related activities for children. The main attraction of the day was the heart-healthy cooking demonstrations, by 3 well known Baltimore chefs, while the chefs prepared healthy dishes, Yvette Rooks, M.D. presented mini- health seminars on the importance of maintaining a healthy lifestyle with food choices, portion control, and preparation.

The event was very well received from the community and we are currently planning to make this an annual event.

Take a Loved One to the Doctor Day

Take a Loved One to the Doctor Day is an annual event focused on improving health in the West Baltimore community. This year's event was held in the heart of Baltimore City at the War Memorial Building. We choose this particular location because of the convenient accessibility to all forms of public transportation and local businesses. Baltimore City employees we allowed 2 hours off from work to attend and many of them brought family members who are in need of healthcare. From community resources, to on site screening for vascular disease and glaucoma, to prevention and wellness information, and

testing for cholesterol, HIV, and diabetes, this event had it all! Something new this year was the team of UMMC Family and Community Medicine residents that were on site for one-on-one consultations. The attendees could feel free to ask questions about specific health concerns, and how to access care.

An estimated 3,000 community members attended the event, making this another great UMMS sponsored event.

Tobacco Prevention for Preschoolers Grant

This grant was funded by the Baltimore City Health Department for 2009. Funding provided a comprehensive tobacco prevention education campaign to preschool children in public and non-public preschools and Head Start programs. During the school year ending in June 2009, 564 preschool and 320 kindergarten children were educated on the hazards of smoking and the harmful effects of secondhand smoke using age-appropriate methods.

Get Fit Kids

This grant was funded by the Maryland DHMH for 2009. Funding provided a 12-week pedometer-based fitness program for third through fifth graders in six Baltimore City public schools. For the school year ending June 2009, 419 children were enrolled in the program with 30% completing four weeks of the program, and 13% completing the entire 12-week program. The goal of the program was to educate the children on the importance of getting 13,000 steps per day as measured by their pedometers. Daily physical activity and nutrition were both components of this program, but physical activity was the program focus. Step counts were measured on day three of the program and the end of the program. Initial mean step count was 6,568, and the final mean step count was 10,804. This difference was statistically significant. For the participating children, this program significantly increased the children's daily step count (physical activity).

In addition to the large community events, the UMMS Community Outreach and Advocacy team participate and coordinate the following: employee health fairs, blood pressure screenings, physician lead health and wellness talks for local businesses, churches, senior & community centers, and many community events and fairs each year. A community newsletter is also produced quarterly. Cancer, diabetes, and heart disease prevention are the main focus of these events.

7. At each of our larger UMMS Community Outreach events, we currently ask each participant for their demographic information and the following: do they currently see a UMMS or other physician, have health insurance, and if they would like to receive information on our up-coming events or other health related information. This information is then put into a database and our business development team is in the process of developing a tracking system when participants go to a UMMS hospital either as inpatient or outpatient care.

Our team performs “on the spot” evaluations by asking various attendees their thoughts about the events, what they liked, disliked, was the location satisfactory, what would they also like to see, etc. Our team then compiles this information in a written summary and shares it with the team at up-coming committee meetings.

We ask our vendors to rate the event by the following; location, time, attendance, how many people they saw, etc. The response from vendors has been overwhelmingly positive, and feels that our events are a true benefit to the community.

Specifically at the Take a Loved One to the Doctor Day event, attendees were asked to complete a 15 item survey which explored their satisfaction of the health fair, the services that they obtained during the event and what health changes they will make as a result of attending the event. Vendors were also asked to complete a five-item survey which explores their satisfaction of the health fair.

8. As an academic medical center, there are no gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
-

Appendix 1

Description of Charity Care Policy

University of Maryland Medical Center's Financial Clearance Program Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

UMMC makes every effort to make financial assistance information available to our patients including, but not limited to:

- Signage in main admitting areas of the hospital
- Brochures explaining financial assistance are made available in all patient care areas
- Appearing in print media through local newspapers

Appendix 2

UNIVERSITY OF MARYLAND MEDICAL CENTER JAMES LAWRENCE KERNAN HOSPITAL UNIVERSITY SPECIALTY HOSPITAL

FINANCE POLICY AND PROCEDURE MANUAL

Effective Date: September 2008

Revision: December 2008

SUBJECT: FINANCIAL CLEARANCE PROGRAM

APPROVALS:

- | |
|---|
| <ul style="list-style-type: none">• SVP & Chief Financial Officer• |
|---|

POLICY STATEMENT

This policy outlines the principles of the Financial Clearance Program, also formerly known as the Financial Assistance Program. The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their prospective or outstanding hospital bill.

SCOPE

The Financial Clearance Program may cover all medically necessary and appropriate hospital-based services provided by the Hospital (which for this policy includes the University of Maryland Medical Center, University Specialty Hospital, and Kernan Hospital) when ordered by a physician on the Hospital's medical staff.

The Financial Clearance Program does not cover the following:

- Services provided by healthcare providers not affiliated with the Hospital (e.g., durable medical equipment, home health services).
- Insurance co-payments for need-based programs such as Medicaid.
- Unpaid balances resulting from cosmetic or other non-medically necessary services.
- Patient convenience items.

-
- Patient meals and lodging.

The Patient Financial Services (PFS) staff administers the Financial Clearance Program and evaluates each application in a fair and equitable manner. If PFS staff is unable to review and financially clear a non-emergent/urgent service *before* it has been scheduled to be provided, such service may be subject to rescheduling, after consultation with Hospital Management and the patient's physician. The Hospital retains the right in its sole discretion to determine a patient's ability to pay.

All patients presenting for emergency services will be treated regardless of their ability to pay.

PROCEDURE

1.1 The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their outstanding hospital bill. In order to be eligible, patients must complete an application and provide all required documentation.

1.2 Individuals are ineligible for the Financial Clearance Program if they:

- 1.2.1 Refuse to provide requested documentation or provide incomplete information.
- 1.2.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Hospital due to insurance plan restrictions/limits.
- 1.2.3 Fail to pay co-payments as required by the Financial Clearance Program.
- 1.2.4 Fail to keep current on existing payment arrangements with the Hospital or one of its affiliate Hospitals.
- 1.2.5 Fail to make appropriate arrangements on past payment obligations owed to the Hospital or one of its affiliate Hospitals (including those patients who were referred to an outside collection agency for a previous debt).
- 1.2.6 Refuse to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.

1.3 Before scheduling hospital based, non-emergent/urgent services for individuals indicating an inability to pay, staff from the faculty practice plans will contact the Hospital's Financial Counseling team to inform them that a patient is being referred for Financial Clearance.

-
- 1.3.1 Patients must have a referring/attending physician on staff at the Hospital before they may be evaluated for Financial Clearance eligibility.
- 1.3.2 Patients can call Financial Counseling staff directly at (410) 821-4140. Hours of operation are Monday – Friday from 8:00 a.m. to 9:00 p.m.
- 1.3.4 The Financial Counselor will work with the patient to determine if he/she qualifies for Financial Clearance. A determination of probable eligibility will be made within two business days following a patient's initial completed request for Financial Clearance services, application for Medical Assistance, or both.
- 1.3.5 Notice of the availability of Financial Clearance/Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the Hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.
- Individual notice of the availability of Financial Clearance/Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the Hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.
- 1.3.6 The Hospital will publish notice of the availability of Financial Clearance/Financial Assistance annually in the Baltimore Sun Paper.
- 1.3.7 If the patient does qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff who may then schedule the patient for the appropriate Hospital-based service.
- 1.3.8 If the patient does not qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff of the determination and the non-emergent/urgent Hospital-based services will not be scheduled.
- 1.3.9 A decision that the patient may not be scheduled for Hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Physician Leader/Clinical Chair. The Financial Clearance Executive Committee is comprised of the Medical Center Chief Financial Officer and Chief Medical Officer or their designees.

1.4 If there is a change in the patient's financial circumstances, an updated or new application must be completed.

2.0 GUIDELINES

2.1 For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving these types of services.

2.2 For scheduled/elective appointments or admissions, all applications to the Financial Clearance Program must be evaluated and approved prior to the patient's date of service.

2.3 The Hospital reserves the right to request and review all pertinent information, including a review of an applicant's credit report history, for purposes of processing the application.

2.4 All applicants will be screened for other programs before screening for the Financial Clearance Program can begin. The other programs are as follows (in order of screening):

2.4.1 Maryland Medicaid—A denial letter may be required, if appropriate.

2.4.2 Other needs based assistance programs.

2.5 Applicants or family members are not eligible for the Financial Clearance Program if they qualify for Medicaid.

2.6 Unemployed applicants who have been unemployed for more than six (6) months and who have no custodial dependents under the age of 12 must provide proof of disability, as evidenced by a physician's certification, prior to qualifying for the Plan. Exceptions to this rule may be considered in accordance with Section 2.19 below.

2.7 Patients who falsify the Financial Clearance Program application or related documentation will be excluded from the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

2.8 One hundred percent Financial Clearance may be granted to uninsured patients whose sources of income is less than two times the federal poverty income level and who have less than \$10,000 in total assets. Financial Clearance will be granted on a sliding scale to uninsured patients with incomes more than two times the federal poverty income level.

2.9 Cost of care will be included in the determination of patient's eligibility for Financial Clearance.

2.10 The amount of uninsured medical costs will be considered in determining a patient's eligibility for the Financial Clearance Program, (*e.g.*, a patient whose income is \$40,000 a year but whose child recently incurred \$200,000 in uninsured medical costs).

2.11 The Financial Clearance Program decisions are valid for a six-month period. In order to continue in the Program, each patient must reapply before the end of each six month period. In addition, patients who have been approved for the Program must inform the Hospital of any changes in income, assets, expenses, or family status within 30 days of such change(s).

2.12 The patient must fulfill all co-payment obligations. Co-payments are due at the time of service. If a patient fails to pay the required co-payment at the time of service, he/she will no longer qualify for the Financial Clearance Program.

2.13 The Financial Clearance Program will not cover co-insurance or deductibles for patients who have insurance, including Medicare.

2.14 Patients who have access to other medical care (*e.g.*, primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Clearance Program.

2.15 Patients whose insurance program or policy denies coverage for services at the Hospital by their insurance company (*e.g.*, HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Clearance Program.

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

2.17 The Financial Clearance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

2.18 Where there is a compelling educational and/or humanitarian benefit, School of Medicine faculty or Hospital faculty may request the Financial Clearance Executive Committee to consider exceptions to the Financial Clearance Program guidelines.

2.18.1 Faculty/Physicians requesting Financial Clearance on an exception basis must submit appropriate justification to the

Financial Clearance Executive Committee in advance of the patient receiving services.

- 2.18.2 The Chief Medical Officer will notify the attending physician and the Financial Counseling staff of the Financial Clearance Executive Committee determination.

Appendix 3

Description of Hospital's Mission, Vision and Value Statements

UMMC's mission statement could best be defined as a formal written document intended to capture our organization's unique and enduring purpose, practices, and core values. We communicate our organization's desire to produce high-quality patient care that result in high patient satisfaction locally, statewide and throughout the region. It reflects our commitment to offering world class training for health care providers, while focusing on our commitment to excellence through the five pillars UMMC identified as core values: innovation, people, safety and quality, service and stewardship.

The vision statement highlights how key partnerships are instrumental to impacting patient care in Maryland, nationally and internationally. It signifies how the institution will continue to promote the growth and success of our broad network of acute care, specialty and tertiary care.

Appendix 4

Mission Statement

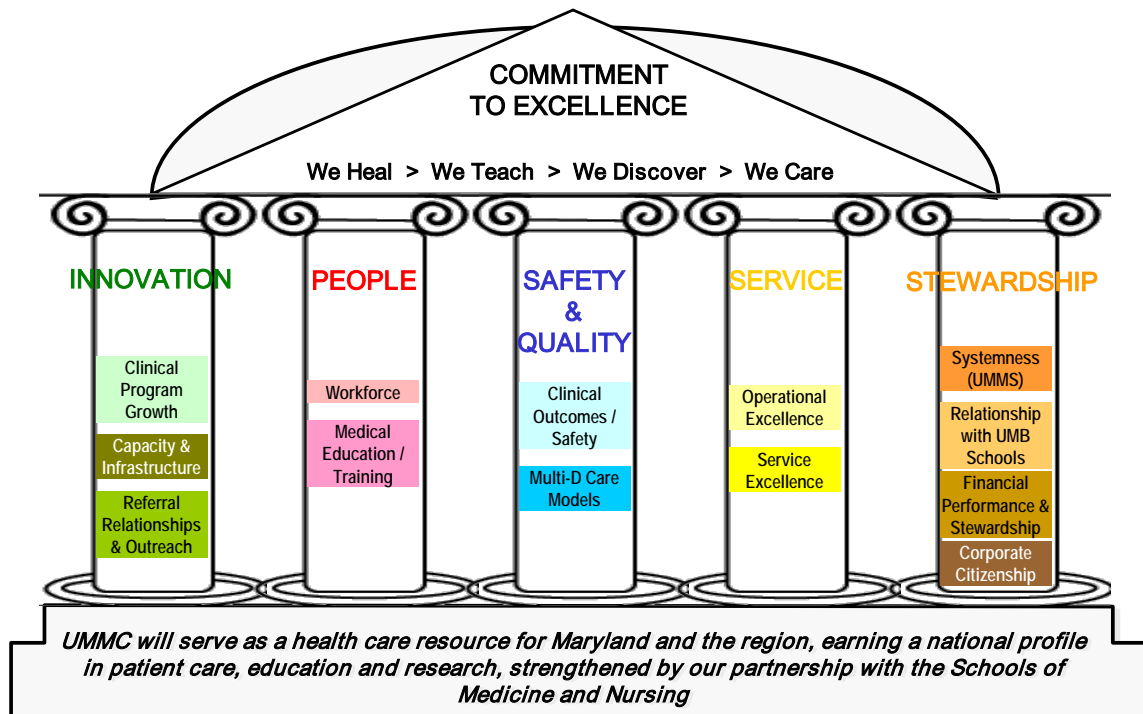
The University of Maryland Medical Center exists to serve the state and the region as a tertiary/quaternary care center, to serve the local community with a full range of care options, to educate and train the next generation of health care providers, and to be a site for world class clinical research.

Vision Statement

UMMC will serve as a health care resource for Maryland and the region, earning a national profile in patient care, education and research, strengthened by our partnership with the Schools of Medicine and Nursing.

Core Values

UMMC has integrated its Objectives and Goals into its *Commitment to Excellence* framework as a foundation for advancing organizational transformation.



FY 2009 UPPER CHESAPEAKE HEALTH NARRATIVE REPORT

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Harford Memorial Hospital (Provider # 21-0006)

- Licensed Beds – 105
- Inpatient Admissions – 8,114

Upper Chesapeake Medical Center (Provider # 21-0049)

- Licensed Beds – 196
- Inpatient Admissions – 16,880

2. Describe the community your organization serves.

Harford County is a suburban county situated between Baltimore County and the mostly rural Cecil County. Having grown 24% between 1990 and 2007, Harford County is one of the fastest growing counties in the state. The 1990 population was 182,132; the 2007 estimated population is 239,993.

The US Department of Defense recommendations of military base changes across the nation have identified Aberdeen Proving Ground as a primary location for Base Realignment and Closure (BRAC). According to state and local planning experts, Harford County's population is expected to increase as much as an additional 19% over the next 10 years in conjunction with activities related to BRAC alone. The recent past and anticipated growth will provide a serious challenge for residents seeking services in a jurisdiction already experiencing difficult access to care issues. A portion of the resulting population growth will be in hourly wage service sector jobs designed to accommodate the base expansion. Many of these jobs will not include health insurance.

With respect to the demographics of the county, the US Census Bureau in 2005 estimates that 84% of residents are White, 11% are Black, and 2% are Latino, though the actual number of Latino residents is thought to be drastically under-reported. The total number of children receiving MCHP benefits in Harford County is 9,458. Of that total, 5,094 are White; 2,968 are Black, and 450 are Latino; 232 are Asian; and 30 are Native American/Pacific Islander.

Harford County has roughly 87,000 households, of which 31,000 (or 29%) have children under the age of 18. The median household income is \$65,000. Poverty households are those that make less than 30% of the county median income. According to the US Census 2005 American Community Survey, an estimated 5% of family households (approximately 12,000 people) in Harford County live below the poverty level. Approximately 38% of the population has attained only a high school degree or lower.

According to the US Census Bureau Small Area Health Insurance Estimates program, approximately 21,000 residents, or nearly 10% of the County is uninsured, though some estimates put that number as high as 34,000. With potential funding cuts to Medicaid and

rising health care premiums, this group is likely to increase. Additional evidence of the loss of health insurance by many residents is the unprecedented 238% growth in MCHP enrollment in Harford County since the year 2000. In addition, underinsurance is known to exist, but is very difficult to measure.

Who are the Uninsured?

Harford County, as is true across Maryland and the Nation, experiences health disparities in several domains of population demographics including health insurance status, income level, race, and ethnicity. Overall, approximately 12,000 county residents have incomes below 200% of the federal poverty level, and an estimated 21,000-34,000 residents are uninsured.

A 2005 Robert Wood Johnson Foundation study shows that the percent rate of uninsured Blacks in Maryland is 17% and 32% for Latinos, much higher than the 10% rate for Whites. While this data is not broken down at the local level, these figures likely provide a reasonable proxy for the racial and ethnic disparity in access to health care in Harford County.

Data analyzed by the DHMH Office of Minority Health Disparities show that in Harford County from 2001 to 2003, the age adjusted death rate in blacks exceeded that of whites, and that this excess in death rate of Harford County blacks compared to whites is greater than twelve other jurisdictions in Maryland, including Baltimore City. This data can have many implications, ranging from lack of minority access to health care, to the neglect of health concerns, and improper health maintenance. All of these issues can be translated to the less than ideal care received by low-income minority children and adults.

The increase in the rate of minority population growth in Harford County is outstripping that of the white population. According to a US Census report, between 2000 and 2007, Harford County's minority population increased quickly while the rate of growth of its white population slowed. In addition, the availability of medical and mental health care in poor neighborhoods is limited. This requires patients to travel or book months in advance for appointments. Transportation and time off from work is always a difficult obstacle and, in the end, care is often delayed until urgent. With our continued population growth and increasing diversification, access to care will become even more challenging.

While most citizens have health insurance through their employer as a benefit, being employed no longer guarantees that a person will have health coverage. This can be from a variety of reasons. Health benefits may not be offered by the employer or workers may not be eligible to receive benefits. Employee contributions towards health insurance premiums make employer offered health coverage unaffordable for many low wage workers. According to the Kaiser Commission, more than 80% of the uninsured come primarily from working families with low and moderate incomes. Only 19% come from families that have no connection to the workforce.

Local Health Services for the Uninsured

For those individuals who do not have commercial health insurance, there are a number of government or public programs, state and federal, which provide health coverage to the County's residents. Medicaid covers three main groups of non-elderly low-income people:

children, their parents, and persons with disabilities. The Maryland Children's Health Program (MCHP), extends Medicaid benefits to children up to 19 years of age whose families have incomes at or below 200% of the Federal Poverty Level (FPL). Pregnant women are covered up to 250% of the FPL. In addition, under MCHP Premium, health coverage is provided to children under age 19 with family incomes up to 300% of the FPL, if the family pays a small premium. In contrast, the role of Medicaid for adults under the age of 65 is extremely limited. Most low-income adults without dependent children, regardless of how poor they are, do not qualify for Medicaid.

One program which addresses the health care needs of uninsured adults whose incomes are too high to qualify for Medicaid yet too low to enable them to obtain individual and even employer-sponsored health insurance is the Maryland Primary Care (MPC) program. Through this state run program, the Harford County Health Department offers primary care coverage to eligible low income adults between the ages of 19 and 64 but they must have a qualifying chronic medical condition(s). Gross income for a family of four cannot be above \$1,571 per month or \$18,852 per year. Due to funding cuts, there have been times where new patients are not being accepted in the program. In addition, this program does not cover hospitalization or specialty care.

The Upper Chesapeake HealthLink Primary Care Clinic provides primary care and extensive case management services on a sliding scale fee to eligible uninsured and underinsured Harford County residents ages 19 and older and whose income is less than 300% of the federal poverty level. This Clinic is currently able to provide primary care services to approximately 1,300 patients.

The Upper Chesapeake HealthLink Primary Clinic and the Harford County Health Department are Harford County's sources of primary care for the uninsured. The staff of each respective agency works interdependently often sharing resources and expertise as appropriate to provide the best overall health services to their cliental.

Health Consequences of being Uninsured

There is a strong relationship between health insurance and ones ability to access health care services. Uninsured people are less than half as likely as people with health insurance to have a primary care provider; to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits. Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance.

According to the Maryland Health Insurance Commission, almost one of every two (49%) uninsured adults with chronic conditions reported forgoing needed medical care or prescription drugs due to cost; one-third reported unmet need for medical care and one of three reported unmet need for prescription drugs. More than 40 percent reported unmet need for dental care. Over six in 10 uninsured black adults who have a chronic condition received no dental care in the past 12 months.

Of special significance is the fact that the uninsured are less likely to have a usual source of care aside from the emergency department. It is estimated that 13% of all Harford County

Emergency Department visits are non urgent self pay patients who are using the ED as their primary care medical home. That is over 11,000 visits that are crowding our emergency rooms every year due to an immediate lack of access to primary care.

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

In December 1993, a group of community leaders, spearheaded by Upper Chesapeake Health, the Harford County Health Department, and Harford County Government, formed Healthy Harford, the Healthy Communities Initiative of Harford County. Incorporated in 1995 as a 501(c)(3), the vision of Healthy Harford - *“to make Harford County the healthiest community in Maryland”* - has consistently motivated the development of this organization’s strategic goals, objectives and programs over the past 15 years. The current President/CEO of Upper Chesapeake Health serves as the President for Healthy Harford; the two primary members are Upper Chesapeake Health and the Harford County Health Department.

Over the years, Healthy Harford has hosted many events and programs designed to promote and improve the general health of adults and children living and working in Harford County. Some of these initial programs included a health carnival, free immunizations for school-aged children, and a Recycle Your Cycle project that encouraged residents to donate their used exercise equipment to benefit the public schools. With a strong commitment to education, Healthy Harford also published yearly health guides, beginning in 1995 with a nutrition “eating out” guide. Since this initial publication, fitness, wellness, healthy heart, substance abuse and cancer prevention guides have been produced and distributed free to the community.

In 1996, Healthy Harford conducted the first Community Health Assessment Project (CHAP), a randomized household phone survey designed to determine the overall health status of community residents based on key health indicators. A 36 member community committee directed this initial process and ultimately identified and prioritized health needs related to preventive health and wellness, heart disease, and cancer. The results of the CHAP assessment also served to align community stakeholders around the common goal of improving the overall health of county residents. Through the creation of Community Action Teams (CATs), Healthy Harford brought together relevant community organizations to develop shared strategies to address each of the top health priorities. Some examples include the “Cancer CAT” that was responsible for implementing a Kids Healthy Lifestyle Program in several Harford County middle schools and the “Heart CAT” that provided education regarding the signs and symptoms of heart attack and stroke to many groups in the community. CHAPs conducted in 2000 and 2005 have enabled Healthy Harford to monitor progress and gather additional information relevant to the community’s overall health. Following CHAP 2000, community report cards were developed with specific goals established for 2005 and 2010 focusing on preventive health and wellness, heart disease, and cancer. Following CHAP 2005, the report cards and 2010 goals were revised based on survey results. The Harford County Master Plan includes and tracks programs, initiatives and education efforts implemented by many organizations in Harford County in support of these goals.

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

The following are the report cards and 2010 goals that were developed following the CHAP 2005 survey:

**Healthy Harford, Inc.
Community Health Assessment Project (CHAP)
Report Cards and 2010 Goals**

Healthy Harford Community Report Card – Preventive Health and Wellness				
Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Flu Vaccine	66% of adults 65 years of age and older have had a flu vaccine within the past year.	80% of adults 65 years of age and older have had a flu vaccine within the past year.	77% of adults 65 years of age and older have had a flu vaccine within the past year.	Increase to 90% of adults 65 years of age and older who have had a flu vaccine within the past year.
Pneumonia Shot				75% of adults 65 years of age and older have had the recommended pneumonia shot.
Seatbelt Use While Driving	80% report they always wear their seatbelt while driving.	89% report they always wear their seatbelt while driving.	90% report they always wear their seatbelt while driving.	Increase to 92% of adults who report they always wear their seatbelt while driving.
Seatbelt Use While a Passenger	76% report they always wear their seatbelt while a passenger.	84% report they always wear their seatbelt while a passenger.	87% report they always wear their seatbelt while a passenger.	Increase to 90% of adults who report they always wear their seatbelt while a passenger.
Helmet Use	75% of parents with children under 20 years of age report their children wear a helmet while riding a bicycle or rollerblading.	64% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle or rollerblading.	79% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle, rollerblading or skateboarding	Increase to 85% of parents with children under 20 that report their children always or often wear a helmet while riding a bicycle, rollerblading, or skateboarding
Sunscreen Use	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors.	Increase to 50% of adults who report they regularly wear sunscreen when outdoors.

Healthy Harford Community Report Card – Heart Disease

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cholesterol	<p>51% have had their cholesterol screened within the past two years.</p> <p>21% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>95% have had their cholesterol screened within 0-3 years.</p> <p>75% have had their cholesterol screened within the past two years.</p> <p>24% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>92% have had their cholesterol screened within 0-3 years.</p> <p>32% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>90% of adults aged 18 years and older have had their blood cholesterol checked within the preceding 5 years. (2010 goal based on revised recommendations).</p>
Overweight	39% of adults have a BMI >30.	26% of adults have a BMI >30.	32% of adults have a BMI >30.	Reduce to 25% of adults who have a BMI >30.
Smoking	<p>18% of Harford County adults smoke.</p> <p>32% of Harford County youth report smoking. (1998 MYTS)</p>	<p>14% of Harford County adults smoke.</p> <p>21% of Harford County youth report smoking. (2000 MYTS)</p>	9.5% of Harford County adults smoke.	<p>Reduce to 9% the level of smoking among adults.</p> <p>Reduce to 10% the level of smoking among youth.</p>
Blood Pressure	<p>68% have had their blood pressure screened within the past two years.</p> <p>21% of residents report they have or have had high blood pressure.</p>	<p>99% have had their blood pressure screened within 0-3 years.</p> <p>86% have had their blood pressure screened within the past two years.</p> <p>31% of residents report they have or have had high blood pressure.</p>	<p>97% have had their blood pressure screened within 0-3 years.</p> <p>32% of residents report they have or have had high blood pressure.</p>	<p>50% of adults 18 years and older with high blood pressure will have their blood pressure under control. (2010 goal based on revised recommendations)</p>

Healthy Harford Community Report Card – Cancer

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cervical Cancer	57% of adult women have had a pap smear within the past two years.	97% of adult women have had a pap smear within 0-3 years. 74% of adult women have had a pap smear within the past two years.	93% of adult women have had a pap smear within 0-3 years.	Maintain 93% of women aged 18 to 70 years who received a pap test within the preceding 3 years.
Breast Cancer	74% of women 50 years of age and older have had a mammogram within the past two years.	51% of women 50 years of age to 69 have had a mammogram within the past year. 76% of women 50 years of age to 69 have had a mammogram within the last two years.	67% of women 50 years of age to 69 have had a mammogram within the past year.	70% of women aged 40 years and older have received a mammogram within the past year. <i>(2010 goal based on revised recommendations)</i>
Prostate Cancer	56% of men 50 years of age and older have had a digital rectal exam within the past year.	62% of men 50 years of age and older have had a digital rectal exam within the past year.	59% of men 50 years of age and older have had a digital rectal exam within the past year.	Increase to 70% of men 50 years of age and older who have had a digital rectal exam within the past year.
Skin Cancer	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors. 69% of adults with children <20 report their children regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors. 65% of adults with children <20 report their children regularly wear sunscreen when outdoors.	Increase to 50% of adults who report regularly wearing sunscreen when outdoors. Increase to 70% of adults with children <20 who report that their children regularly wear sunscreen when outdoors.
Colorectal Cancer	13% report they have been tested for colorectal cancer.	33% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 18% of respondents >50 have had a sigmoid/colonoscopy within the past year.	55% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 29% of respondents >50 have had a sigmoid/colonoscopy within the past year.	75% of adults 50 years and older report either having a FOBT in the past year or a colonoscopy within the last 10 years. <i>(2010 goal based on revised recommendations)</i>

Healthy Harford Community Report Card – Cancer				
Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Oral Cavity and Pharynx	<p>87% of adults report they have been to the dentist in the last two years.</p> <p>88% of children go to the dentist for regular check-ups.</p>	<p>76% of adults report they have been to the dentist in the last year.</p> <p>94% of parents report their children go to the dentist for regular check-ups.</p>	<p>79% of adults report they have been to the dentist in the last year.</p> <p>88% of parents report their children go to the dentist for regular check-ups.</p>	Increase to 90% of adults with dental screenings within the last year.

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

Decisions to determine which needs in the community would be addressed through community benefits activities of the hospital was a collaborative effort of the following:

- The Director of Community Health Improvement chairs a community “Access to Care” Committee comprised of representatives from Upper Chesapeake Health, the Harford County Health Department, The Office of Mental Health/ - Core Services Agency, and the Department of Social Services. With the Upper Chesapeake HealthLink Primary Care Clinic serving as the sole provider of primary care and specialty referral services for the uninsured in the County, the Committee works towards collaborative efforts to meet the comprehensive scope of access to care needs for those that are uninsured and underserved in the County. In 2007, the Committee was successful in obtaining an MUA designation for Harford County through a Governor’s Exceptional Designation; they also developed an Access to Care Strategic Plan that identified the strengths, challenges, opportunities and goals for enhanced Access to Care Services in Harford County.
- Through collaboration with the Healthy Harford Board, several community benefit programs were developed based on the CHAP Report Cards and 2010 goals.

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

The following are examples of community benefit programs that resulted from the needs and 2010 goals identified in the CHAP 2005 survey:

- Flu vaccines were offered directly in all Senior Centers Long Term Care facilities as well as the majority of Assisted Living Facilities in Harford County.

- Pneumonia shots were offered to all Senior Centers and to three underserved minority faith centers.
- Health and well being programs were conducted throughout the year. The educational programs were focused on tobacco, stroke, mental health, tattoo and body piercing safety, cardiac health, diabetes and breast health.
- Several community education programs focused on sunscreen use were conducted during May.
- Based on the results of the CHAP Survey with respect to the lack of proper nutrition and daily activity of Harford County residents, a major Healthy Harford Community Action Team has been developed and will begin the task of developing a comprehensive Nutrition and Physical Activity Plan for Harford County in January 2009. Support and direct participation for this project is community-wide and includes Upper Chesapeake Health, the Harford County Health Department, the Harford County Executive's Office, Harford County Council, the Town of Bel Air, Havre de Grace City Council, Aberdeen City Council, Harford County Chamber of Commerce, Harford Community College, the ARC Northern Chesapeake Region, Harford County Public Schools, Harford County Parks 'n Recreation, Harford County Public Libraries, Harford County Sheriff's Office, and the Boys and Girls Club of Harford County. This is a 12 to 18 month project.
- Free blood pressure screenings are offered throughout the County at numerous locations on an on-going basis.
- Through collaboration with Upper Chesapeake Health physicians, free screenings for prostate cancer, skin cancer, colorectal cancer, and head and neck cancer are provided free of charge once a year at each hospital.

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

A primary evaluation strategy is through the Healthy Harford Community Health Assessment Project (CHAP) that is now conducted every 5 years to determine progress on the community report cards and 2010 goals. Planning for CHAP 2010 will commence in early 2009. On an on-going basis, evaluations are given to consumers at the HealthLink Primary Care Clinic and at all community-based events. These evaluations are reviewed on an on-going basis so that improvements and changes can be made based on feedback received.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

The Upper Chesapeake HealthLink Primary Care Clinic (UC HealthLink PCC) is a primary care clinic that serves low income (300% of the Federal poverty level) uninsured and underinsured patients ages 19 and older. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Since Harford County does not have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices, we are at the mercy of the generosity of local private physicians and medical service providers to

donate pro-bono and reduced cost services to our patients. Upper Chesapeake HealthLink has a specialty network coordinator who visits all of the specialists and tries to reach an agreement for them to see our patients on an agreed basis whether that be weekly, monthly, etc..

9. Physician subsidies.

Physician subsidies at Upper Chesapeake Health consist of the cost of on call coverage for physicians who would not work there unless compensated by the hospital. The amounts reported for 2009 include:

Upper Chesapeake ED physician subsidies: \$402,063

Harford Memorial ED physician subsidies: \$317,409

Harford Memorial Behavioral Health physician subsidies: \$115,841

Appendix 1:

Describe your Charity Care policy

A summary of Upper Chesapeake Health's Financial Assistance policy is available to every patient who registers for patient care services at Upper Chesapeake Medical Center and Harford Memorial Hospital. There are signs (written in both English and Spanish) located at every patient registration station that notifies a patient that Upper Chesapeake Health provides financial assistance to those patients who are eligible or who have concerns about paying their bill. Along with the Financial Assistance summary, patients who are registered as self-pay as well as any patient who expresses interest or concern receive an application and a cover letter that instructs the patient how to apply for government benefits (MD Medical Assistance) as well as the health system's charity program and who they should contact with questions.

Appendix 2:

Include a copy of your hospital's charity care policy

UPPER CHESAPEAKE HEALTH HOSPITALS Patient Accounting Department Policy Manual

TITLE: FINANCIAL ASSISTANCE POLICY

Page 1 of 2

APPROVED BY:

Director of Patient Financial Services _____

Original Date: 02/99

Revised Date: 12/08

Next Scheduled Review Date: 12/09

Related JCAHO Functional Area Chapters: RI

PURPOSE:

The Financial Assistance Policy has been established to provide financial relief to those who are unable to meet their financial obligation to UCH.

POLICY:

Eligibility will be based on 150% of the Federal Poverty Level as published annually by the Federal Government. Percentage determination will be based on income and family size with net liquid assets not exceeding \$10,000.00.

PROCEDURE:

1. All income determinations will be based on Gross income with the exception of Social Security/Pension income which will be determined based on Net income. The patient's/guarantor's eligibility will be determined using the following as proof of income:
 - Employment (most current 3 paystubs)
 - Retirement/Pension Benefits
 - Social Security Benefits
 - Public Assistance Benefits
 - Disability Benefits
 - Unemployment Benefits
 - Veterans Benefits
 - Alimony
 - Rental Property Income
 - Strike Benefits
 - Military Allotment
 - Farm or Self-employment

2. Exclusions from requiring income information:

➤ Deceased Patients

If it is determined that there is no estate on file, and the patient expired at either Upper Chesapeake Medical Center or Harford Memorial Hospital, the account will be referred for 100% Financial Assistance. If the patient expired anywhere else, a copy of the death certificate will be required before the write off.

➤ Out of State Medical Assistance

If the patient's account balances total less than \$1000.00, the Medical Assistance Follow Up Representative must contact the out of state Medical Assistance plan to verify the patient's eligibility for that date of service. If the patient was eligible, the account will be referred to the Patient Financial Liaison to prepare the account for Financial Assistance. The account balances will be eligible for 100% Financial Assistance. If the patient was not eligible with the out of state Medical Assistance plan for that date of service, the account balance will become Self Pay.

➤ Over 18 Being Supported by Others

If the patient is not working and has no proof of income, the account will be referred to the appropriate collection agency for verification. A notarized letter is required signed by the person who is providing for the patient.

3. With each application, all prior accounts with a patient liability for this guarantor must be identified and listed on the determination form with the exception of accounts in a Bad Debt status. Once a final determination is made, the Patient Financial Liaison will complete a *Financial Assistance Determination* form that will be submitted to the Patient Accounting Supervisor who will determine approval and forward for additional approval as follows:

Adjustments up to \$ 2,500.00	Patient Accounting Supervisor
Adjustments up to \$ 5,000.00	Patient Accounting Manager
Adjustments up to \$10,000.00	Patient Accounting Director
Adjustments over \$10,000.00	V.P. of Finance

4. After the final determination has been made, the patient will either receive a *Financial Assistance Patient Notification* letter to advise him of the Assistance he will receive or the *Financial Assistance Denial* letter to advise him of the reason that he did not qualify.

5. Any exceptions to the above must be authorized by the Supervisor and/or Director.

Appendix 3/4:

UPPER CHESAPEAKE HEALTH MISSION, VISION, VALUE

Vision: The Vision of Upper Chesapeake Health is to become the preferred, integrated health care system creating the healthiest community in Maryland.

Mission: Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. UCH is committed to service excellence as it offers a broad range of health services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Excellence: We constantly pursue excellence and quality through teamwork, continuous improvement, customer satisfaction, innovation, education and prudent resource management.

Compassion: People are the source of our strength and the focus of our mission. We will serve all people with compassion and dignity.

Integrity: We will conduct our work with integrity, honesty, and fairness. We will meet the highest ethical and professional standards.

Respect: We will respect the work, quality, diversity, and importance of each person who works with or is served by Upper Chesapeake Health.

Responsibility: We take responsibility for our actions and hold ourselves accountable for the results and outcomes.

Trust: We will strive to be good citizens of the communities we serve and build trust and confidence in our ability to anticipate and respond to community and patient needs.

Washington Adventist Hospital FY2009 Community Benefit Report

1. Washington Adventist Hospital is a 288 licensed bed facility with 19,432 inpatient admissions between July 1, 2008 and June 30th, 2009.
2. The service area of Washington Adventist Hospital covers a large area, with a population estimated at over 725,000 for 2009.

Zip Code	City/Area
20912	Takoma Park
20011, 20012, 20018, 20019, 20020	Washington
20707 & 20708	Laurel
20715, 20720, 20721	Bowie
20772 & 20774	Upper Marlboro
20781 – 20785	Hyattsville
20850, 20853	Rockville
20877 – 20878	Gaithersburg
20901 – 20906 & 20910	Silver Spring
20705 & 20706	Beltsville & Lanham
20712	Mt. Rainier
20722	Brentwood
20735 & 20737	Clinton & Riverdale
20740	College Park
20743 & 20744	Capital Heights & Fort Washington
20747 & 20748	District Heights & Temple Hills
20770	Greenbelt
20866	Burtonsville
20874	Germantown

-- Demographic characteristics of the service area include the following (2009 Estimates):

Population	725,134
Median Household Income	\$93,539
Life Expectancy (2006 estimate)	77.7

-- According to the US Census Bureau, the area has families below the poverty level ranging from 5.1% to 7.8%:

Montgomery County	5.1%
Gaithersburg	7.1%
Rockville	7.8%

-- Payor mix for Washington Adventist Hospital's patients, including the uninsured & Medicaid patients is as follows:

Medicare	38.5%
Medicaid	19.8%
HMO	14.9%
Self Pay	10.7%
Blue Cross	7.5%
Commercial Insurance	6.4%
All Other	2.2%
Total	100%

3. (Shady Grove Adventist Hospital ("SGAH") / Washington Adventist Hospital ("WAH")) has served the Greater Washington metropolitan community for more than (three decades / 100 years). Our mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing. Each year, SGAH / WAH, go through an extensive environmental scan using internal and publically available data sources, partnerships, and community organizations that better understands the needs within the community. Over the years, Adventist HealthCare, the parent corporate of (SGAH/WAH) has identified health care disparities in our region. As a result, AHC's pioneering Center for Health Disparities, assisted by its Blue Ribbon Advisory Panel of community leaders, has three areas of focus: increased services for underserved populations; a research program to identify and promote best practices of healthcare for the underserved; and an education initiative to improve the ability of caregivers to provide quality care to those populations. Progress continues on a number of the panel's recommendations including an annual health disparities report card, a Maternal Services Center, a Patient Advocacy Program/Linguistic Access and Disparities Awareness Program, and cultural training programs for physicians and staff.

Identification of Community Needs:

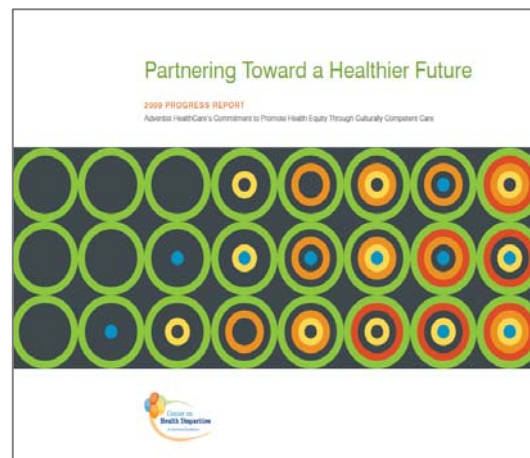
In 2007, The Center on Health Disparities at AHC, published "Partnering Toward a Healthier Future" Progress Report. The Report highlighted health disparities issues that exist in Montgomery, Prince Georges and Frederick Counties. The report proposed three recommendations:

1. Expansion of outreach and services for needs of racial and ethnic minorities is needed.
2. We need to pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers.
3. Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.



Many resources were utilized when compiling this report; U.S. Census Bureau, Maryland Department of Health and Mental Hygiene, Montgomery, Prince Georges and Frederick Counties Departments of Health and Human Services, Office of Minority Health, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, Maryland Behavior Risk Factor Surveillance System, Maryland Healthcare Commission, Centers for Medicare and Medicaid Services, Kaiser Family Foundation State Health Facts, amongst others.

We conducted a 2008 progress report that highlighted our community partnerships and their accomplishments towards achieving equity. In 2009, our progress report focused on Adventist HealthCare initiatives and programs as a response to the 2007 report recommendations.



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

1. Expansion of outreach and services for needs of racial and ethnic minorities is needed.
 2. We need to pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers
 3. Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices
- 5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?**

In addition to AHC Leadership, The Center on Health Disparities has a Community Advisory Board that helped us guide and provided input into the programs that we have implemented to address the issues identified in the 2007 progress report (question 4)

- 6. Do any major community benefit program initiatives address the needs listed in #4 and if so, how?**

Yes, after discovering that 28% of Latinos and 40% of Asians are linguistically isolated in our county, we have implemented the Qualified Bilingual Staff program that trains and certifies our bilingual staff in proper interpreting skills in a medical encounter. So far we have trained over 230 individuals on our staff and also other community organizations.

We live in a very diverse community, close to 30% of Montgomery County Residents are foreign born. This statistics bring a set of opportunities when diverse individuals seek access to care. As a result we implemented the Culturally Competent Care training for health providers and staff. We have developed three modules:

Module 1	Educate participants on community/patient demographics, health disparities, Center programs and services, and cultural/linguistic competence and standards.
Module 2	Explore how personal values, biases and assumptions impact patient-provider relationships, adherence to treatment, and consequently health outcomes.
Module 3	Teach cross-cultural communication skills to facilitate communication, cultural beliefs and practices of diverse populations, and highlight implications for providers and staff.

We have established a relationship with the University of Maryland, School of Public Health, with the goal of developing a research agenda for our disparities initiatives.

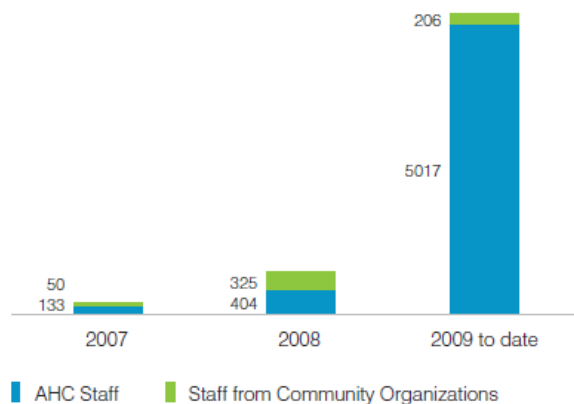
We partnered with the Brookings Institution in order to standardize demographic data collection and develop Quality Reports stratified by Race, Ethnicity and in the near future ad Language proficiency and country of origin.

Adventist HealthCare also established a partnership with Montgomery County to provide prenatal care to 1000 underserved women in the county. As well as partner with Mobile Med Clinics, Mercy Clinic and Mary Center for the provision of primary care to our most vulnerable and uninsured residents.

The Center on Health Disparities at AHC convened a conference with over 250 attendees form our community partners to highlight area accomplishments and provide a venue for transferring of best practices when implementing Health Disparities Programs.

7. Please provide description of any efforts taken to evaluate or assess the effectiveness of major community benefit program initiatives.

Cultural Competency Training Participants*



* Participants defined as individual receiving some aspect of training.
Source: Center on Health Disparities staff.

Qualified Bilingual Staff Interpreters

232 participants
95 QBS certified
QBS certified interpreters in 10 languages

QBS Evaluation Process

PHASE I	PHASE II	PHASE III	PHASE IV
<p>Manager's survey: Assess effectiveness and impact of QBS protocol from managers' perspective</p> <p>QBS interpreter's survey: Assess impact on staff morale, usefulness of training to interpreter, and impact on patient population</p> <p>QBS interpreter's log: Collect data on frequency, type of interpretation, providers that utilize QBS services</p> <p>QBS focus groups</p>	<p>Physician's survey: Assess utility of QBS staff to healthcare encounters, knowledge of QBS availability, quality of services</p> <p>Physician education: Educate physicians on QBS use and related cultural competency issues</p>	<p>Patient's survey: Assess quality of interpreters encounters, impact on patients' view of AHC, identify areas for improvement</p>	<p>Quality Study: Assess quality of QBS encounters, health outcomes of patients, cultural/linguistic sensitivity on an organizational level</p>

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Washington Adventist Hospital has noted an increase in the numbers of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our services area. Listed below are the specialties where we believe there are current gaps in availability of coverage for our underserved and uninsured population:

Family Practice
Internal Medicine and certain subspecialties
Obstetrics & Gynecology
Orthopedics
Urology
Neurology
Neurosurgery

General Surgery
Psychiatry
ENT

As the demographics of our service area continue to evolve we believe that there will be additional gaps in the availability of specialist providers.

9. If you list physician subsidies in your data, please provide detail.

Physician Category	Amount
Emergency Department On-Call	\$8,886,556
Non-Resident House Staff and Hospitalist	\$523,807
Recruitment of Physicians to meet community need	\$0

**Washington Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 1

Charity Care Policy

Washington Adventist Hospital informs patients of their eligibility for financial assistance under its charity care policy at several intervals. The Hospital's charity policy is clearly posted in the emergency room and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy at either the time of admission or discharge a copy of the charity policy will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is told that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines that the patient may be eligible for Medicaid an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance a copy of the Hospital's charity application will be sent to them.

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

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Charity Care Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	1 of 14

SCOPE

This policy applies to all AHC-affiliated facilities, except for Hackettstown Regional Medical Center, which has its own financial assistance policy that is compliant with New Jersey regulations.

PURPOSE:

To provide a systematic and equitable way to provide medical services to those who have a need and lack adequate resources to pay for those services. To provide service while recognizing the need to preserve the dignity of individuals in need of this assistance.

BENEFITS:

Increase in uncompensated care for community residents, decrease in bad debt placement of accounts with collection agencies . Enhanced community service by providing quality medical services regardless of a patient's ability to pay.

POLICY:

All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance. Printed public notification regarding the program will be made annually.

Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's circumstances. Circumstances could include; the needs of the patient and/or family, available income and/or other financial resources. It is part of Adventist Healthcare's mission to provide necessary medical care to those who are unable to pay for that care. However, this policy encourages a patient or their representative to cooperate with, and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for the services related to the request for Financial Assistance.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Charity Care Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	2 of 14

SCOPE:

- A.** The Financial Assistance policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Potomac Ridge Behavioral Health, Hackettstown Community Hospital or Adventist Rehab Hospital of Maryland. A patient may apply for Financial Assistance at anytime. Services not covered by the Financial Assistance policy:
1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
 2. Cosmetic, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
 3. Patients who qualify for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Financial Assistance Program to the extent that services would be covered under those programs.
- B.** The patient would be required to complete an application for Financial Assistance and be approved using established guidelines, completion of the “Income” and “Family Size” portions of the State Medicaid Application could be considered as “an application for Financial Assistance”. An approved application for assistance will be valid for six months from the effective date and can be applied to any qualified services(see “A” above), rendered within the six month period . The patient or Family Representative may reapply for Financial Assistance if their situation continues to merit assistance.

This program provides for care to be, either free or rendered at a reduced charge to those most in need, based on limited income and family size, (i.e., individuals who have income that is less than or equal to 300% of the federal poverty level), and the absence of other available financial resources. See attached Sliding Scale Chart, attached.

- C.** Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Financial Assistance without having completed a formal application.

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
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Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	3 of 14

This would occur after a determination that other family members have no legal obligation to provide financial assistance. After receiving appropriate authorization, adjust the account balance via the appropriate adjustment Codes 23001 – Account in active AR, 33001 – Account in Bad Debt.

- D.** Where a patient is from out of state with no means to pay, follow instructions for “C” above.
- E.** A Maryland Resident who has no assets or means to pay, follow instructions for “C” above..
- F.** A Patient who files for bankruptcy, and has no identifiable means to pay the claim, follow instructions for “C” above..
- G.** Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, follow instructions for “C” above..
- H.** A Patient is denied Medicaid but is not determined to be “over scale” follow instructions for “C” above.
- I.** A Patient is an approved participant in the Montgomery County Maternity Partnership Program, but requires services not covered under the program and, services are rendered prior to the birth of the child, approve 100% Financial Assistance. The patient has already met the qualifications for Financial Assistance using the Federal Poverty Guidelines in their MCMPP Application.
- J.** Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, will have their current balances adjusted using Financial Assistance Adjustment Codes. See “C” above.

PROCEDURE:

- A.** Financial Counselor(s), Registration, Collection and Patient Communication staff should be thoroughly familiar with the criteria and process for financial assistance..

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

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Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Charity Care Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	4 of 14

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- B.** An individual notice of Financial Assistance availability should be provided to each person who seeks services in the Hospital. The notice is presented at the time of preadmission or admission, or upon request.
- C.** Patients being admitted should be prescreened for potential Financial Assistance qualification, using the questions found in the Registration- Financial Assistance Pathway.
- D.** All inpatients without documented Insurance Coverage will be referred to the Government Services Vendor by the Admitting Office Staff to complete a Medicaid application.
- E.** All applications for Financial Assistance should be sent to the Patient Financial Services Office. The Application should include at a minimum, information regarding the patient's family size and income level. **Manager of Collections and Customer Service (or designee) will take the following actions:**
1. Review application to ensure that all remaining information is complete and if necessary, contact patient/guarantor specifying what information is still needed.
 2. Determine probable eligibility within two business days of the initial request.
 3. If the patient/guarantor is deemed over scale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are over scaled per the Federal Poverty Guidelines.
 4. If the patient/guarantor qualifies according to their income, the Customer Service Manager(or designee) will query the patient accounting system to identify all of the patient or guarantor's accounts, looking for patient responsibility balances.
 5. Accounts still outstanding with the patient/guarantor's insurance carrier for payment will be held until the insurance either makes or denies payment, it will then be processed according to policy for Financial Assistance.

Appendix 2
ADVENTIST HEALTH CARE, INC.
Corporate Policy Manual
Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Charity Care Policy	Origin:	PFS
Reviewed:	02/09	Authority:	EC
Revised:	05/09, 06/09	Page:	5 of 14

6. The Manager (or designee) will then complete an adjustment form, using the Financial Assistance adjustment code, 23001 or 33001. Also, if the account is in collections document the account using the following activity codes:

Financial approval follows the following guidelines:

- a. CHDN - Financial Assistance denied- require more information.
 - b. CHLT - Financial Assistance approval sent to patient.
 - c. CHWO - Financial Assistance write-off approved.
7. The Manager (or designee) will notify any agencies that hold accounts for the patient/guarantor that they have been given Financial Assistance, providing details if there is any patient/guarantor responsibility.
 8. The application will then be forwarded to imaging to be scanned into the patient folder.

AUTOMATED PROCESS - Accounts sent to outsourced agencies:

Outsourced agencies are using software to determine a patient or guarantor's Payment Predictability Score (PPS). Where the PPS meets criteria for Financial Assistance, an adjustment will be made to the Patient's Account, See "C" above.. Adjustments will be processed electronically via an electronic report sent to the PFS Regional Director for review and final approval. The approved accounts are automatically written off by PFS per the amount of Financial Assistance applied to each account. Supporting Documents for the write-offs are kept in Electronic Files on the PFS – "N" Drive, by Vendor.

Appendix 2

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
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SAMPLE NOTICE TO BE POSTED IN ALL DESIGNATED AREAS ACCESSABLE TO THE PUBLIC

ADVENTIST HEALTHCARE NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE

Shady Grove Adventist, Potomac Ridge Behavioral Health System, Washington Adventist Hospital, Hackettstown Community Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Financial Assistance is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than twice these amounts, you may qualify for Financial Assistance.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

2008 Poverty Guidelines

<u>Size of Family Unit</u>	<u>Guideline</u>
1 _____	\$10,400
2 _____	\$14,000
3 _____	\$17,600
4 _____	\$21,200
5 _____	\$24,800
6 _____	\$28,400
7 _____	\$32,000
8 _____	\$35,600

Note: The guidelines increase **\$3,600** for each additional family member.

If you feel you may be eligible for Financial Assistance and wish to apply, please obtain an application for Community Financial Assistance from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made within thirty working days of your request.

Appendix 2

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

Effective Date	01/08	Policy No:	AHC 3.19
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Revised May 2009

Appendix 2

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual
Financial Assistance

Effective Date 01/08
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ADVENTIST HEALTHCARE

Patient Financial Services, 1801 Research Blvd, Suite 300, Rockville, MD 20850

- ☐ Washington Adventist ☐ Potomac Ridge ☐ Shady Grove Adventist
☐ Adventist Rehab Hospital of Maryland ☐ Hackettstown Community Hospital

COMMUNITY FINANCIAL APPLICATION- DEMOGRAPHICS

Date: _____ Account Number(s) _____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____

Social Security #: _____ US Citizen: _____ No Residence: _____

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application _____

Dependents Listed on Tax Form:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Employment: Patient employer

Spouse employer

Name: _____ Name: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

Social Security #: _____ Social Security #: _____

How long employed: _____ How long employed: _____

TOTAL FAMILY INCOME \$ _____

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months worth of pay-stubs, or a statement from your employer and also include your 2007 taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses.

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

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COMMUNITY FINANCIAL APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _____
Food _____
Transportation _____
Utilities _____
Health Insurance premiums _____
Medical expenses not covered by insurance _____
 Doctor: _____

 Hospital: _____

TOTAL: _____

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

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

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

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Applicant Signature: _____ **Date:** _____

**Return Application To: Adventist HealthCare
Patient Financial Services
Attn: Customer Service Manager**

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

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1801 Research Blvd, Suite 300
Rockville, MD 20850

COMMUNITY FINANCIAL ASSISTANCE APPLICATION- OFFICIAL DETERMINATION ONLY

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

The reason for Denial:

What additional information is needed:

Approval Details:

Patient approved for _____ %
\$_____ will be a Financial Assistance Adjustment
\$_____ will be the patient's responsibility

Approval Letter was sent on _____

AUTHORIZED SIGNATURES:

CS/COLLECTION MANAGER
UP TO \$1500.00

Sr. ASSISTANT DIRECTOR
UP TO \$2500.00

REGIONAL DIRECTOR
UP TO \$25,000.00

HOSPITAL CFO
OVER \$25,000.00

Revised October 2008

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

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2008 Poverty Guideline

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	\$10,400	100% ALLOWANCE	0%
2	100%	\$14,000	100% ALLOWANCE	0%
3	100%	\$17,600	100% ALLOWANCE	0%
4	100%	\$21,200	100% ALLOWANCE	0%
5	100%	\$24,800	100% ALLOWANCE	0%
6	100%	\$28,400	100% ALLOWANCE	0%
7	100%	\$32,000	100% ALLOWANCE	0%
8	100%	\$35,600	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	125%	\$13,000	100% ALLOWANCE	0%
2	125%	\$17,500	100% ALLOWANCE	0%
3	125%	\$22,000	100% ALLOWANCE	0%
4	125%	\$26,500	100% ALLOWANCE	0%
5	125%	\$31,000	100% ALLOWANCE	0%
6	125%	\$35,500	100% ALLOWANCE	0%
7	125%	\$40,000	100% ALLOWANCE	0%
8	125%	\$44,500	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	150%	\$15,600	100% ALLOWANCE	0%
2	150%	\$21,000	100% ALLOWANCE	0%
3	150%	\$26,400	100% ALLOWANCE	0%
4	150%	\$31,800	100% ALLOWANCE	0%
5	150%	\$37,200	100% ALLOWANCE	0%
6	150%	\$42,000	100% ALLOWANCE	0%
7	150%	\$48,000	100% ALLOWANCE	0%
8	150%	\$53,400	100% ALLOWANCE	0%

ADVENTIST HEALTH CARE, INC.

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	\$18,000	100% ALLOWANCE	0%
2	175%	\$24,500	100% ALLOWANCE	0%
3	175%	\$30,800	100% ALLOWANCE	0%
4	175%	\$37,100	100% ALLOWANCE	0%
5	175%	\$43,400	100% ALLOWANCE	0%
6	175%	\$49,700	100% ALLOWANCE	0%
7	175%	\$56,000	100% ALLOWANCE	0%
8	175%	\$62,000	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	200%	\$20,800	60% ALLOWANCE	0%
2	200%	\$28,000	60% ALLOWANCE	0%
3	200%	\$35,200	60% ALLOWANCE	0%
4	200%	\$42,000	60% ALLOWANCE	0%
5	200%	\$49,600	60% ALLOWANCE	0%
6	200%	\$56,800	60% ALLOWANCE	0%
7	200%	\$64,000	60% ALLOWANCE	0%
8	200%	\$71,200	60% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	225%	\$23,400	50% ALLOWANCE	50%
2	225%	\$31,500	50% ALLOWANCE	50%
3	225%	\$39,600	50% ALLOWANCE	50%
4	225%	\$47,700	50% ALLOWANCE	50%
5	225%	\$55,800	50% ALLOWANCE	50%
6	225%	\$63,900	50% ALLOWANCE	50%
7	225%	\$72,000	50% ALLOWANCE	50%
8	225%	\$80,100	50% ALLOWANCE	50%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	\$26,000	40% ALLOWANCE	60%
2	250%	\$35,000	40% ALLOWANCE	60%
3	250%	\$44,000	40% ALLOWANCE	60%
4	250%	\$53,000	40% ALLOWANCE	60%
5	250%	\$62,000	40% ALLOWANCE	60%
6	250%	\$71,000	40% ALLOWANCE	60%
7	250%	\$80,000	40% ALLOWANCE	60%
8	250%	\$89,000	40% ALLOWANCE	60%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	275%	\$28,600	30% ALLOWANCE	70%
2	275%	\$38,500	30% ALLOWANCE	70%
3	275%	\$48,400	30% ALLOWANCE	70%
4	275%	\$58,300	30% ALLOWANCE	70%
5	275%	\$68,200	30% ALLOWANCE	70%
6	275%	\$78,100	30% ALLOWANCE	70%
7	275%	\$88,000	30% ALLOWANCE	70%
8	275%	\$97,900	30% ALLOWANCE	70%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	300%	\$31,200	20% ALLOWANCE	80%
2	300%	\$42,000	20% ALLOWANCE	80%
3	300%	\$52,800	20% ALLOWANCE	80%
4	300%	\$63,600	20% ALLOWANCE	80%
5	300%	\$74,400	20% ALLOWANCE	80%
6	300%	\$85,200	20% ALLOWANCE	80%
7	300%	\$96,000	20% ALLOWANCE	80%
8	300%	\$106,800	20% ALLOWANCE	80%

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual Financial Assistance

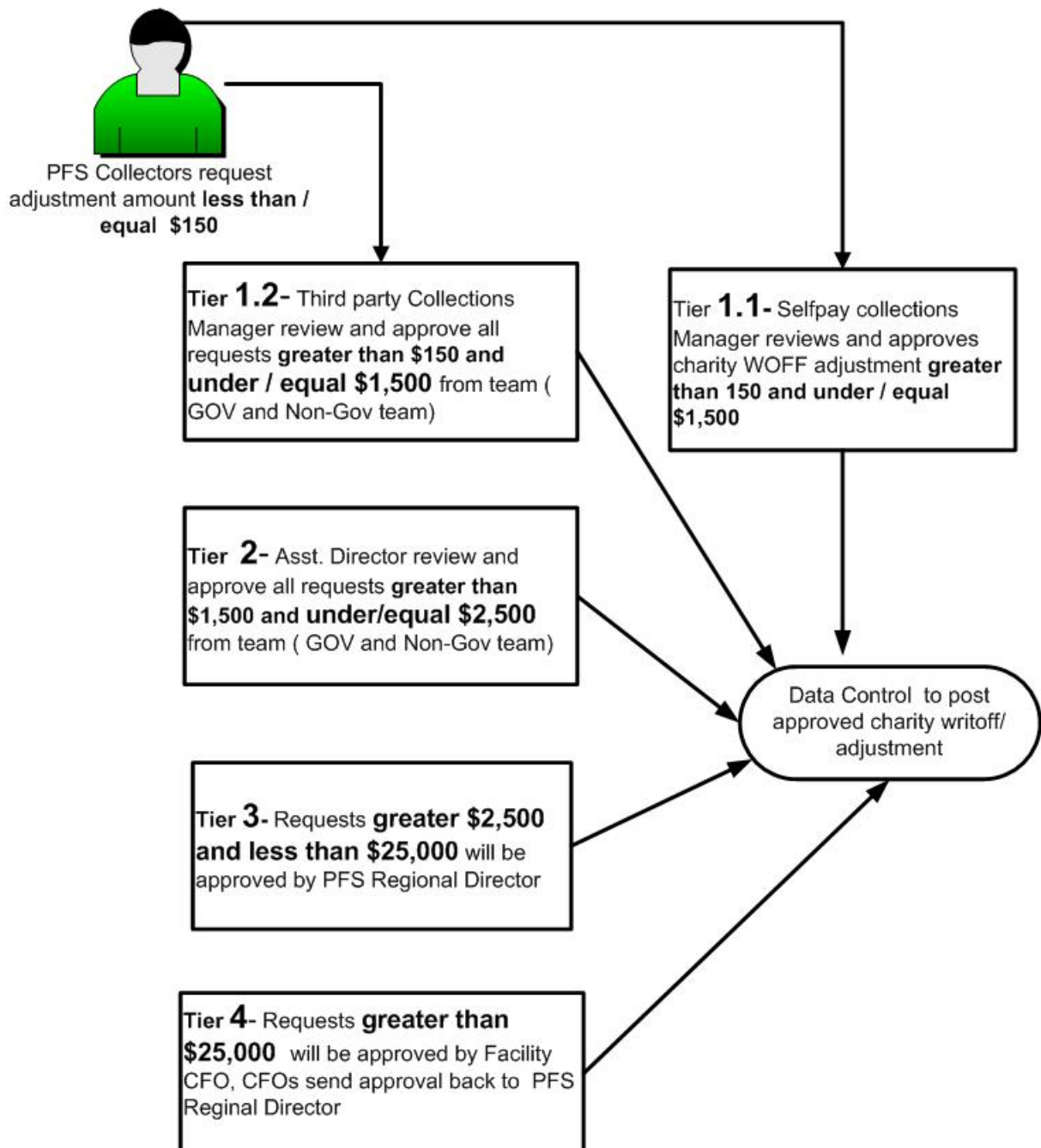
Effective Date 01/08
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PFS Current Manual Writeoff and Adjustment > \$100 Process
Tuesday, November 25, 2008



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



**Washington Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2009**

Appendix 3 & 4 – Description of Hospital's Missions, Vision, and Value statement

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

Shady Grove Adventist Hospital's Missions, Vision, and Value statement was developed based on the following five concepts:

1. Respect: Recognize the infinite worth of each individual and care for each individual as a whole person.
2. Integrity- Be above reproach in all that we do.
3. Service: Provide compassionate and attentive care in a manner that inspires confidence.
4. Excellence: Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.
5. Stewardship: Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.



WASHINGTON COUNTY
HOSPITAL

21-0001

Community Benefit Narrative
Reporting Requirements
FY2009

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Effective 07/01/08 – 06/30/09, the licensed bed designation for Washington County Hospital Association was 286. This was designated as follows:

- 212 MSGA Beds
- 18 Obstetric Beds
- 10 Pediatric Beds
- 18 Psychiatric Beds
- 28 Acute Rehabilitation Beds

Our hospital is also designated for 41 Newborn Bassinets.

*Please note: Effective 07/01/09, our licensed bed designation increased to 288 from 286.

Number of Inpatient Admissions for FYE 06/30/09 = 18,208

2. Describe the community your organization serves. The narrative should address the following topics: (The items below are based on IRS Schedule H, Part V, Question 4).

• Describe the geographic community or communities the organization serves

Service Area – WCHA functions as a regional medical center for residents of a seven-county area spanning three states including Washington County and portions of Frederick County, Maryland; Franklin County and Fulton County, Pennsylvania; and Morgan County, Jefferson County, and Berkeley County, West Virginia. The Hospital's primary service area is Washington County, whose residents accounted for 13,255 (82%) of the Hospital's 16,217 discharges (excluding newborns) in fiscal year 2007. 2,087 (13%) of the Hospital's discharges were among residents of its secondary service area, comprising portions of neighboring Pennsylvania, West Virginia and Frederick County, Maryland. The remaining 875 (5%) of Hospital discharges during fiscal year 2007 were among residents of areas outside the Hospital's combined primary and secondary service areas.

- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates)**

Population – According to the United States Census Bureau, the total population of the Hospital’s primary service area grew from approximately 131,923 in 2000 to approximately 144,925 in 2007, an increase of 9.9%. This population is projected to grow by approximately 8.4% to 157,071 by 2013. Population estimates and projections for the Hospital’s primary and secondary service areas are shown below:

Population by Service Area	2000 Estimated	2013 Projected	Projected % Increase
Primary	131,923	157,071	19.1%
Secondary	312,091	391,592	25.5%
Combined	444,014	548,663	23.6%

Source: Washington County MD and Frederick County MD – Maryland Department of Planning; Pennsylvania and West Virginia – US Census Bureau

Income – The change in median income per capita and average household income from 2000 to 2006 for the Hospital’s primary service area is as follows:

Per Capita	2000	2006
Primary	\$22,267	\$31,015
Per Household		
Primary	\$44,450	\$47,050

Source: Washington County Economic Development Commission

Unemployment Rates – The following table shows selected unemployment rates for Washington County, Maryland and the United States:

	1990	1995	2000	2007
Washington County	7.0%	6.2%	3.2%	4.2%
United States	6.7%	5.6%	3.9%	4.7%

Source: Washington County Economic Development Commission

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (based on IRS Schedule H, Part V, Question 2).

Washington County Hospital completed a community health needs assessment in the fall of 2008. It was sent to major community agencies to determine what they knew and perceived to be the most important healthcare needs of Washington County residents. Twenty agencies were surveyed, including the healthcare organizations, the United Way, and the Department of Social Services. Internal healthcare providers were also surveyed; some of them included the health management department, medical director of internal medicine, and the community health education and outreach department.

Respondents completed a survey which asked them to identify: the three most important health needs they have encountered; which ones they have designated as current fiscal year priorities; and to name any other agencies that should be included in the survey.

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

Yes

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

Respondents listed the following as the most important health needs: mental health services, services for the elderly, dental services, and obesity.

They identified three that are fiscal year priorities: mental health, dental services, and substance abuse.

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

A team was assembled that included both internal health system members and external community members. Representatives internally included the vice presidents of patient care services and business integrity along with directors of health management, behavioral health services, public relations, human resources development, and community health education outreach.

External representatives included the health officer and director of the Washington County Health Department, United Way, the Washington County Mental Health Authority, and the Washington County Community Partnership for Children and Families.

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

Washington County Hospital participates in an on-going, nationally recognized program called KidShape. It seeks to improve the health and well-being of children from ages six to 13. It targets obesity in children by involving them and their parents in a program that emphasizes eating management and fun activities to get kids active. The program benefits the whole family. Children are referred by their physicians and parents may self-refer. It is an outreach program implemented by the hospital's community health education outreach department.

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

The KidShape program was initiated in April 2008. Since that time, four cohorts of children and parents have completed the course. Evaluations were done at the end of each course. KidShape staff reported the following:

- 50 families attended the program
- 39 families completed it
- Over the four groups,
 - the average BMI maintained or decreased by 69 percent
 - 64 percent decreased systolic or diastolic blood pressure, and
 - 38 percent increased the hours they exercised after school.

As a result of the evaluations, the hospital is continuing its commitment to providing the KidShape program in our community.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

The uninsured patients in the community served by Washington County Hospital have difficulty obtaining care for conditions treated by the providers in the following specialties:

General Surgery
Neuro Surgery
Primary Care – Uninsured Patients
Plastic Surgery
Pain Management
Dermatology
Thoracic Surgery
Vascular Surgery

Also, patients insured through Maryland Physicians Care, an HMO serving the Medicaid population, have difficulty obtaining Podiatry care for related medical conditions. As a result, many patients go untreated for medical conditions requiring care by providers in the specialties identified above. Specialty care has been one of the ongoing challenges we face in making the effort to provide a full range of medical care to our uninsured patients.

9. If you list Physician Subsidies in your data, please provide detail.

C6 Emergency Department Physician Subsidy – Contract terminated effective 10/01/08

Monthly Payment (Jul-Sep 08)	\$310,000
Termination Payment	<u>\$350,000</u>
	\$660,000
Less: Administrative Fee (\$85,000 prorated for 3 months)	<u>(\$21,250)</u>
	\$638,750

C7 On-Call Fees – Emergency Specialist Call

Cardiology	\$146,000	(\$400 per day)
Critical Care	\$146,000	(\$400 per day)
ENT	\$63,875	(\$175 per day)
Eye	\$63,875	(\$175 per day)
GI	\$63,875	(\$175 per day)
General Surgery	\$383,250	(\$1050 per day)
Neurology	\$91,500	(\$250 per day)
Pediatrics	\$63,875	(\$175 per day)
Plastics	\$127,750	(\$175 per day; \$500 per day for days worked over the 1 and 4 call schedules)
Urology	<u>\$63,875</u>	(\$175 per day)
	\$1,213,875	

To Be Attached as Appendices:

- 1. *Describe your Charity Care policy (taken from IRS Schedule H, Part V, Question 3):***
 - 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)***
 - b. Include a copy of your hospital's charity care policy (label appendix 2).***
- 2. *Describe the hospital's mission, vision, and value statement(s) (label appendix 3).***
 - a. Attach a copy of the statement (label appendix 4).***

Washington County Hospital
FY2009 Community Benefit Report
Appendix 1 – Financial Assistance Policy Description

Washington County Hospital (WCH) is committed to providing quality health care for all patients regardless of their inability to meet the associated financial obligation and without discrimination on the grounds of race, color, national origin or creed. Financial assistance can be offered during, or after services are rendered. The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their own ability to pay.

WCH informs patients and/or their families of the hospital's financial assistance policy by providing a copy of the policy and contact information as part of the intake process. The financial assistance policy and contact information is posted in the admitting area, emergency room and other areas throughout the facility where eligible patients are likely to present. When applicable, a representative of the hospital discusses the availability of financial assistance as well as Medicaid and other governmental benefits with patients or their families. The hospital makes every effort to inform patients of this policy throughout their visit.

Appendix 2

WASHINGTON COUNTY HOSPITAL POLICIES ADMINISTRATIVE POLICIES

Page 1 of 4

TOPIC: Financial Assistance

POLICY NAME: FINANCIAL ASSISTANCE
POLICY NUMBER: ADMN 0436
ORIGINATOR: Patient Financial Services
EFFECTIVE DATE: 08/15/97
REVISION DATE: 03/26/99, 03/22/00, 03/14/03, 02/23/04, 03/03/04, 06/10/04,
10/28/04, 6/27/05, 3/2/06, 2/1/07, 3/27/07, 1/23/08, 3/23/09
3/30/09
REVIEW DATE: 12/01/00, 02/24/03, 03/24/04
Signed Copy on file in Administration

I. SCOPE The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their own ability to pay. The underlying theory is that a person, over a reasonable period of time can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance.

II. PURPOSE:

Washington County Hospital (WCH) is committed to providing quality health care for all patients regardless of their inability to meet the associated financial obligation and without discrimination on the grounds of race, color, national origin or creed. Financial assistance can be offered during, or after services are rendered and the hospital will inform the applicant regarding a probable eligibility determination within 2 business days. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment.

While flexibility in apply guidelines to an individual patient's financial situation is clearly needed, certain objective criteria listed below are essential to assure consistency in the implementation of the hospital's financial assistance program.

III. DEFINITIONS:

- 3.1 Financial Assistance is determined by using the U.S. Department of Health and Human Services, U.S. Federal Poverty Measure guidelines. Patients must be a US citizen and have a valid social security number.
- 3.2 The Poverty Guidelines are issued each year in the Federal Register by the (HHS). The guidelines are a simplification of the Poverty thresholds for use for administrative purposes.

Approved by: Revision No.: Effec/Rev Date:

1. _____
President Date

2. _____
Responsible Vice President Date

- 3.3 The Poverty Guidelines are available on-line at: <http://aspe.dhhs.gov/poverty> then choose the guidelines you wish. See Appendix 1.
- 3.4 Poverty Guidelines are updated each year by the Census Bureau thereby thresholds are used mainly for statistical purposes and weighted for the average poverty thresholds determination.
- 3.5 Public Assistance Programs are available to assist patients for services and specific diagnoses. Patients who present for services who may qualify for these public programs will be referred to the appropriate agency:
 - a. Medicaid
 - b. Medicare
 - c. DHMH Woman's Breast/Cervical Cancer Program
 - d. DHMH Colorectal Cancer Program
 - e. Other
- 3.6 WCH will follow the Maryland Hospital Association Standards for Financial Assistance for Maryland.
 - a. WCH will provide 100 percent free hospital care for patients below 150 percent of Federal Poverty levels and who have less than \$10,000 in net assets.
 - b. When a patient's income and/or net assets does not qualify them for 100 percent Financial Assistance, they may be eligible to qualify for financial assistance based on a sliding scale as referenced in Appendix 1.
 - c. WCH will consider the size of a patient's bill relative to their ability to pay in determining financial assistance and financial assistance options, which could include payment plans.
 - d. WCH will grant financial assistance for services determined to be medically necessary.
 - e. It is recognized that Amish and Mennonite patients do not rely on in any manner on any type of government programs or private insurance based upon their religious beliefs. These groups rely on their religious community to pull resources together to pay for healthcare bills for members of their community. These patients, who are 100% self-pay, will be granted a 25% discount when bill is paid in full within 30 days of service.

IV. POLICY:

- 4.1 This policy is to ensure established and standardized procedures for Financial Assistance. This policy will be uniform hospital wide, ensuring a satisfactory level of control is maintained over adjustments to accounts receivables.
- 4.2 Financial Assistance written notices will be posted at all registration areas throughout the hospital and made available to a patient or family.
- 4.3 An annual notice may be published in the local newspaper or other media may be used i.e., radio, web site, etc., to inform the public of the hospital's Financial Assistance program.
- 4.4 A Patient Financial Services Representative will use the criteria in this document for eligibility of Financial Assistance.
- 4.5 Eligible care covered under this program is deemed as all medically necessary medical care provided.

V. PROCEDURE:

- 5.1 Financial eligibility criteria will be based on gross family income of the patient and/or responsible guarantor. Exception allowance will be deducted for each person living in the gross family income. Annual income criteria used will be 150% of the current poverty guidelines as published in the yearly Federal Register and those who have less than \$10,000 in net assets.
 - 5.1.a Adjustment of accounts meeting the criteria will be entered as Financial Assistance for patients which are US citizens and have a valid social security number.
 - 5.1.b Some persons may exceed established income levels but still qualify for Financial assistance with additional factors considered. These will be reviewed case by case.
- 5.2 Gross income, refers to money wages and salaries from all sources before deductions. Income also refers to social security payments, veteran's benefits, pension plans, unemployment and worker's compensations, trust payments, alimony, public assistance, union funds, income from rent, interest and dividends or other regular support from any person living in the home or outside of the home. Also included, as regular income, is 100% of all liquid or near liquid assets (i.e., certificates of deposit, stocks, money market funds, etc.)
- 5.3 Assets refer to real and chattel/personal property. These may be evaluated for inclusion as regular income.
- 5.4 All other third party resources will first be applied including Medicaid Medical Assistance, before a Financial Assistance adjustment will be granted. The individual must apply for available Medical Assistance funds as appropriate in each individual case.

- 5.5 Patients requesting Financial Assistance may apply prior to treatment by contacting a Patient Financial Services Representative for a Financial Application.
- 5.6 Probable determination for Financial Assistance eligibility will be completed within two (2) business days, depending upon the availability of the specific required documentation as covered in the HHS, U.S. Federal Poverty Measure guidelines.
- 5.7 Financial Assistance applications will also be considered for accounts final billed and aged in accounts receivable.
- 5.8 Request for Financial Assistance may not be considered for patients who are in bad debt and did not respond to collection activity or statements prior to an account referral to an outside collections agency.
- 5.9 A financial application form may be requested by a Patient Financial Services Representative from the patient or responsible party listing all available assets and expenses. All applications and attachments will be forwarded to the Customer Services Unit of the Patient Financial Services Department for review.
- 5.10 During the application process, one or more of the following specific documents must be submitted to gain sufficient information to verify income for each employed family member:
 - 5.10.a Copy of payroll stub to include year to date wages.
 - 5.10.b Letter from employer verifying gross income.
 - 5.10.c Letter from federal or state agency indicating the amount of assistance received.
 - 5.11.d Copy of most recently filed federal income tax return.
 - 5.12.e Proof of other income for all persons living in the family.
- 5.11 Every effort will be made to identify a patient's qualifications/approval at or prior to time of admission of service. However, it is recognized that there will be cases in which accurate determinations, at time of admission are not possible and that events may occur subsequent to service with may affect a patient's ability to pay.
 - 5.11.a Emergent or medically necessary services will not be delayed based on the financial status of the patient. WCH follows the federal EMTALA regulations for emergency services rendered.
- 5.12 An approval or denial letter will be mailed directly to the patient or responsible guarantor to inform of the final disposition of the request for Financial Assistance.

- 5.13 Open "self-pay" receivable balance of deceased patients for which no estate has been filed with the Register of Wills, may be considered for Financial Assistance without a financial assistance application on file.
- 5.14 Open "self-pay" balance of Medical Assistance patients for which have a valid Medical Assistance number and which Medical Assistance is active or eligible, may be considered for Financial Assistance without a financial assistance application on file.
- 5.15 A financial application that has been approved for Financial Assistance will remain eligible for a period of six months. Patients or guarantors incurring accounts after the six month period will be required to reapply so that any changes in their financial status can be reassessed.
- 5.16 Accounts receivable accounts approved for Financial Assistance will be reconciled by the Finance Department at fiscal year end and reported annually to the Health Services Cost Review Commission (HSCRC) of the State of Maryland.
- 5.17 If Financial Assistance is denied, a payment arrangement will be obtained on any balance due by the patient or the guarantor by a Patient Financial Services Representative.

VI. REFERENCE:

- 6.1 U.S. Department of Health and Human Services, U.S. Federal Poverty Measure Guidelines.
- 6.2 Administrative Policy 300
- 6.3 Maryland Hospital Association Standards

APPENDIX 1

WASHINGTON COUNTY HEALTH SYSTEMS FINANCIAL ASSISTANCE GUIDELINES 2009

FAMILY SIZE	100%	80%	60%	40%	20%	0%
1	0 - 16,245	16,246-20,307	20,308-24,369	24,370-28,431	28,432-32,490	32,490.01+
2	0 - 21,855	21,856-27,319	27,320-32,783	32,784-38,247	38,248-43,710	43,710.01+
3	0 - 27,465	27,466-34,332	34,333-41,199	41,200-48,066	48,067-54,930	54,930.01+
4	0 - 33,075	33,076-41,344	41,345-49,613	49,614-57,882	57,883-66,150	66,150.01+
5	0 - 38,685	38,686-48,357	48,358-58,029	58,030-67,701	67,702-77,370	77,370.01+
6	0 - 44,295	44,296-55,369	55,370-66,443	66,444-77,517	77,518-88,590	88,590.01+
7	0 - 49,905	49,906-62,382	62,383-74,859	74,860-87,336	87,337-99,810	99,810.01+
8	0 - 55,515	55,516-69,394	69,395-83,273	83,274-97,152	97,153-111,030	111,030.01+
9	0 - 61,125	61,126-76,407	76,408-91,689	91,690-106,971	106,972-122,250	122,250.01
10	0 - 66,735	66,736-83,419	83,420-100,103	100,104-116,787	116,788-133,470	133,470.01

SOURCE: Federal Register, Vol. 70, No. 33, March 1, 2006, pp. 8373-8375.

Washington County Hospital
FY2009 Community Benefit Report
Appendix 3 – Hospital’s Mission, Vision, and Core Values Description

The mission, vision, and values of Washington County Hospital are summarized in our pledge: *Responsiveness to need. Excellence in Caring. Respect for All.* The pledge says quite simply that we strive to meet the healthcare needs of the citizens of the tri-state region, that we are dedicated to providing quality patient care in a safe and caring environment, and that we esteem the personal dignity of patients and staff alike.

Every day, the hospital’s employees live out our values by treating others as we would like to be treated. We participate in a variety of activities that focus on the well-being of our patients, including committees and teams that evaluate our progress in the areas of quality patient care, patient safety, and professional development. Many staff members provide outreach to the community through educational offerings which have been identified by a survey of community health education needs.

Washington County Hospital is a vibrant healthcare facility, where dedicated staff engages patients and their families in their care, promoting a partnership that leads to improved patient outcomes. At the same time, employees work together to plan a future that focuses on the well-being of the citizens of our tri-state region.

Appendix 4

WASHINGTON COUNTY HOSPITAL ADMINISTRATIVE POLICIES

Page 1 of 2

POLICY: VISION, MISSION AND CORE VALUES OF WASHINGTON COUNTY HOSPITAL
POLICY NO.: ADMN 0145
ORIGINATOR: Senior Management
EFFECTIVE DATE: 3/01/92
REVISION DATE: 3/27/95, 4/1/98, 4/11/01, 7/18/03, 6/27/05
REVIEW DATE: 7/3/03
Signed Copy on file in Administration

- I. SCOPE: This policy applies to all members of the hospital family.
- II. PURPOSE: To define the mission and core values of Washington County Hospital.
- III. TEXT:

A. Mission Statement

The Mission of the Washington County Hospital is to be the most effective provider of health services in our service area through:

- Leadership and responsiveness to our community's healthcare needs;
- Accessibility to those services in partnership with our extended community;
- The high level of respect we afford our patients, physicians, customers, and employees.

B. Vision

The Washington County Hospital will succeed in accomplishing its mission of ensuring it is the community's preeminent quality healthcare provider via a five-part strategy.

1. Create and enhance regional healthcare through an integrated delivery system.
2. Form a framework of partnerships and affiliations;
3. Establish centers of excellence in partnership with the medical community;
4. Provide excellent health education in cooperation with appropriate institutions; and
5. Ensure adequate Health Insurance coverage for the community that aligns incentives properly for payors and providers.

Approved by:

1. President Date
2. Vice-President Date

C. Core Values

Washington County Hospital holds the following values to be most important in the management of our corporation:

1. A caring and responsive attitude toward patients, their families and guests.
2. Respect for employees, volunteers and medical staff and their individual commitment and contributions.
3. Quality services through staff expertise and state-of-the art equipment and facilities.
4. Financial viability through the provision of services at a reasonable cost.
5. Anticipation of, and planning for the future health care needs of our service area.

Community Benefit Report FY09
Western Maryland Health System
(Memorial Hospital and Braddock Hospital)

Narrative Report

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Braddock Hospital is licensed for 154 beds and had 9,407 inpatient admissions in fiscal year 2009. Memorial Hospital is licensed for 150 beds and had 8,740 inpatient admissions in fiscal year 2009. Combined WMHS was licensed for 292 beds and 12 bassinets in fiscal year 2009. Together there were 17,067 adult inpatient admissions and 1080 newborns in fiscal year 2009.

2. Describe the community your organization serves. Includes geographic, demographic characteristics relevant to the needs WMHS seeks to meet-population, average income, % households with incomes below fpl, % patients who are uninsured or receive Medical Assistance, life expectancy and mortality rates.

The Western Maryland Health System primarily serves Allegany County in Maryland, and also treats patients from Garrett County, Maryland, two neighboring counties in Pennsylvania, and five counties in West Virginia. The population of Allegany County is 72,238 (based on US Census data for 2008). Allegany County does not fare as well economically as the rest of Maryland. The median household income is \$37,171 in Allegany County versus \$67,989 for the state. This results in 14.2 percent of County residents living below the federal poverty level, as compared to the statewide rate of 8.3 percent. Approximately 15,800 individuals (or 22 percent of the population) in Allegany County are enrolled in Medical Assistance programs in Maryland.

Eighteen percent of the population is age 65 or older, and 9.7 percent of this population reported having an income below the federal poverty level for the past 12 months, according to the American Community Survey for 2006-2008.

The life expectancy for Allegany County residents is 77.0 years, which is just slightly less than 78.1 years overall for Marylanders. Two of the leading causes of death are heart disease and chronic lower respiratory disease, which occur at a rate significantly higher than much of Maryland.

3. Identification of Community Needs. Describe process WMHS used for identifying the health needs in the community most recently. Did you consult with the local health department?

Western Maryland Health System (Braddock & Memorial Hospitals) has a long history of addressing community needs and is often approached by members of the community for support. The mission of the WMHS is to improve the health status and quality of life of the individuals we serve, especially those in need. Commitment to the cause extends from the employees to the Board of Directors, and

is reflected in the strategic plan and goals. Through the strategic planning process, adequate resources are identified and community service initiatives are aligned with system-wide objectives. Community service priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable. Through responsible management of resources and collaboration with tax exempt and government organization partners, WMHS is committed to sustain programs that address the community service priorities.

The Allegany County Health Department's Priorities for Improving Community Health Status included in the Maryland Health Improvement Plan (2001) was the last needs assessment completed by the local health department and has been a reference used by the health system. Between February – June 2009, WMHS participated in a community needs assessment process and summit lead by the County United Way to identify key priorities in the surrounding counties. This process involved brainstorming with stakeholders, voting on priorities, roundtable discussions at a needs assessment summit, and the distribution of a report.

When exploring the needs and feasibility of various projects, WMHS also uses data compiled by the state or federal government such as, Maryland Vital Statistics, Healthy People 2010, Behavioral Risk Factor Surveillance System, US Census Bureau, and various reports from the Maryland Department of Health and Mental Hygiene, Maryland Health Care Commission, and Health Services & Cost Review Commission. Utilization and discharge data is also analyzed to determine or clarify needs.

Community needs related to wellness and access to care are regularly discussed via the Community Health Improvement Partners and Workgroup on Access to Care. Both groups meet bimonthly and include representatives from the local health department, social services, local non-profit organizations, health care organizations, and community leaders. In FY09 CHIP met on the following dates: 2008-August 12, September 25, November 6, and 2009-January 8, February 12, March 19, April 9 and May 21. The Workgroup on Access to Care met in 2008 on July 17, September 18, November 13 and in 2009 on January 15, March 12 and May 14.

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

Poverty, access to care and prevention.

WMHS is in a medically underserved and economically depressed region of western Maryland. Nearly thirty-seven percent (36.75%) of Allegany County residents live below 200% of federal poverty and almost twenty-two percent (21.7%) of its population are uninsured (Community Survey-Marketing Solutions, 2002 & American Community Survey, 2006). Eighteen percent of the population is over the age of 65 and the 45-64 year old cohort is the only one expected to grow. Mortality data shows the leading causes of death in the Allegany County area to be cardiovascular disease, respiratory disease, cancer, cerebral vascular disease, and these rates are higher than elsewhere in the state (Maryland Vital Statistics 2006).

These needs were reexamined through the needs assessment process lead by the County United Way. In their initial sessions, the identified priorities in health included cost of prescription drugs,

lack of insurance and access to care, and wellness and prevention. In the summit report, the priority needs for both Allegany and Mineral Counties included focus on wellness and prevention, and more program collaboration.

Whether it is a discussion with the Western Maryland Health System Foundation, the Workgroup on Access to Care, County United Way, or clients at the various health and human service agencies; access to health care, particularly mental health, oral health and specialty care are always noted as needs. Over the last year there has been an increasing discussion of prevention and wellness. WMHS's community benefits initiatives continue to reflect evidence-based needs for health improvement, community investment, and access for the low income uninsured.

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

Strategic planning at the Western Maryland Health System includes representation from the governing boards, Administration, Community Advisory Board, Physicians, and indirectly from staff and external customers. Community benefits planning involve staff from the following departments: Finance, Community Relations, Community Health and Wellness, Parish Nursing, Perinatal & Pediatrics, Financial Assistance Program, Forensic Nurse Examiner Program, Dietary, Cancer Services, and other services as appropriate. Staff and customers from these areas share suggestions and concerns throughout the year that are incorporated into the planning process whether it be the addition of a service, submission of a grant application, advocacy or donation.

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

WMHS targets the needs of the low-income uninsured and underserved populations, prevalence of chronic disease and associated risk factors, and community asset development, reflective of the needs listed above. Priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable.

As a not-for-profit health system, WMHS provides care to all, regardless of their ability to pay. In fiscal year 2009, we provided over \$7 million in charity care. There are a number of patient care services that are not self-supporting that we continue to provide since we are the community's only provider. We provide patient and family-centered services through responsible management of our human and fiscal resources.

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

Through Community Health & Wellness preventive health screenings, health fairs and education programs are offered throughout the community. With the Community Health Improvement Partners and Workgroup on Access to Care, WMHS is able to increase its outreach and enhance the impact. In FY09 these groups collaborated on grant projects to increase access to mental health services, to promote physical activity among youth, and to address the increase in obesity.

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

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

The community benefit initiatives at WMHS are divided into three major categories: Health Improvement, Access for Uninsured, Low Income & Underserved, and Community Investment-Safety. Each year the output from activities in each of these major categories is assessed along with the resource allocation to determine its status. The table below highlights the findings in FY09.

Major Categories	Nature of Evaluation	Result of Evaluation
Health Improvement	<ul style="list-style-type: none"> • Participation in community health education and screenings (Number of encounters) • Weight loss & activity levels of challenge participants • Review of evidence based best practices • Revenue & Expenses 	With an increased number of encounters and the support of best practices, it was determined to continue most of the activities within this category. Due to the successful outcome of the challenges, there will be an increase in services addressing healthy living and reducing obesity. Support of breastfeeding was increased due to evidence based literature and its link to obesity. Skin cancer screening was discontinued based on review of evidence based literature and the associated resource allocation. Based on resource allocation, Lifeline was moved to another community entity.
Access for Uninsured, Low Income, & Underserved	<ul style="list-style-type: none"> • Participation in programs for the uninsured (Number of encounters) • Intakes, Referrals and Enrollments in the Community Access Program Management Information System • Number of uninsured clients linked to public programs and/or private insurance • Percentage of Emergency Room Use by uninsured clients 1 year pre and post enrollment in the program 	Data related to the uninsured is compiled monthly and reviewed regularly with the Workgroup on Access to Care. When the number of intakes, referrals, and enrollments were skewed the partners discussed the possible causes, adjusted processes, and occasionally requested edits in the CAP MIS specifications. Except for the breast & cervical cancer program for the uninsured, participation has increased. This increase and the positive results of linking clients with coverage and reducing ER use have resulted in continued support for these services. With grant funding, access to mental health services for the uninsured was increased and exceeded expectations. After a year of case

	<ul style="list-style-type: none"> • Number of uninsured clients provided access to mental health services • Revenue & Expenses 	<p>reviews with the psychiatrist, the primary care providers have increased confidence to handle some of their patient's mental health needs. Also patients are averting an inpatient admission by being referred to the Compass House (crisis beds).</p> <p>With numbers down in BCCP due to expansion of a similar service offered by the health department, its status will be evaluated more closely in the coming year. In FY09 a cost benefit analysis of the Adult Medical Day Care program was done and the program closed in May.</p>
Community Investment-Safety	<ul style="list-style-type: none"> • Financial and value of in-kind contributions to the community 	<p>The WMHS Administration and Board of Directors discuss the impact these contributions have on the community along with financial projections when determining what to approve in the next year's budget. No significant cuts were made in this category.</p>

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Western Maryland is still affected by the physician shortages that were documented by the 2007 study by the Maryland Hospital Association and Med Chi. Areas of identified shortages include general surgery, neurosurgery, obstetrics/gynecology, ophthalmology, orthopedic surgery, plastic surgery, and urology. Based on input from uninsured patients and community agencies, there is a gap in the availability of orthopedics, psychiatry, endocrinology, cardiology, and primary care in FY09. The successful recruitment of a psychiatrist and the return of a urologist who left the area will help ease shortages in those two specialties in FY10. The health system also covers the cost of locum tenens to provide orthopedic and other specialty coverage as needed and continues its recruitment efforts for medical staff to meet community need.

Appendices:

1. Describe Charity Care Policy-how inform patients about eligibility (Appendix 1)
2. Copy of Charity Care Policy (Appendix 2)
3. Describe hospital's mission, vision and value statements (Appendix 3)
4. Copy of statement (Appendix 4)

Appendix 1- Informing Patients of Eligibility
WMHS-Braddock & Memorial Hospitals FY09

Description of the Charity Care Policy

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

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

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

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

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

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

UNCOMPENSATED CARE (FINANCIAL ASSISTANCE PROGRAM)

POLICY

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

PROCEDURE

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

When determining indigency, the following indications are considered:

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

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

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

UNCOMPENSATED CARE (FINANCIAL ASSISTANCE PROGRAM)

Page 2

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

Approved:

Director, Business Operations

Senior Vice President/Chief Financial Officer

SLIDING SCALE ADJUSTMENTS Based on FPL for 2007

Community Health Access Program (CHAP) PATIENT RESPONSIBILITY PERCENTAGES

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

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

WMHS Financial Assistance Program (Charity Care) PATIENT RESPONSIBILITY PERCENTAGES

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

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

SLIDING SCALE ADJUSTMENTS Based on FPL for 2008

Community Health Access Program (CHAP) PATIENT RESPONSIBILITY PERCENTAGES

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

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

WMHS Financial Assistance Program (Charity Care) PATIENT RESPONSIBILITY PERCENTAGES

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

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

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

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

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

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

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

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

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

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9. Patient Financial Obligation

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

Approved:

Director, Business Operations

Vice President, Financial Services

SLIDING SCALE ADJUSTMENTS Based on FPL for 2009

Community Health Access Program (CHAP) PATIENT RESPONSIBILITY PERCENTAGES

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%
1	0 (\$10,830) - \$16,244	\$16,245- \$18,952	\$18,953 - \$21,767
2	0 (\$14,570) - \$21,854	\$21,855- \$25,497	\$25,498 - \$29,285
3	0 (\$18,310) - \$27,464	\$27,465- \$32,042	\$32,043 - \$36,802
4	0 (\$22,050) - \$33,074	\$33,075- \$38,587	\$38,588 - \$44,320
5	0 (\$25,790) - \$38,684	\$38,685- \$45,132	\$45,133 - \$51,837
6	0 (\$29,530) - \$44,294	\$44,295- \$51,677	\$51,678 - \$59,354
7	0 (\$33,270) - \$49,904	\$49,905- \$58,222	\$58,223 - \$66,872
8	0 (\$37,010) - \$55,514	\$55,515- \$64,767	\$64,768 - \$74,389
FPL range	Thru 149%	150% - 174%	175% - 200%

Each additional person, add \$3,740 to base FPL.

WMHS Financial Assistance Program (Charity Care) PATIENT RESPONSIBILITY PERCENTAGES

Size of family unit	30%	40%	50%
1	\$21,768 - \$24,367	\$24,368 - \$27,074	\$27,075 - \$29,674
2	\$29,286 - \$32,782	\$32,783 - \$36,424	\$36,425 - \$39,922
3	\$36,803 - \$41,197	\$41,198 - \$45,774	\$45,775 - \$50,169
4	\$44,321 - \$49,612	\$49,613 - \$55,124	\$55,125 - \$60,417
5	\$51,838 - \$58,027	\$58,028 - \$64,474	\$64,475 - \$70,665
6	\$59,355 - \$66,442	\$66,443 - \$73,824	\$73,825 - \$80,912
7	\$66,873 - \$74,857	\$74,858 - \$83,174	\$83,175 - \$91,160
8	\$74,390 - \$83,272	\$83,273 - \$92,524	\$92,525 - \$101,407
FPL range	201% -224%	225% - 249%	250% - 274%

Each additional person, add \$3,740 to base FPL.

Appendix 3: Description of Mission, Vision & Values

WMHS-Braddock & Memorial Hospitals FY09

Mission, Vision & Values

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

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

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

WMHS is also the region's largest employer and, as such, one of our strategic initiatives is to be a good corporate neighbor. As a not-for-profit health system, we provide care to all, regardless of their ability to pay. In fiscal year 2009, we provided over \$7 million in charity care. There are a number of patient care services that are not self-supporting that we continue to provide since we are the community's only provider. We provide patient and family-centered services through responsible management of our human and fiscal resources.

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

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

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

Western Maryland Health System Mission/Values Alignment Matrix Fiscal Year 2009

Mission

- Improve health status and quality of life.
- Improve patient and family-centered services.
- Respect and support life.
- Preserve the dignity of individuals.
- Promote a healthy and just society through collaboration.

Vision

With a commitment to excellence, we envision a premier health care system of quality services that advances the health and well-being of the communities of the Tri-State region. Through partnership with our medical staff and other organizations, we will provide for ease of access to a coordinated network of services that addresses the needs of individuals and families.

Statement of Organizational Ethics

Consistent with our Core Values, we hold all persons and business partners who provide health care services to our patients accountable for their performance in accordance with the standards of business and professional ethics as defined and promulgated by the WMHS Board of Directors.

Values

Respect
Integrity
Quality
Community Advocacy
Resourcefulness

Strategic Goals:

Mission Integration

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

Quality/Safety

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

Financial Viability

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

Leadership/ Organizational Effectiveness

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

Market Position Enhancement

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

Key Strategies:

1. Continue an organized community health program emphasizing lifestyle choices affecting regional health problems, particularly child and adult obesity.
2. Participate actively in community efforts to provide affordable health insurance.
3. Strengthen internal and external awareness of WMHS's community benefit.
4. Increase employee involvement in community and mission-related activities.

1. Promote culture of safety by involving all stakeholders in safety initiatives, including appropriate review and resolution of adverse events.
2. Continue to support national, statewide, and local patient safety initiatives.
3. Eliminate "never events" at WMHS and focus on related performance improvement initiatives.
4. Participate in external benchmarking of patient outcomes and utilize results to assess and enhance patient care.
5. Standardize and develop patient care initiatives based on best and evidenced-based

1. Successfully complete capital campaign and prepare the boards and staff to move into the new hospital, embracing a culture of philanthropy which centers around community/staff involvement and sustainable giving.
2. Improve WMHS on the HSCRC screens through improved documentation, coding, and utilization on both inpatients and outpatient ambulatory surgery.
3. Work with HSCRC to obtain an appropriate combined rate order for the new hospital opening in FY

1. Provide continuing direct oversight to all activities related to the 2009 completion of the new WMHS Regional Medical Center.
2. Continue to strengthen responsiveness to physician needs through expanded attention to retention and increased accountability.
3. Become an industry leader in patient and employee satisfaction through stronger focus on the Service Excellence culture and hardwired accountability for outcomes.
4. Recruit, select, and retain top talent throughout the organization at all levels

1. Continue developing specialty centers and align with physicians in the following areas:
 - a. Cardiology and Interventional Cardiology;
 - b. Orthopedics/Destination Total Joint Center;
 - c. Cardiovascular and Thoracic Surgery;
 - d. Gynecological Oncology;
 - e. Regional Adult Trauma Center; and
 - f. Cancer Center.
2. Improve outreach program to enhance WMHS throughout the region, including strengthening of core and specialty services to meet referral needs.

Western Maryland Health System

Mission/Values Alignment Matrix

Fiscal Year 2009

Key Strategies: (Continued)	<u>Mission Integration</u>	<u>Quality/Safety</u>	<u>Financial Viability</u>	<u>Leadership / Organizational Effectiveness</u>	<u>Market Position Enhancement</u>
		practices.	2010.	(staff, physicians, boards, etc.)	
		6. Maintain patient safety during the move to the new hospital through identification of potential risks and appropriate intervention prior to the move.	4. Improve on Revenue Cycle Metrics to position WMHS to achieve the best practice targets in at least three additional categories. 5. Implement a cost savings/ revenue enhancement program at WMHS for all managers and directors.		3. Focus on strengthening Emergency Departments as true “front door” to WMHS, improving physician coverage and patient/ community satisfaction. 4. Enhance access to primary care by recruiting new physicians; also recruit specialists to support critical community needs and WMHS specialty centers.

2.06.08