

### 1 - New CBR Requirement

The Maryland General Assembly added a new requirement during the 2005 Legislative Session that hospitals provide a “written description of gaps in the availability of specialist providers to serve the uninsured in the hospital.” Please include this brief written description with the hospital’s community benefit report submission:

***Response:*** *AAMC has call rotations in every specialty for which there may be an emergency or inpatient need. Call coverage is a medical staff bylaw requirement and is provided regardless of insurance status. There are no gaps in availability of any specialty for uninsured patients. In addition, the hospital has Hospitalist programs in Medicine, Pediatrics, General Surgery, Obstetrics and an Intensivist program which provide 24-hour in-house coverage for each of these areas for uninsured and insured patients.*

2 - Only those policies and documents that have been modified or updated since the FY 2004 submission (January 1, 2005) should be re-submitted to the HSCRC for the FY 2005 data collection period (January 1, 2006). That is, if any of the following additional materials have been modified or updated, please include a written copy of the most recent:

- Hospital mission statement
- Hospital charity care policy
- Community needs assessment

***Response:***

- *Hospital mission statement and charity care policy have not been revised since 2005 submission.*
  
- *Revised community needs assessment used – See attachment C.*

3 - narrative describing the hospital’s efforts to evaluate the effectiveness of its community benefits initiatives. A hospital should use the evaluation framework to complete this narrative as part of its Community Benefit Report submission to the HSCRC (please see Section M. Community Benefit Evaluation, for additional detail).

To provide a description of efforts taken to evaluate the effectiveness of a hospital’s community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

***Response:*** *Community benefits’ reporting is part of the hospitals strategic plan, and is included in the hospital’s annual operating plan. The Community Health and Wellness Services Department coordinates community Benefits planning, monitoring, and reporting for the organization.*

2. Were hospital staff and leadership involved in developing the plan?

***Response:*** *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.*

- **Community Needs Assessment**

3. Does the hospital's plan target specific areas of community need?

***Response:*** *Anne Arundel County Health Department established five areas of top priority in its fiscal year 2007 Local Health Plan. The five priorities are: Emergency Preparedness; Elimination of Disparities in Health Status and Health Care Access; Healthy Children and Families; Prevention and Management of Communicable Disease and Chronic Illness; and, Environmental Safety and Health.*

*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 13 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 opened a free adult dental clinic in March 2006. Seventy-nine dentist volunteers have provided free dental care for hundreds of community members in this (07) 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. This individual is responsible to provide staff training, coordinate disaster drills, and keep the hospital's disaster preparedness supply inventory up to date.*

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.

***Response:*** See Attachment C

- **Community Benefits Initiatives**

5. Does the hospital identify its Community Based Initiatives?

***Response:*** *The hospital identifies, monitors and documents its community-based initiatives. A community benefits reporting system has been designed for hospital departments and staff members. A software program is used to organize and store the community benefits data. A staff member from the Community Health and Wellness Services Department oversees the process.*

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

***Response:*** *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 – see attachment C.*

*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 20 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.*

*For example: In this reporting period, hospital staff worked with program administrators of the Anne Arundel County Dept. of Health to modify the Health Smart Minority Church Program in response to the expressed needs of program participants. Program participation increased as a result.*

*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.*

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

***Response:*** *Many of our 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. Two examples would be: our wellness education and exercise classes, and our individual outpatient diabetes or Healing Arts services.*

• **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?

***Response:*** *There are many instances where community members, community partners, or public, or private industry have become involved, identified needs or issues, or partnered with the hospital in planning and /or implementing community benefits activities.*

*Examples of direct collaboration with community members can be seen in the hospital's sponsorship of support groups. The hospital currently sponsors 20 support groups designed to address community needs.*

*Another example of direct collaboration with community members and patients is at the hospital's free clinic, the Annapolis Outreach Center. The center sees several hundred patients each month. The visits to primary care clinics generate referrals for outpatient laboratory / diagnostic testing, or to one of the many specialty clinics. The need to expand specialty clinics or specialist office referrals is gauged by the needs identified in the weekly primary care clinics. Community need has been the impetus to increase the number of GYN clinics each month, to begin the Orthopedic Clinic, and the Dental Clinic at the Annapolis Outreach Center.*

*The hospital has many public and private community based partnerships. All of these partnerships positively impact the community. Here is a list of some recent collaborations:*

- *With Bayer Healthcare, and Quest Diagnostics to provide laboratory testing to our uninsured and underserved population;*
- *With Anne Arundel County Health Department and area hospitals through the Conquer Cancer Advisory Council, to identify cancer trends in the county, develop recommendations and standards to assist in the design of countywide cancer education and screening initiatives;*
- *With the American Cancer Society to provide prostate screening and education at the Annapolis Outreach Center;*
- *With the University of Maryland School of Nursing, and Johns Hopkins School of Nursing to provide educational opportunities in community health for their nursing students;*

- *With the University of Maryland Baltimore College of Dental Surgery to provide educational opportunities in community health for their Dental Hygiene students.*
  - *With the County Health Department and Johns Hopkins University to provide monthly HIV / Aids Clinic at the hospital's free clinic;*
  - *With the Annapolis Youth Services Bureau and the Anne Arundel County Mental Health Agency Inc. to provide weekly Mental Health Clinic at the hospital's free clinic;*
  - *With the American Cancer Society, and the United Way, in fundraising campaigns for their organizations;*
  - *With the county health department to provide outreach to area African America church members for blood pressure screening and education;*
  - *With hundreds of doctors, dentists, nurses and private citizens who donate their time and expertise at the hospital's free clinic;*
  - *With Phillips Medical, Tyco Healthcare, Sullivan Schein Dental, Novo Nordisk, Wheeler Goodman Masek & Associates Inc., Anne Arundel County Health Department, the City of Annapolis, to donate needed equipment, or services to the hospital's free medical and dental clinics;*
  - *With the AA County Health Dept., the County Public Schools, and American Cancer Society to provide tobacco education to Anne Arundel County teens;*
  - *With the Harry and Jeanette Weinberg Foundation to assist low-income, uninsured patients in gaining access to low-cost or no-cost medications;*
  - *With the Nathan and Suzanne Cohen Foundation, to provide prosthodontics to uninsured and underserved adult dental clinic patients.*
9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

***Response:*** See response to question 8. for specific information on partnerships and collaborations.

*The hospital participates in many community organizations and partnerships. These organizations are public, private, and faith-based. Our relationships with community partners provide us with information on community needs, community resources, and new community based activities and initiatives in our community. Awareness of, and involvement in our community at many different levels, positively impacts our community benefits planning efforts.*

• **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?

***Response:*** Community Benefits Activities are monitored through assigned individuals in the hospital's Community Health and Wellness Services Department, along with the Patient Financial Services Department.

*Specific target goals in each area of reporting have not been identified. The Lyon's Software program has been used for the past three reporting periods to assist in data collection, organization, monitoring and report writing.*

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

**Response:** *The hospital's Leadership Council is given periodic progress updates and, as in prior years, this fiscal year's community benefits results will be included in the hospital's Annual Report.*

## **Attachment C**

### **Community Needs Assessment**

#### A. Anne Arundel County Needs Assessments

To determine the specific public health needs of County residents, the Anne Arundel County Department of Health has conducted or contracted for a number of “needs assessments.”

The first comprehensive public health needs assessment was conducted In 1991-92 through a contract with the Johns Hopkins University Health Program Alliance and Lewin-ICF. The report identified several significant public health concerns, most of which continue to be Department priorities. Programs were developed to address these concerns. Later assessments of needs and reviews of existing data helped us to fine-tune our initiatives and focus on newly emerging problems. Some of those reviews and assessments were:

Ongoing reviews:

- Surveillance of Hospital Discharge data
- Surveillance of Maryland Cancer Registry data
- Surveillance of birth certificate and death certificate data
- Reviews of Centers for Disease Control and Prevention data
- Reviews of statewide and national Behavior Risk Factor Surveillance System data
- Reviews of the Maryland Adolescent Survey (on Substance Use) data
- Reviews of Annual CRF Cancer Reports
- Reviews of Statewide CRF Tobacco Reports
- Reviews of U.S. Census Bureau Statistics, including Current Population Survey results
- Reviews of Infant Mortality statistics
- NHANES Review
- Review of Cancer Registry data
- Review of Uniform Crime Report data

Local Assessments:

- LTL Pulse Survey of Teen Smoking
- An annual internal review of the health of the County's adolescents, including school performance, substance use, teen pregnancy, injuries, diseases, and arrests
- A 1995 internal review of services available to people with developmental disabilities
- A 1996 Healthier Communities Community Health Assessment Project
- Anne Arundel County Department of Health participation in a 1997 Community Health Needs Assessment sponsored by Harbor Hospital
- A 1997 Department of Health Diabetes Work Group review of diabetes in the County
- A 1998 well water survey
- A 1998 survey of small businesses in the County about health in the workplace
- A 1998-99 study of existing data on patterns of substance abuse and its treatment in Anne Arundel County

- A 2000 Learn To Live Public Opinion Survey (countywide)
- A 2000 Young Men's Behavioral Health Survey (Ages 18 to 35)
- A 2001 countywide Dietary Survey
- A 2001 county-specific Behavioral Risk Factor Surveillance System (BRFSS) Survey, as well as special BRFSS surveys for the Korean American and Hispanic/Latino American populations
- A 2003 Learn To Live Public Opinion Survey (countywide)
- A 2004 county-specific Behavioral Risk Factor Surveillance System (BRFSS) Survey
- A 2004-2005 review of health disparities
- A 2005 Learn To Live Public Opinion Survey
- A 2005 review of Department of Juvenile Services and Department of Health data for youth assessed for mental health and substance abuse needs
- A 2005 review of substance abuse data and survey of providers and other organizations to assess substance abuse treatment needs
- A 2005 Assessment of the Health Department's Capacity to Serve Individuals with Limited English Proficiency
- A 2005 in-depth analysis of factors influencing the County's infant mortality rates
- A 2005 communicable disease retrospective comparing local, state, and national data
- A 2006 School Health Needs Assessment survey of students, parents and teachers/administrators

Ongoing work with community groups and community participation in advisory committees and councils create a continuing needs assessment process, bringing new ideas from Anne Arundel County residents into the planning process.

In April 2006, the Department will issue its ninth annual "Report Card of Community Health Indicators," which will provide a profile of Anne Arundel County's public health issues. The "Report Card" will continue to be revised and expanded regularly, as new information becomes available about the health status of County residents. Ongoing review of the above-mentioned data sets allows us to recognize patterns in disease and high-risk behavior among County residents, and respond with appropriate interventions. The 2005 "Report Card of Community Health Indicators" is available at the following website address:

[http://www.aahealth.org/App\\_pdfs/aahealthreportcard2005.pdf](http://www.aahealth.org/App_pdfs/aahealthreportcard2005.pdf)

The Department conducted its second county-specific Behavioral Risk Factor Surveillance System (BRFSS) Survey in August and September of 2004. Portions of the Department's previous Dietary Survey were incorporated into the BRFSS to consolidate surveying activities. Over-sampling in certain parts of the County assured that minority populations were adequately represented. A BRFSS for the Hispanic community will be conducted in early FY 2007.

# Atlantic General Hospital Community Benefits Evaluation 2006

## Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?
2. Were hospital staff and leadership involved in developing the plan?

Atlantic General Hospital does include community benefits as part of its strategic plan. The hospital includes all departments in its planning and implementing of community benefit services. There is a Community Benefits committee with representation from each department which meets quarterly and as needed to share ideas and plan community events.

The Community Education Department was developed in 2001 as one way to meet our mission statement, “to provide quality care, personalized service and education to improve individual and community health” for the residents and visitors of Worcester County, Md. and our surrounding areas. This department is involved in coordinating free community education and health screenings. We do this through collaboration with other community agencies and affiliates in our area. Some of the educational events that we coordinate include:

- Community health fairs
- Free CPR classes
- Speakers’ bureau
- Hypertension clinics
- Smoking Cessation clinics and classes
- Free health screenings
- The Visions for Total Health Conference

Also as part of our community benefit plan we sit on many health advisory boards and participate in many community initiatives. Listed below are a few examples of some of those:

- Tri County Go Red
- Local Management Board
- Living Well Chronic Disease Health Initiative
- Minority Health Symposium
- Diabetes Tri County Alliance
- YMCA
- Local School Boards
- Local Chamber Boards

## **Community Needs Assessment**

3. Does the hospital's plan target specific areas of community need?

Yes. Our Strategic Plan specifically directs our focus toward improving or developing programs related to: Emergency Care, Women's Services, Cardiac/Vascular Care, Cancer Care, Orthopedics, Diabetes, Pulmonary Medicine, and Wound Care. These areas of focus were derived from State of Maryland hospital discharge statistics, community census data, "ShoreTrends" data from Salisbury University for the Berlin/Ocean City market, etiological data from state and national sources, hospital-specific utilization data, and feedback from area physicians and community members

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.

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

- the health assessment publication from the health department
- Worcester County Local Health Plan , FY 2007
- Tri-county Adolescents Association
- PRC Community Survey
- 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

## **Community Benefit Initiatives**

5. Does the hospital identify its Community Based Initiatives?
6. Do the hospital's community benefits initiatives reflect evidence-based needs?
7. Were the initiatives performance-based and did they involve process and/or outcome measures?

The hospital does identify its Community Benefits Initiatives. They are included in the Senior Leadership Goals for each year. These goals are implemented/addressed through the hospital's Community Benefits Committee

as well as the entire Leadership Team.. The Community Benefits Committee is made up of representatives from each department at Atlantic General Hospital (AGH) and the community Health System (AGHS). Planning for AGH occurs through input supplied from: hospital associates, senior leadership, the Board of Directors, Medical Staff and community members.

The initiatives reflect evidence-based needs. These needs are identified through outsourced consultant firms, patient evaluations, community needs assessments and published data. An example of an evidence based need being addressed and being reported in Community Benefits is our Visions Conference. The evaluations from past conferences showed that people wanted the conference to address the needs of our local community. Based on needs assessments from the County Health Department, our Local Management Board and conference evaluations we changed the format and location of the conference. We planned our speakers on specific local needs. The results: a larger attendance at the conference and improved evaluations which included comments such as “you finally have seen and addressed our needs”.

Another way that we determine the needs of the community is through the use of focus groups and needs assessments. Worcester County Health Department has provided us with their current needs assessment for 2006 to 2010 and also their Local Health Plan for 2007. In those documents the leading causes of death is identified as Heart Disease and Cancer.

The leading types of newly diagnosed cancers are:

- Lung
- Prostate
- Colorectal
- Breast

Based on this information we have done extensive education on risk factors and prevention of cancers, targeting the ones that top the list.

Currently we are in the planning phase of collaboration with cancer physicians and treatment centers in the area to bring more comprehensive care locally.

These reports show that one fourth of Worcester County residents are over 65. Along with this age group comes a higher incidence of chronic disease. Topping the list of those is:

- High Blood Pressure
- Arthritis/Rheumatism
- Diabetes
- High Cholesterol

In response we do multiple hypertension clinics throughout the region in which we provide screening as well as education. We also have a Diabetic Education Program as well as support groups and are part of a Tri-county Diabetes Alliance. We are also involved in an educational initiative using the Chronic Disease Self Management Program from the Stanford evidence based model. We have held several workshops and the response from participants has been

extremely positive about the improvement in their quality of life. We work with the local AARP to provide a large health fair where many free screenings are available. For the coming year we have several educational sessions planned on joint replacement for the young.

Because of our location, close to the beach, another identified need is youth and accidents. One way that we have addressed this need is through our E.N.C.A.R.E. program. This is a group of emergency room nurses/techs who volunteer their time in the community. They provide education on injury prevention, drug prevention as well as provide on-site first aid assistance at community events.

Another identified need in our area is access to health care. In Worcester County there is 1 full time primary care physician for every 7,600 people living in or visiting the county. There is 1 full-time psychiatrist available for every 40,800 residents and 132,200 visitors to the county. Atlantic General is always in the physician recruitment mode. It is our goal to continue to open physician offices and other services throughout the region to make healthcare more available. This is a very diverse county and people like to receive care in their hometown when possible. Over the past year we have acquired 2 new practices in outlying areas in this county and a neighboring county. We also partner with many agencies to help to meet the needs of the residents.

## **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?
9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

As mentioned previously in this report AGH involves the community in many ways in the planning, implementing and evaluation process of Community Benefits. We are a **community** hospital. We are very much dependant on the members of our community to supply us with the information needed to plan and implement our services to them. We work with many local agencies including Worcester County Health Department, the Health Department Prevention office, Worcester Youth and Family Services, the Chamber of Commerce in the towns and cities that we serve, the Local Management Board, the Mid Delmarva YMCA, MAC Incorporated ( department of aging) to name only a few.

We also have a Visions Committee 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, are working and those that aren't. It is through this committee that we put on a major health conference each year which provides health education as well as screenings.

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

## **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?
11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

The hospital does monitor our community benefits through continuous progress reporting. We compile data from all departments through the Community Benefits Committee on a monthly basis. This report is in turn presented to the Board of Directors on a monthly basis. It is compared to our strategic plans and evaluated and re-directed as needed. The people involved in review of the progress are: the Administrative Assistant, the Community Education Coordinator, Director of Finance, Vice President of Public Relations and the Board of Directors. Senior leadership is kept informed through monthly reports on the progress of Community Benefits. Department directors are held accountable for their activity

by the Vice President to whom they report. ATLANTIC GENERAL  
HOSPITAL  
Strengths, Weakness, Opportunities, Threats (SWOT) Analysis/  
Gap Analysis

**Inpatient Care Delivery**

Strengths

1. Hospitalist Program
2. Clean Facility
3. Private Rooms
4. Low Turnover RN/Great RNs/Physicians
5. Compassionate Care
6. Patient/Nurse Ratio (workload)
7. Diabetic Guidelines Glucose Control on Floor
8. Resource for Patients
9. Development Clinical Pathways
10. Three Intensivists
11. Rapid Response
12. Multidiscipline Care/Team Rounds/ MS/CCU
13. Patient Education
14. Chaplain
15. Charge RN

Weaknesses

1. Subspecialist Available
2. Space – Rooms/Storage/Waiting/OR/Pharmacy
3. Decreased Staffing (in general)
4. Patient/Family Involvement in Care
5. Mental Health Services Available Inpatient
6. Lapses in Communication
7. Pediatric Support
8. Parking
9. Vacancies in Management
10. Surgery Management IS (computer)
11. Lack of Equipment
12. Deteriorating Plant & Major Equipment (decor, beds, etc...)
13. Availability of Capital
14. All About Hospital, i.e. TV
15. Medication Safety
16. Lack of CPOE
17. Post-acute Access to Resources = 2<sup>o</sup> Market
18. Rehab

19. Staff Education
20. Central Sterile Area, Lack of

#### Opportunities

1. Marketing Development of Hospitalists Program
2. Hospital EMR
3. Recruit/Retain Subspecialties (geri/psych...)
4. Clinical Resources on Floor
5. Expand Cardiac Care
6. Community Outreach/ED
7. Short Stay/ Observation Unit
8. Oncology – Medical/Infusion Services
9. Palliative Care
10. Expand Diabetes Care Inpatient (NP)
11. Surgical RN/Practitioner/PA
12. Improve Recruitment Allied Health
13. Pharmacy Expansion
14. Asset Management
15. Direct Admit Process (not ED)

#### Threats

1. Availability of Capital
2. PRMC Hospitalist Group
3. Inability to Increase Patient Satisfaction
4. MRSA Outbreaks/Readmits
5. Community Perception
6. Regulatory Guidelines – Impact
7. Decreasing Reimbursement
8. PRMC Primary Care & Referral Pattern
9. Dr./Staff Burnout
10. Dr./Healthcare Worker Shortages
11. Capacity
12. Aging RNs
13. Skilled/Post Acute Centers
14. Liability Exposure
15. Healthcare Employee Injuries
16. Specialty Call

#### Gaps

1. Mental Health
2. Dialysis (Peritoneal)
3. Cardiac Cath
4. Emergency Admissions/Direct
5. Increase Communication Technology (hand held telephones)
6. Inpatient Discharge → Post Acute/Dialysis
7. Resources Staff/Patient Education
8. PE Resources

9. Communication Between IS – Systems (Cerner, IMED, etc.)
10. Diabetes Care
11. Pediatrics
12. Barcode Medication Administration
13. Infection Prevention
14. Sub-specialty Availability
15. Patient Isolation identification
16. Hospitality Services for Patients/Visitors

## **Emergency Department Care Delivery**

### **Strengths**

1. 30-Minute ER Promise
2. Staff/Medical Clinical Excellence
3. 90% + NCR-Picker Scores
4. Availability/Capacity
5. Working Relationship – Registration to Clinic
6. Relationship with EMS
7. Relationship with PRMC/ESA
8. Age of Facility
9. Volunteers
10. Fast Track Capacity
11. Throughput
12. Functionality of Physical Space
13. PACS
14. Lab Turn Around Times
15. Patient Tracking System

### **Weaknesses**

1. Lack of Storage
2. Call Coverage – Physician
3. Lack of Rooms at Peak Times
4. CAT Scan – Diversions
5. Manual Documentation Inefficiency
6. Registration – Non-EMS – Point of Entry
7. Carpet in waiting area
8. Vending in waiting area
9. Fish Tank maintenance

### **Opportunities**

1. Triage/Protocol/Space
2. Fast Track Hours
3. Support Physician Taking Call (Malpractice?)
4. Trauma Level Increase
5. E-documentation
6. Recruitment of More ED Physicians vs. PA
7. Patient Advocate
8. Communication ED – Inpatient
9. Case Management
10. Scanning Tools Registration
11. Stronger Presence in Community (Seat Belt, Drugs, etc.)
12. Establish Relationship with Community Providers (Safety Net – Mental Health)
13. Valet Parking (Golf Cart)
14. Code HOPE
15. Bed tracking

## 16. Increase Collaboration with Tertiary Centers

### Threats

1. Walmart/Retail “doc-in-a-box” centers
2. PRMC New ED
3. Urgent Care Centers
4. Lack of Physicians to Take Call
5. Pandemic threat/preparedness
6. Freestanding ED – Millville
7. Inappropriate Use
8. Direct Admits
9. Increasing Uninsured
10. Associate Safety (3<sup>rd</sup> Shift)

### Gaps

1. Mental Health
2. Subspeciality Care; plastics/ENT...
3. Trauma
4. Pediatric (vents)
5. Address Social Needs (Community Case Management ER)
6. Appropriate Referrals (Addiction, Homeless, Psychosocial)
7. Tertiary Referral/Network
8. Access to Community Records

## **Outpatient Care Delivery**

### **Strengths**

1. Patient Satisfaction
2. Centralized Scheduling
3. Customer Service
4. Location
5. Availability
6. GI – Ortho Services
7. Costs of Services
8. Growth – MOB
9. Pulmonary/Sleep
10. Access in Pocomoke
11. Registration Staff
12. Ambulatory Surgery
13. Diabetes Program
14. Wound Care Center
15. Women’s Diagnostic Center
16. Lab/Radiology

### **Weaknesses**

1. Packaging of service delivery
2. Hours of Service
3. Signage
4. Radiology/OR Waiting Room
5. Registration Process
6. Lack of Volunteers
7. Age/Condition of Building
8. Wait Time for New Patient Appointments
9. Transport/Wheelchairs
10. Too Much Room for Clerical Error
11. Central Entry Bottleneck
12. Patient Education – Results
13. CT Scanner Access/Conflicts
14. MRI – Insurance Issues
15. Available Outpatient Uninsured → ED
16. Limitation Classroom Space – Education
17. Patient Transport

### **Opportunities**

1. Offsite Imaging
2. Occupational Health
3. Essential Services Dept.
4. Increase Offering in Community/Local
5. Increase Cardiology
6. Outreach Software Maryland Office

7. Scanning & System Interfaces
8. Senior Population (geriatric center)
9. Urology
10. Increase Ortho
11. Hours of Services
12. Increase Funding
13. Screening/Prevention Opportunity
14. Increase Patient Education
15. Increase Community Bond with Community Leaders
16. Outreach to the Home Bound
17. Negotiating Reimbursement Rates
18. Scheduling (Lab)
19. Mutual EMR Integration to Private Physicians
20. Insulin Start Clinic

#### Threats

1. Outside Agency Regulating Referrals
2. Freestanding Clinics
3. Insurance Companies Dictating
4. HSCRC Outpatient Caps
5. Boutique Practices
6. Commercial Labs
7. Peninsula Imaging – New Center
8. PRMC/Beebe
9. Price/Cost

#### Gaps

1. Uninsured Access to Specialty
2. Promotion of Services
3. Timeliness of Patient Appointment
4. Limited Services @ Pocomoke
5. Chemotherapy
6. Certain Procedures (Int. Radiology)
7. Insulin Pump Education

## **Physician Practice Network**

### Strengths

1. Convenient Community Locations
2. Increased Locations – Increased Geography coverage
3. Quality of Care
4. Increased Stability
5. High Caliber Physicians
6. Quality Facilities
7. Centralized Scheduling
8. Walk-in Care
9. Diversity of Specialty
10. EMR in Progress
11. Referral Base → AGH
12. Expanded Hours

### Weaknesses

1. Supply of New Physicians
2. Endocrinology
3. Reimbursement Payors
4. Communication – Personal – Telephone
5. After Hours Call
6. Advertising
7. Condition of Building (AHC, 10<sup>th</sup> Street)
8. Length of Appointment Time (to get)
9. Community Involvement
10. Waiting Time in Office
11. Separation/Lack of Integration – Geography
12. Market Share
13. Lack of Staff Retention
14. Pay

### Opportunities

1. EMR - Health Screening referrals – Community
2. New Markets (DE/Pocomoke/Salisbury?)
3. Atlantic ImmediCare
4. Partnership with Other Providers, Schools, Health Dept.
5. Increase NP – PA Use
6. Occupational Medicine
7. Legislative Advocacy – Increase Reimbursement
8. Strategic Plan for 10<sup>th</sup> Street
9. Collaboration NIH – Research
10. Additional Consolidation – Central Scheduling
11. Increase Medical Student Rotation in Area
12. Increase Access/Hours
13. Marketing Hours for Walk-in

14. Same Day Appointment
15. Presence in Retirement Communities
16. Convenient Care
17. One-stop Shopping
18. Pediatricians
19. Pay for Prevention

Threats

1. Pending Medicare Cuts
2. DE/PRMC Primary Care
3. Doc In the Box – Urgent Care Center
4. Private Entities
5. Non-insured Population Increase
6. Malpractice
7. Physician Discontent

## **Visions for Total Health**

### Strengths

1. Flu Clinic
2. Health Fairs
3. News Articles
4. AHC
5. On-Call
6. Diabetes & Support Group
7. AGHS
8. Community Support
9. Dawn –RN – Outreach
10. Programs – Uninsured/Indigent
11. Increase Verbal Word of Mouth
12. Screening Programs
13. Relationship to Health Dept.
14. Volunteers
15. Tri-county Diabetes Alliance
16. Quality Staff Personalized Services
17. Public Safety Net Vision – Mental Health
18. Associate Employees – Weight Watchers
19. Colleges/School for Student Participation
20. Scholarship Program
21. BCCP
22. Free Vaccine Program

### Opportunities

1. Smoke Free
2. Lead by Example
3. Employee Wellness
4. Smoking Cessation
5. New Marketing – Business/Communities
6. Creating Bridging with Center of Excellence
7. School System – Outreach – Healthy Choices
8. Master Patient Index – Reminders
9. Staff Education
10. Slots
11. Going “Green”

### Weaknesses

1. Staff/\$ Expand Screening
2. Space – Conference Room – Education
3. Alliance with Legislators
4. Patient Availability to Health Record
5. Lack of Control – Reimbursement
6. Inability to Target Population

7. Recruitment Healthcare Providers
8. Visibility
9. Language Barriers (cultural)
10. Finite Resources (Lack of funding)
11. Transportation
12. Healthy Food Choices – Events
13. Smoke-Free Campus

#### Threats

1. Market Consolidation – physicians
2. 2 Insurance Companies controlling 90% of market
3. Seasonal Influx
4. Patient Apathy
5. Lack of \$
6. Environment – Resort
7. Gambling
8. Aging Population
9. Genetic
10. Cost of Living

#### Gaps

1. Coordination Regionally
2. Wellness vs. Acute Care
3. Mental Health – Substance Abuse
4. Trust in Hospital
5. “Go Green”
6. Outreach Access – Mobility
7. Relationship with Partners
8. Reimbursement
9. Encourage Creative Pathways (Internet Use)
10. Associate Programs
11. Patient Portals
12. Acute vs. Chronic Care Model
13. Education to Diverse Community (Language)

## **Gap Analysis – Service Areas**

### **Women's Health**

1. 24-hour Gyn Coverage
2. Gyn Recruitment
3. OB
4. Digital Mammo
5. Not One-stop Shopping (Gyn – McWhite – Mammo)
6. Domestic Violence
7. Bone Disease
8. Dermatology/Urology
9. Oncology
10. Lifestyle Medicine
11. Cardiac Awareness

### **Orthopedics**

1. New Recruit
2. NSG Support in Center
3. Changing Equipment Technology
4. Equipment Costs
5. MRI Reimbursement
6. Outreach
7. Rehab
8. Marketing expanded areas

### **Cancer Care**

1. Lack of Services – Infrastructure: Infusion, Med/Onc
2. Education
3. Oncologist On Staff
4. Palliative Care
5. Screening
6. Physician Recruitment
7. Hospice Services (Knowledge of)
8. Support Groups
9. Clinical Knowledge

### **Cardiac/Vascular**

1. No Cath Lab
2. Decrease Invasive Procedures
3. Electronic Online EKG
4. Availability of Services on Weekend
5. Change in EMS Procedure/Protocols
6. Chest Pain Center/Protocol
7. Cardiologist Support

### **Pulmonary Medicine**

1. Outpatient Pulmonology (Pulmonology Rehabilitation)
2. Hospitalist Coverage of Intensivists (1<sup>st</sup> Call)
3. Staff Recruitment
4. Office Space (Physician) (Location)
5. Lung Cancer Screening
6. Respiratory Records Not Readily Available on Floor

### **Diabetes**

1. Compliance to Best Practice Guidelines
2. Early Outpatient Insulin
3. Marketing
4. Inpatient Education
5. New Onset Diabetes Education
6. Case Management
7. Classroom Space
8. Reimbursement and Management of Patient (Group Visit)
9. Endocrinologist
10. Only One (1) CPE
11. Insulin Pump
12. Prevention/Awareness (Early Detection)
13. Bariatric Surgery
14. Chronic Disease Management – Mental Health
15. Occupational Medicine

### **Wound Care Center**

1. Hyperbaric, lack of
2. Advertisement
3. Lack of Physician Specialty (plastics)
4. Screening
5. Increase Incidence with \$ Penalties (inpatient)
6. No Ostomy Care

**Needs Assessment and Evaluation of Community  
Outreach Programs  
Baltimore Washington Medical Center - CBR 2007**

**301 Hospital Drive  
Glen Burnie, Maryland 21061  
Contact: Kim Davidson  
Phone: 410-787-4366**

**Needs Assessment**

Baltimore Washington Medical Center's Manager of Community Outreach utilizes the Anne Arundel County Report Card of Community Health Indicators to research, develop and implement programs that are beneficial to the community. Through the free health screenings, educational lectures, health fairs and various other outreach programs offered, the medical center directly provides community members with the tools necessary to lead a healthy lifestyle. More specifically, BWMC takes a proactive approach to community healthcare needs by developing programs that have a direct impact on each individual. As a result, the medical center has strong relationships with local organizations and communities, working together to maximize our outreach efforts.

## **Evaluation of Programs**

The quality of care provided at Baltimore Washington Medical Center extends beyond the medical center's walls and into our community. Each year, BWMC's community outreach efforts continue to grow, reaching more people through the education of the importance of prevention and early detection. One important way BWMC evaluates outreach efforts is by clinical quality - how the service improves patient outcomes and quality indicators.

### **Stork's Nest**

With Maryland ranking 46 out of 50 for high infant mortality rates, Anne Arundel County has seen a 30% increase in infant mortality in the past five years. These staggering rates prompted BWMC to partner with The Anne Arundel County Department of Health, The March of Dimes and Zeta Phi Beta Sorority to open the county's first Stork's Nest, a national, incentive-based prenatal education that helps keep pregnant women and their babies healthy while fighting infant mortality.

Stork's Nest is made up of six-class sessions, focusing on everything from nutrition, exercise and stress in pregnancy to how to bathe and diaper a newborn. Participants receive points for each class they attend, as well as physician visits and healthy behaviors. Participants can then use those points to purchase baby items at BWMC's outreach center in Arundel Mills, including infant clothing, strollers, car seats, diapers, feeding supplies, portable cribs and first aid supplies.

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

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

Anne Arundel County infant mortality rates are trended annually and are included in the Anne Arundel County Report Card of Community Health Indicators. Prenatal demographic data and post-natal birth data is collected on each participant and is collated and trended annually by Baltimore Washington Medical Center to determine program impact.

### **Cancer Screenings**

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 to the community each year. In FY07, both prostate and skin cancer screenings were offered. After each screening, physician follow-up letters are sent to all screening participants. This letter contains screening results and if indicated, the recommended follow-up such as scheduling an appointment with his/her 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.

## **Gaps in the Availability of Specialist Providers at BWMC for the Uninsured**

While Anne Arundel County is generally not considered underserved, there is a significant portion of the population surrounding BWMC that houses an underserved, uninsured, and indigent population.

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

### **OB/GYN Services**

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

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

## **Bon Secours Baltimore Health System**

### **Evaluation Framework Report**

Bon Secours Baltimore Health System has a community benefit plan and includes these benefits as part of its Strategic Quality Plan (SQP). Hospital staff and leadership are involved in developing this plan as part of the Building Healthier Communities section of the SQP.

The hospital's plan targets the needs of low income families and seniors in the West Baltimore area, as well as other community needs as identified. Policy dictates that all new programs will be taken to the Senior Leadership group for approval to determine the appropriateness of the program with our SQP.

The leadership team for the Foundation office meets periodically with local community associations such as OROSW in order to develop the hospital's plan for Community Development. Bon Secours does not receive current needs assessments from the local health departments to compile the annual plan.

Currently The Bon Secours Hospital of Baltimore manages the following Community Based Initiatives:

- Family Support Center
- Investment in Senior Housing
- Nursing Advancement Program
- Our Money Place
- Community Faith Nurse Ministry Alliance
- Legislative Advocacy
- Tele-Heart
- Native Flower Competition Club
- CIBS – Department of Behavioral Medicine
- Ryan White Grants
- Tree Planting & Neighborhood Revitalization
- Unity Properties
- Vegetable Garden Club
- Women's Resource Center
- Youth Employment & Entrepreneurship Program
- Hospital Charity Care

These initiatives are performance based and involve measures such as participation and community feedback. Each corporate grant funded program is evaluated monthly with a tool that specifically rates each element of the program. The elements include: Desired Service Outcomes, Community Needs and Capacities, Strategic Quality Plan Alignment, Service Outcomes and Customer Satisfaction. The results of these assessments are reported back to the grantors as well as hospital leadership monthly.

The Bon Secours corporate office also performs a monthly Mission Composition Assessment in each of its local markets, Baltimore included. All Community Benefit programs are included or evaluated during the Strategic Planning and Budget preparation period when the direction of the organization is solidified and monthly when operating results are reported on the local and corporate dashboards. External consultants may assist with any component of the assessment or evaluation.

### **Gaps in Availability of Specialist Providers**

Specialist needs for both the uninsured and insured within our facility include ENT Specialists, limited G.I. (Gastrointestinal Specialists), Neurologists, Urologists and Endocrinologists. Bon Secours has contractual arrangements to reimburse physicians as well as surgeons who provide care to the uninsured.

**Calvert Memorial Hospital  
2007 Community Benefit Evaluation Report**

**Specialist Gaps to Serve the Uninsured in the Hospital**

Calvert Memorial Hospital (CMH) does not have any gaps in the availability of specialist providers to serve the uninsured while a patient in the hospital though such a gap is present in the local community for follow-up care. CMH is served by both a Hospitalist and a Pediatric Hospitalist Program that are available to all patients (adult and pediatric) who don't have a primary care provider and who present to the hospital with a medical problem requiring admission. This service is available regardless of ability to pay or insurance status. While in the hospital, all patients are provided specialty care when a consultation is requested by the admitting provider. CMH ensures that full call coverage is maintained for all specialties provided at CMH.

**Physician Subsidies**

CMH has identified the need to provide a variety of physician subsidies in order to insure that comprehensive care is available to its patients. These subsidies are classified into the following categories per the HSCRC guidelines:

1. Non-resident House staff and Hospitalists –
  - a. CMH has continued its Hospitalist program for adults and added a Pediatric Hospitalist program in FY07.
  - b. Weekend call coverage for pediatrics was provided in the early part of FY07 until the Pediatric Hospitalist program was implemented.
  - c. Medical coverage for weekend psychiatric services is provided through physician subsidy. With the addition of a new psychiatrist on staff, this weekend call coverage subsidy has been reduced though not yet eliminated.
2. Coverage of Emergency Department Call – CMH subsidized only Emergency Department call coverage for specialty care in ENT services in FY07.
3. Recruitment of Physicians to Meet Community Need as shown by a Hospital's Medical Staff Development Plan – An income guarantee was provided to one vascular surgeon in FY07 in order to ensure adequate coverage for vascular care at CMH.

**Section M. Community Benefit Evaluation**

**Community Benefit Planning**

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Calvert Memorial Hospital (CMH) maintains a very strong commitment to the community it serves and this commitment is reflected throughout its strategic

plan. Its mission statement says” CMH works in partnership with the community to improve the health status of its members.” One of its annual goals is to “assess and pursue those programs and services that focus on improving the health status of the population in accordance with the hospital’s vision and mission statement”. Within this goal are specific objectives that drive the actions of numerous programs within the institution. Examples of these objectives include

- Collaborate with the Community Health Improvement Roundtable to address community health needs.
- Support Calvert HealthCare Solutions in providing healthcare services to the uninsured.
- Facilitate newly implemented faith-based ministry program.
- Coordinate healthy living programs for youth and adults solely and in partnership with other community organizations.
- Collaborate with Calvert County Health Department on youth tobacco cessation programs.

In FY 2005, CMH completed a thorough strategic plan that explored demographic changes within the community it serves, technology innovations that would enable CMH to bring additional services to the area and meet the anticipated health care demands from the community. This strategic plan identified four major clinical areas that should be the focus of future service line development including: orthopedics, cardiovascular services, cancer services and maternal/child services. CMH continues in FY07 to develop programs and facilities in these areas that span the continuum from disease prevention, early detection, diagnosis, treatment and support which are available to our community.

## 2. Were hospital staff and leadership involved in developing the plan?

Throughout the planning process both hospital staff and leadership were integral players in developing the annual plan as well as the strategic plan. Staff input was solicited for the hospital’s mission and vision statements as well. These recommendations were presented to the executive management team and CEO of the institution. Once that approval was received, the goals were presented to the hospital’s Board of Directors for approval and funding.

When the strategic plan was developed, physicians, staff, administrators and hospital affiliates were invited to focus groups to discuss community needs. Individual meetings were held with physicians who were unable to attend focus groups. The Board of Directors reviewed and discussed the draft strategic plan at a Board retreat and formally adopted the plan at a subsequent Board meeting.

## **Community Needs Assessment**

3. Does the hospital's plan target specific areas of community need?

There are several specific areas of community need that direct the hospital's focus. These areas include cardiovascular services, orthopedic services, oncology services and maternal-child health services. Development of additional services and enhancement of current services within these areas were a focus in FY07. Two examples of these new services include the pediatric hospitalist program within the maternal-child health service line and development of a vascular services partnership with the Washington Hospital Center which was actually implemented in early FY08.

CMH uses recommendations from the Calvert County Community Health Improvement Roundtable to plan for future services. The areas that were focused on in FY07 from Roundtable recommendations were obesity, adolescent health, dental care for children and elderly care and end-of-life care.

Care for the uninsured of Calvert County's service area continues to be a priority for CMH. In order to reduce inappropriate utilization of the Emergency Department and to improve access to primary care services, CMH submitted a proposal to the Maryland Community Health Resources Commission which was awarded in February 2007. CMH also is a major partner in Calvert HealthCare Solutions whose mission is to address the health care needs of the uninsured in the community.

4. Did the local health department 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.

Calvert County is fortunate that the local health department and the hospital share the same campus. The health department utilizes its own community assessment to identify projects of priority for their organization. This facilitates an effective partnership on projects that require joint collaboration for success. For example, the hospital and the local health department collaborate on the "Improved Pregnancy Outcome Program" initiative. In FY07, this initiative continued to work on: 1) review of medical records and maternal interview of those with low birth weight babies to identify potential interventional opportunities through community programs and services; 2) programs to address risks for low-birth weight babies such as a tobacco-cessation program for pregnant women, 3) improvement in communications between service agencies and health care providers and 4) education of mothers on preventive efforts to reduce incidence of preterm labor. The hospital and local health department also work together on tobacco prevention and cessation activities as well as join together on the county's colorectal cancer coalition. New this year is a collaborative project to provide tobacco cessation programs for teens in the community.

CMH is the chair of Calvert County's Community Health Improvement Roundtable which meets bimonthly to address local health needs. Members of the Roundtable include the local health department, county government, Calvert County Public Schools, Department of Social Services, and Office on Aging, Calvert County Hospice, Department of Juvenile Justice, Calvert Alliance against Substance Abuse, ARC of Southern Maryland and a clergy representative. The Roundtable conducts a formal community health assessment every five years. An assessment of secondary morbidity and mortality data was conducted in the spring of 2007 with the assistance of the Institute for Governmental Service, University of Maryland. In addition to this data, a community health survey project was developed with the assistance of the Schaefer Center for Public Policy at the University of Baltimore. The survey tool was piloted in FY07 with wide distribution in early FY08. Results of this new community health assessment will be available in FY08.

Calvert Memorial Hospital also identified community health needs through the following:

- Calvert HealthCare Solutions, which is a community-based initiative that focuses on access to care for the uninsured. CMH is a member of the governing board of this organization
- Board membership on local chapters of Hospice, American Cancer Society, American Red Cross and United Way.
- Partnerships with Calvert County Public Schools and the College of Southern Maryland for health care career initiatives
- Committee memberships with the School Health Advisory Board, the Office on Aging's Senior Summit and the County's Emergency/Disaster Planning Task Force.
- Statistical Data such as Census data for demographic trends and populations shifts, market share data for health service delivery trends, hospital discharge and readmission data, etc.

### **Community Benefit Initiatives**

#### 5. Does the hospital identify its Community Based Initiatives?

The hospital's community based initiatives are specifically identified in its annual goals and objectives. Examples are as follows:

- Develop and implement a faith-based ministry program. This program is coordinated by the Director, Community Wellness and currently has 13 churches representing over 6,700 parishioners. By establishing key health contacts in the local faith community and providing them with the tools they need to educate their congregations on health issues, conduct health screenings and help enroll people in health care services and programs, CMH is able to touch thousands of individuals personally and help them on the path to improved health.

- Expand clinical services offered at Twin Beaches Community Health Center to meet population needs – responds to needs for primary care services by the uninsured or underinsured in a medically underserved area. In FY07, a family practice physician was hired to provide office hours 20 hours/week. This is in addition to the family nurse practitioner who also provides 20hours/week of coverage to the Center. Grant funding was awarded in February to expand hours of service, case management and partnerships with Calvert HealthCare Solutions and the Calvert County Health Dept’s Mental Health Services.
6. Do the hospital’s community benefits initiatives reflect evidence-based needs? Please give one or two examples.

One area identified by the Community Health Improvement Roundtable, the hospital’s strategic plan, hospital discharge data and census data is the continued need for services to the elderly with health care issues. For example, Calvert County has only 2 nursing homes available to community residents and these facilities frequently have waiting lists. Often, patients needing transitional or nursing home care must be placed outside the community which is a burden to families. CMH provides temporary care between hospital and home through its Transitional Care Unit which reduces need for nursing home placements, keeping patients closer to their families and the community that supports them. Insurance reimbursements do not cover expenses associated with the operations of this unit so CMH continued to offset these expenses through its mission driven services.

In many counties, the local health department provides woman’s wellness services through Breast and Cervical Prevention (BCCP) program funding. In the past, there has been a shortage of OB-GYN providers in this county as well a state and nationwide for many years. As a result, priorities were placed on Obstetrics and acute GYN care. Waiting times for well woman (preventive or early detection) exams can exceed 6 months based on provider availability. As a result CMH determined it would be of community benefit to be able to provide disease prevention/early detection services through the use of a certified registered nurse practitioner. In Calvert County, the local health department was not interested duplicating services with CMH so it contracted with CMH for the BCCP program designed for women 40-64 who are uninsured and low income. After five years of success with this program, the Department of Health and Mental Hygiene (DHMH) together with the Calvert County Health Department (CCHD) decided to work directly with CMH for provision of services under the BCCP program in this county. In FY07, a proposal was submitted and successfully awarded for five more years of funding for the BCCP program at CMH’s Woman’s Wellness Center. CMH is one of only a few hospitals in Maryland that has this agreement with the state. In FY07, 797 women received these services at the Woman’s Wellness Center of which 312 were covered by the BCCP program.

CMH recognizes its role as a model for healthy behaviors in the community. Since many of the employees at CMH are also community members, CMH was concerned with smoking behaviors exhibited by its employees while at work. It was also concerned with the health impact of exposure to second-hand smoke from patients, visitors and employees on community members seeking services at its facilities. To respond to these concerns, CMH developed and implemented a smoke-free campus plan on June 1, 2007. In preparation for this event, free tobacco cessation programs were offered to employees and to the community. A media campaign was developed and implemented in the community. Presentations were made to community organizations. While it is not expected that all visitors will comply with this initiative, smoking on campus has been reduced as a result of this initiative.

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

The new Faith-Based Nursing Initiative that was implemented in FY07 is performance based. Calvert County has been identified as a strong faith-based community. CMH developed a faith-based ministry program and shared its services with areas churches to assist them with identifying unique disease prevention/early detection programs that improve the health of their specific congregation. Some are working with CMH in the development of blood pressure screening programs where medical professionals in that specific church are taught the fundamentals of blood pressure screening and stroke awareness. CMH provides the training and patient education materials but the church members conduct the program when appropriate for that specific population. CMH also provides related materials about community resources for the specific disease management – weight loss programs, tobacco cessation programs, exercise programs etc.

### **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?

Participation from the county's Community Health Improvement Roundtable has been essential in the hospital's planning of community benefits activities. Composition of members was presented earlier in this report. The hospital's Board of Directors are all volunteer community members and are key in providing financial support to these programs. A town meeting in partnership with the local health officer and an area physician was held at the local community college to solicit input regarding the health of the community as part of the community health assessment project. With this information along with the other data from the assessment, a community health strategic plan will be developed in FY08.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/implement its community benefits activities?

The hospital is a regular participant in numerous outside organizational efforts to plan/implement community benefit activities. One example is the key role CMH plays in Calvert HealthCare Solution's efforts to improve access to care for the uninsured. CMH is a member of its Board of Directors and assists in guiding program development and implementation. In October 2006, a grant request of \$500,000 was submitted to the Maryland Community Health Resources Commission by CMH in collaboration with Calvert HealthCare Solutions and the Calvert County Health Department's Mental Health Division to expand services to the uninsured in our community. CMH provides free basic diagnostic services (lab and x-ray) to those enrolled in Calvert HealthCare Solutions through its charity care program.

CMH is a partner in both the county's tobacco coalition and its cancer coalition that are coordinated by the local health department. The hospital provides the room for its quarterly meetings as well as staff resources to the programs that are offered through the coalitions. New in FY07 is the teen tobacco cessation program that the health department funds but CMH provides the educators.

The local school system has started to address the childhood obesity problem by looking at the school food programs offered on its campuses. CMH continued to provide both health educators and dietitians to assist the school system with review of its programs and in teacher training. A \$10,000 grant, received from the American Cancer Society in FY06, has resulted in more programs in which CMH collaborated with Calvert County Public Schools to improve nutrition education and exercise for all school age children with a goal of addressing obesity issues with children and families.

### **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?

Within the hospital's annual goals and objectives are sections of assigned accountability and responsibility by the Board of Directors, Administration, Management and Staff with individual names attached. Quarterly reports are due for each component of the action plan. In addition, all providers of community-benefit activities are required to complete activity reports on numbers served by program, staff resources and any revenue offsets. Within the Clinical Services Division, a staff member is assigned to collect this data throughout the year and prepare the required annual community benefit report.

Statistics are maintained by the Community Wellness Department for all community education and outreach programs, screenings and support groups. Each department manager is responsible for providing administration with annual reports on their department specific programs.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

The hospital leadership is kept informed as to progress and results of the community benefits program through a variety of methods. The hospital's president prepares an annual report for the Board of Directors which highlights these initiatives. Additionally, throughout the year, there are Board education presentations on specific community benefit initiatives as well as presentations to special committees such as planning and marketing with more program specific information. Department managers meet monthly and are provided updates on community benefit programs. Several times a year, the President holds round-the-clock meetings to inform all staff of current hospital and community benefit activities.

The community is kept informed as to progress and results of community benefits programs through a variety of hospital printed materials. For example, CMH publishes a yearly calendar that includes its annual report. The hospital also publishes an annual cancer report that informs the community about cancer services available at CMH from prevention and early detection to treatment and living well with cancer in conjunction with its support groups. CMH's quarterly newsletter, Healthy Outlook, is mailed to all county households and provides community benefit updates, educational articles and resources on a variety of topics as well information about specific services available at the institution. With such a rapidly growing community as Calvert County, this information assists new residents with accessing healthcare within a reasonable travel distance.



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## **Evaluation Framework Proposal FY 2007**

### Community Benefits Planning

As the leaders of Carroll Hospital Center determine what services we will provide or plan to add, what screenings we offer, what classes we teach or what other outreach programs we want to develop, we always move forward with community needs in mind. Part of our newly revised vision and mission state that we are to be responsive to the needs of the individuals in our service area and maintain focus on improving the health, wellness and quality of life of those we serve. The leadership of Carroll Hospital Center is actively engaged in all phases of the decision-making process as it relates to community benefit. Their commitment is evidenced by the programs, services and leading-edge technology that they continue to make a priority for our organization. Examples of this include dedicated and expanded staff in The Women's Place and The Learning Center—two departments whose primary focus is health education, screenings, support groups and wellness promotion. Both departments continue to expand in terms of staff, staff hours and offerings.

### Community Needs Assessment & Community Benefits Initiatives

Through a variety of community partnerships, Carroll Hospital Center has been able to identify, track and trend the salient health care needs in the community. Another affiliate of the hospital, The Partnership for a Healthier Carroll County, Inc., which was initiated by the hospital in partnership with the Carroll County Health Department after a comprehensive community needs assessment in 1997, continues to carry on the work of helping to identify where our community benefit efforts should best be directed.

The ongoing work of The Partnership to collaborate with community groups, service organizations and other health-minded work groups helps Carroll Hospital Center keep its "finger on the pulse" of which community health care needs are the most important. In 2006, the hospital, through The Partnership, was instrumental in updating a 1995 health indicators study. The study focused not only on the delivery and access of health care, but served as a broad based assessment of progress and gaps from the original study. Many of the areas identified in the study continue to be areas of concentration for Carroll Hospital Center—the uninsured and access to health care, availability of behavioral health services, health promotion and screenings.

In particular, our behavioral health services are continually expanding to meet the diverse needs of those with mental illness and addictions issues. Whether it's an inpatient stay or an intensive

outpatient program or support group, Carroll Hospital Center offers a variety of programs to address the growing and constantly changing needs. In fact, through a grant provided by the Carroll County Children's Fund, our transition program for teens transitioning back to school after psychiatric treatment was just expanded to a full-time program because of the need.

Another innovative program the hospital offers to address one of the other measured areas—substance abuse—is our Emergency Room Nurses Care (ENCare) program. With ENCare, Emergency Department nurses go out into the community and help teach school age children about the consequences of drug and alcohol use.

The Partnership, with support from the hospital, is currently working on an Elder Health Needs Assessment to be conducted in the spring of 2008. The comprehensive study will provide a variety of information about the needs and perspectives of the senior population in our primary service area. The findings also will be used in determining future program and service development for seniors and their caregivers.

One of our most far-reaching community benefit initiatives continues to be Access Carroll, Inc., a provider of primary health care for uninsured residents of Carroll County. The number of people who had no access to health care and no health insurance was apparent through the updated study referenced above and by cases noted by the local health department and in our Emergency Department. Through a partnership with Carroll County Health Department, Carroll Hospital Center initiated the push to create Access Carroll, Inc. in 2005. To stay in operation, Access Carroll draws on the resources of the community for office space, staffing, physicians, nurses and all of its supplies. In its second full year of operation, Access Carroll had 4,477 patient visits, up 48.4% from FY 06, and for the same time period, physician, nurse and administrative volunteers clocked over 3,119 hours of service.

Also this year, our affiliate, Carroll Hospice, celebrated its first year of providing inpatient care for hospice patients in its new eight-bed hospice house, located on the hospital property. In FY 07, Carroll Hospice provided 494 patient days of care in its inpatient facility and conducted 14,676 home-based visits, regardless of a patient's ability to pay. Carroll Hospice also expanded its support services offered to patients and their families through its bereavement center.

### Community Collaboration

Carroll Hospital Center maintains an open and vibrant relationship with the Carroll County Health Department and other community groups and organizations as we plan our community benefit activities. Nurse educators from The Learning Center conduct no-cost or low-cost screenings for blood pressure, cholesterol, diabetes, osteoporosis and other conditions at area churches, libraries, post offices and shopping centers. Similar education programming, as well as support groups and classes are offered through the hospital's women's center. Physicians and nurse educators who participate in our Speakers Bureau are frequently requested by community organizations to present on a wide range of health-related topics that meet the education needs of our community members, always free-of-charge. Hospital associates also participate in many area fairs, festivals and conferences, in addition to being the lead organizer for the Family Health Festival held each October for the last 20 years.

For every program, screening and class, participants are asked for feedback on the usefulness of our programs. In addition, we periodically survey our community by sending out 60,000 surveys to measure interest and preference in classes, programs and screenings, as well as days and times to offer them. We evaluate this information so that we can tailor our future programming to meet as many community benefit needs identified as possible.

This year, to meet the growing health care needs of one of our bordering cities, Carroll Hospital Center ventured into an unprecedented agreement with a competing hospital, Frederick Memorial Hospital, establishing Mt. Airy Health Services. A jointly operated satellite medical office building offering physicians, specialists and advanced health care resources to the Mt. Airy community, the initiative will better serve the Mt. Airy community by providing the care they need, close to home.

Another serious, ever increasing dilemma facing health care organizations—in not only this region, but nationally—is the pool of skilled providers available to meet current and existing need. To help expand local capacity for clinical education, Carroll Hospital Center has previously worked closely with Carroll Community College, the local community college, to develop its nursing program. Additionally, through very close collaboration with several local colleges, including Villa Julie; University of Maryland; Carroll, Frederick, and Catonsville Community Colleges; as well as the Carroll County Career and Technology Center, Carroll Hospital Center provides clinical training for many of our future nurses and technologists, with hundreds of students completing their general and specialty clinical rotations here. In addition, various scholarships are awarded to nursing students to continue their education.

#### Community Benefits Implementation

Participation in and reaction to any and all programming provided by The Learning Center, The Women's Place, and at area screenings, fairs or conferences is monitored by the individuals in charge of each event or program. These individuals report the success to their supervisors who provide a full analysis of the impact of our efforts to leadership. This grassroots approach ensures that the opinions and needs of the people for whom the community benefits are intended are heard by the people who have the power to enhance or improve the benefit programming. Reporting is made informally through recurring staff interaction and formally through community conferences and board meetings. All of this information is used continually to enhance our offerings and be innovative in our approach of improving the health of the communities we serve.

Additionally, community benefit activities are tracked continuously through a comprehensive data base (electronic report included with this filing). Data is entered throughout the year to allow accurate monitoring of activity and management team updates. Goals to further improve community benefit collaboration for future years include the development of a formal community benefit plan and exploring the feasibility of conducting a more in-depth community assessment in partnership with the Carroll County Health Department and other local organizations.



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## **Community Benefit - FY 2007 Physician Subsidies and Gaps in the Availability of Specialists to Care for the Uninsured**

Like most hospitals, Carroll Hospital Center is challenged to provide care to an ever-increasing number of uninsured patients. Last fiscal year, 9,728 patients received some form of charity care/financial assistance from the hospital, totaling \$3,696,570. Assistance ranged from emergency, inpatient and outpatient care and testing that was written off, to free medicines dispensed at discharge and 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 the ED. That gap is most significant in surgical specialties including, orthopaedics, otolaryngology (ENT) and general 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 implemented two major, costly initiatives to address the gap proactively. First, the hospital currently 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 FY07, the expense to pay physicians for ED call has cost the hospital nearly \$600,000 annually.

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 call may help with the gaps in coverage, 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 FY07, Access Carroll had 4,477 patient visits, up 48.4% from FY 06. 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 second full year, Access Carroll has been very successful in helping their 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 physicians required to continue to provide adequate health care for all patients.

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. A private company was contracted to assist the hospital in conducting 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. Nearly \$5 million was spent in fiscal year 2007 in this effort.

## **CHESTER RIVER HOSPITAL CENTER COMMUNITY BENEFITS EVALUATION**

### **Community Benefits Planning**

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Chester River Hospital Center does not have a formal written community benefit plan; however, there is a very strong philosophy among the senior leadership and the Board of Directors that we have an obligation to improve the health of our community. Toward that end, part of our strategic plan calls for us to “play a more active role in community health and wellness” and specific action plans call for conducting a community health assessment, identifying partnership opportunities with other organizations that provide health and wellness programs and developing a community health and wellness plan.

2. Were hospital staff and leadership involved in developing the plan?

The strategic plan was developed by hospital staff and Board leadership with guidance from a planning consultant. The staff and leadership take ownership of the plan.

### **Community Needs Assessment**

3. Does the hospital’s plan target specific areas of community need?

With the information that will be provided through a health assessment within the next year, the tools will become available to help us target our efforts to make the best possible use of limited resources.

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.

Our local health department has not conducted a needs assessment in many years. We have discussed the possibility of working together to conduct an assessment which would give both of our organizations the benefit of the findings. Otherwise, needs are identified more informally through Board members who serve as community representatives and physicians on our medical staff who are undoubtedly the most knowledgeable individuals in our community regarding the local health care needs.

### **Community Benefits Initiatives**

5. Does the hospital identify its Community Based Initiatives?

Two of the hospital’s specific priority community benefit initiatives at this time are working with other community organizations to address issues related to mental health and playing a leading role in the community in terms of disaster preparedness.

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

Mental health initiatives are related to the increase in the number of psychiatric patients visiting our Emergency Department, the increase in the severity of these cases and the increased length of stay.

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

The initiatives are performance based, and the disaster planning initiatives involve process measures while the mental health initiatives involve outcome measures.

### **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?

As discussed in questions 6 and 9 the hospital works closely with other community organizations to address community needs. The community at large is represented by Board members in the governance process. This is an area where we have an opportunity to improve.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

The hospital is an integral part of the community and works on an ongoing basis with other community organizations including local schools and colleges, the Local Emergency Planning Committees for Kent County and Queen Anne's County, both county health departments, health associations such as the American Cancer Society, American Heart Association, etc. Representatives from Administration and clinical departments serve on various task forces and coalitions to address community needs.

### **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?

Since we are now required to develop an annual community benefits report the evaluation and monitoring process is becoming more formal. The Vice President, Development & Communications is assigned responsibility for monitoring the plan.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

We communicate the community benefits the hospital provides to the public through community newsletters, publicity, speaking engagements and other types of communication programs. The Board of Directors is kept informed through reports and updates at Board meetings; there is an increasing awareness of and interest in the topic among Board members.

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### **CHESTER RIVER HOSPITAL CENTER GAP ANALYSIS**

According to the most recent formal physician needs assessment conducted by our hospital, 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  
Obstetrics  
Neurology  
Psychiatry  
Ophthalmology

For additional information please contact:

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***CIVISTA MEDICAL CENTER'S  
FY 2007 COMMUNITY BENEFITS EVALUATION  
SUBMITTED: DECEMBER 28, 2007***

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- **Community Benefits Planning**

1. *Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?*

We do not have a separate community benefit plan. Several objectives featured in our strategic plan deal specifically with community benefits. Part of our mission is to foster a healthy community by providing service, education and access to care in concert with other community organizations.

One of our strategic objectives is to design services in accordance with community health needs, including cancer, cardiovascular disease, infant mortality and women's health. Another objective is to evaluate strategic partnerships and alliances with other health care providers to meet community needs.

2. *Were hospital staff and leadership involved in developing the plan?*

Both staff and leadership are involved in the development of the organization's strategic plan including areas dealing with community benefits. Staff regularly shares feedback and ideas on programs and areas of community need with their managers and supervisors. The Board of Directors is regularly updated on community-related activities and their feedback is also solicited.

- **Community Needs Assessment**

3. *Does the hospital's plan target specific areas of community need?*

Civista's strategic plan and community benefits activities do target specific areas of community need. We work closely with the Charles County Health Department and

Partnerships for a Healthier Charles County in identifying the major health-related needs of the community. Areas identified as requiring attention in Charles County include: cancer, chronic disease (like diabetes, cardiac, and obesity), motor vehicle accidents, mental health, infant mortality/pre-maturity, and substance abuse.

4. *Did the local health department 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.*

In FY 2006, the hospital and Charles County Health Department commissioned a needs assessment for Charles County. The hospital and health department both serve as steering committee members for a group called Partnerships for a Healthier Charles County (PHCC). This group works diligently to improve the health of the community. Collaboration is key to the success of this group. Workgroups exist for the following topics: chronic disease, cancer, motor vehicle safety, substance abuse and mental health.

The needs assessment done in 2006 affirmed that the PHCC group continues to target the top health-related issues for Charles County. Leading causes of death for Charles County include: Cancer, Heart Disease, Chronic Lower Respiratory Disease, Cerebrovascular Disease, Accidents and Diabetes. These areas are on the radar screen for both Civista and PHCC.

- **Community Benefits Initiatives**

5. *Does the hospital identify its Community Based Initiatives?*

Yes. Our initiatives are included within our strategic plan. Upcoming screenings, classes, programs, etc. are advertised to the community in a variety of ways to invite them to participate including: in print ads, in our community newsletter, on our website, and are listed in a calendar we mail out upon request to community members and local organizations.

6. *Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.*

Charles County has a higher cancer rate than the state of Maryland. As such, cancer education, prevention and treatment are one of our primary goals. Three activities that we sponsor faithfully each year focus on seeking early treatment when cancer symptoms are found, celebration of cancer survivorship, and detection of prostate cancer. In June of each year, we sponsor the Cancer Survivor's Walk which serves as the opening of the Charles County Relay for Life event. Over 200 survivors join us each year to kick on the Relay for Life. We sponsor this particular activity to emphasize the fact that people do survive cancer and that individuals should seek treatment. Surviving Cancer: A Photographic Essay held each October in conjunction with breast cancer awareness month features breast, colon and prostate cancer survivors and their stories of the disease from discovery through recovery. In FY 2007, 18 cancer survivors were highlighted in the display. Cancer detection guidelines are included in

the exhibit and health information is provided to visitors the day the exhibit opens at the local mall. Finally, each September, we sponsor a prostate screening for men in our community. In FY 2007, 112 men participated in Civista's free screening.

7. *Were the initiatives performance-based and did they involve process and/or outcome measures?*

Most of our initiatives involve outcomes measures. For example, we know that we screened 187 men at the September 2005 prostate screening; 39 men received abnormal PSA results and 3 received abnormal DRE results. All results were sent back to the participants along with instructions to visit their physician for follow-up.

- **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?*

Civista Medical Center regularly involves other organizations and community members in the planning of our community benefits activities. As an example, the Civista Women's Health Center has an advisory group made up of women from the community who help to plan classes and events that are offered to the public. The committee is comprised of a diverse group of women to help ensure all needs are being considered. Civista also works closely with Chesapeake-Potomac Home Health Agency in arranging for flu shots for the community.

9. *Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?*

We have participated in numerous community efforts aimed at improving the health of the community. Since 1993, we have participated in a group called Partnerships for a Healthier Charles County. This group is made up of four steering committee members consisting of Civista Medical Center, Charles County Health Department, Charles County Public Schools and College of Southern Maryland. Another 40 – 50 organizations participate in this group with the goal of creating a healthier community. Many of our activities are tied into the key areas of focus of Partnerships (mentioned previously). Rather than duplicating efforts out in the community this group works together and supports one another in improving the health of the community. Goals are set and worked on within subcommittees and progress is report quarterly. In addition to PHCC, Civista sponsors the health-related efforts of many other organizations. Some examples are Civista teams at the annual March of Dimes walk, Alzheimer's Walk and Relay for Life. Civista also asked its management and staff to participate with other organizations by volunteering or serving on their Board of Directors. Examples are: Charles County Nursing and Rehabilitation Center, Hospice of Charles County, Health Partners Clinic, United Way, etc. These organizations all impact the health of community members. We are very accustomed to working with other groups to implement our activities which are aimed at improving community health.

- **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?*

Activities and corresponding outcomes are reported monthly to our Board of Directors by our President and CEO.

*11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?*

Yes. Activities are reported to hospital administrators weekly and department managers several times per year. Information on Civista's community benefits activities are reported to the community through the quarterly meetings of groups like Partnerships for a Healthier Charles County. Civista's annual report regularly includes information on the organization's community benefits activities. Civista's Board of Directors also receives regular updates on community benefits activities and occasional educational presentations on the topic.



***FY 2007 COMMUNITY BENEFITS ACTIVITIES BY DATE***

<b>Activity Name</b>	<b>Dates</b>
<b>Baby Care</b>	7/8/2006 8/5/2006 9/16/2006 10/14/2006 11/25/2006 1/13/2007 2/11/2007 3/10/2007 4/14/2007 5/12/2007 6/9/2007
<b>Breastfeeding Basics</b>	8/26/2006 10/7/2006 12/2/2006 3/3/2007 4/28/2007 6/2/2007
<b>Cancer Survivors Walk</b>	6/9/2007
<b>Career Days</b>	Various days
<b>Charles County Government Health Fair</b>	5/2007
<b>CPR Recertification for Healthcare Providers</b>	Monthly
<b>Diabetes Education Fair</b>	10/28/2006
<b>Finicky Kids, Frustrated Parents</b>	3/7/2007
<b>Glucose Meter Trade Out Day</b>	10/12/2006
<b>Information Night for Weight Management for Women</b>	8/31/2006 1/4/2007 5/3/2007
<b>Lowering Cholesterol Class</b>	7/25/2006 8/2/2006 9/26/2006 10/2/2006 11/6/2006 2/26/2007 5/29/2007
<b>Matters of the Female Heart Screening</b>	2/10/2007

<b>Mindful Yoga</b>	1/17/2007 4/18/2007 6/13/2007
<b>Pandemic Flu: Is your family ready?</b>	10/18/2006
<b>Parkinson's Disease Support Group</b>	9/23/2006 10/28/2006 11/18/2006 12/2006 1/27/2007 2/24/2007 3/24/2007 4/28/2007 5/2007 6/23/2007
<b>Prostate Screening</b>	9/19 and 9/20/2006
<b>Senior Driving</b>	9/9/2006 10/7/2006 11/11/2006 2/17/2007 3/17/2007 4/21/2007 6/16/2007
<b>Sibling Class</b>	7/23/06 8/20/2006 9/17/2006 10/29/2006 11/26/2006 12/10/2006 1/21/2007 2/18/2007 3/18/2007 4/29/2007 5/26/2007 6/24/2007
<b>Sight Saving, Low Vision Seminar</b>	10/14/2006
<b>Surviving Cancer Exhibit</b>	Health Fair 10/2/2006 On display in Community 10/2/2006 – 11/2/2006
<b>Yoga Classes</b>	2 times per week
<b>Yoga I Foundations</b>	9/11/2006 11/6/2006 1/22/2007 4/2/2007



***GAPS IN THE AVAILABILITY OF SPECIALIST PROVIDERS  
TO SERVE THE UNINSURED IN THE HOSPITAL***

Civista Medical Center is currently recruiting for several specialists including: a General Surgeon, OB/GYN, and an Orthopedist. These gaps have been identified for the community at large. A recent report, December 2007, from Maryland Hospital Association and Maryland Med Chi have identified Southern Maryland as a region with the greatest shortage of physicians.

## Community Benefit Evaluation

### Community Benefits Planning

Doctors Community Hospital includes community benefit programs as part of the strategic planning process. This process involves hospital staff, hospital leadership and other community members.

### Community Needs Assessment

Doctors Community Hospital has continued to identify and target gynecological and breast cancer awareness and education, diabetes screenings, diagnosis, treatment, education, fitness and medical management, stroke prevention education, blood pressure & cholesterol screenings and prostate cancer screenings as specific areas of need in our community.

We identified these needs through use of demographic risk analyses as well as CDC, NIH, ZYNX and other health risk assessment resources.

### Community Benefits Initiatives

Our community based initiatives are women's health education and screenings and education for diseases for which the community is at higher risk due to demographics

We used actual hospital discharge data (Maryland and Washington, D.C.) for epidemiology benchmarking for greater risk. Our programs are focused on women's health and wellness, prostate cancer screenings, blood pressure, cholesterol and diabetes screenings at multiple events/venues. We provide an extensive wellness program for individuals over 50 years of age called OASIS. This program provides educational, fitness and self help programs on a daily basis.

These initiatives were based on data and satisfaction measurement through surveys with 83% return rate. Screenings outcomes were tracked and benchmarked for positive results requiring referral to provider for treatment. Patient outcomes were tracked in the diabetes program, C-PORT, breast cancer and joint & spine surgery, to assess outcomes and need for further intervention if patients don't meet criteria.

### Community Collaboration

Doctors Community Hospital utilizes the members of our pastoral care program, local churches, schools and community based organizations, such as, the American Cancer Society, Bowie Chamber of Commerce, Bladensburg and Greenbelt Rotary Clubs and the City of Greenbelt and New Carrollton to both plan and implement many of our community benefit activities.

The hospital has also worked with the Prince George's County Health Department and health action groups (Diabetes awareness campaigns, breast cancer awareness campaigns, and

the American Heart Association, Lymphoma & Leukemia Society, the American Cancer Society and others)

### Community Benefits Implementation

The community benefit programs/plan are monitored by the Vice President of Planning. The Community Relations staff track attendance and outcomes that are reported to the Board of Directors annually.

### **Gaps in availability of Specialist for the uninsured**

Doctors Community Hospital has specialists available for referral and services while the patients are hospitalized or in the Emergency Department in all specialties except plastic surgery.

The hospital continues to find that the issue is not necessarily that we do not have specialists to refer uninsured patients to for follow-up; the problem is that many of the specialists request that the patient pay up front prior to receiving follow-up or referral services.

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**Beds: 37**

**Submission Date: December, 2007**

### **Executive Summary**

During reporting year 2006-2007, Fort Washington Medical Center (FWMC) provided benefits to the community that included charity care, teaching-preceptorship opportunities, health screenings, community health education, community sponsorship opportunities, disaster preparedness and hospital strategic planning activities.

These contributions amounted to \$646,657 in community benefits, an increase of 12% or \$67,454 from FY 2006. The benefits were in four areas: (a) increased participation in nursing and allied health preceptorship programs; (b) charity care reporting (c) increased health screenings in part with community organizations and (d) increased community awareness.

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

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

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

### **Expand Capacity to Meet Community Needs**

In FY 2005-2006, FWMC undertook a feasibility study to determine the community’s viability in supporting a hospital expansion project. In this

reporting year, FWMC has continued to work with outside counsel to develop a case for community support for a capital expansion program. Community leadership, including local churches, community and civic associations, businesses and community leaders has been approached about this effort.

In early 2007, FWMC began meeting with community and civic associations on the project; and in June, hosted the first of what will be on-going meetings with Prince George's County clergy around the issue of expansion, but also on issues surrounding the transformation of the region's healthcare, sparked by the National Harbor. In this reporting year, a bond of \$560,000 has been awarded by the State to support the initiative. FWMC must raise matching funds to meet this obligation.

Under the expansion initiative, the hospital will increase the size of its Emergency Room from 14 bays to 21; 51 new single occupancy rooms, a change from 37 double - occupancy beds; expand spaces for other services, including the Radiology Department, the laboratory, and pharmacy; and an increase in the size of the surgery suites. In addition, the cafeteria will be expanded to allow for food preparation on-site, and areas will be developed for community education. Currently, the only site available for community education is the cafeteria. The capital expansion is scheduled to take place from 2008 to 2010.

### **Maintain Clinical Excellence and Improve Community Health**

To carry out the goal of "Maintain Clinical Excellence and Improve Community Health," FWMC has carried out this mission through the publication of the community newsletter "Healthy Vision" and to engage strategic partners. The newsletter, published in August 2006, featured its strategic health partners. The goal of the newsletter is to come out twice a year, and is circulated to 15,000 households in the Fort Washington service area, including the towns of Fort Washington, Oxon Hill, and Temple Hills, Maryland.

The strategic partners include the American Heart Association, American Lung Association, YMCA-Potomac Overlook, the American Red Cross, Harmony Hall (Maryland Parks and Planning), and the Prince George's Health Department (PGHD).

The Health Department has been 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, plan the 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 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 promotion of the program is carried out by FWMC.

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 organization 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 Health Department, featured in the Healthy Vision’s newsletter, provides key services at a health fair held at FWMC during this reporting period. During the fair, the Health Department co-sponsored along with the hospital for the community a presentation on “Preparing for the Pandemic Flu.” The community campaign was supported also by the Maryland Hospital Association.

The Hospital continued to work with its strategic partners, including the American Lung Association (ALA). Members of FWMC’s Respiratory Therapy Department coordinated participation from FWMC for ALA’s Annual Asthma Walk, held in May 2007 at the National Mall. The purpose of the walk is to raise awareness and funds to support programming that will help improve the health of more than 160,000

children in Maryland and the metropolitan area diagnosed with asthma. The walk is one of several activities planned with ALA, including annual workshops on asthma and other respiratory conditions.

The American Red Cross (ARC), Greater Chesapeake and Potomac Region, has begun working with Fort Washington Medical Center on a regular basis. In FY 2005, one blood drive was held. In FY 2006, a total of six blood drives were held, roughly every 50 to 55 days, thereby increasing blood capacity, a tremendous benefit to the community at large. FWMC's partner in the effort was the YMCA Potomac Overlook, which contributed space and manpower to provide further visibility to the drives, and to increase community access.

The YMCA also works with FWMC to coordinate health fairs at its facility, as well as participation at the television-sponsored NBC4Your Health event, held in Washington, at the D.C. Convention Center. For that event, FWMC medical personnel were available to work and talk to fair participants about health matters. The YMCA through FWMC, has worked with the Prince George's County Links, to provide weekly health education and fitness instruction, for a cardiovascular program launched in April, 2007.

### **Community Training/Preceptorships**

Fort Washington Medical Center's teaching – preceptorship program continues to be a major portion of community benefit. In reporting year 2006-2007, nursing and allied training preceptor - ships have increased at FWMC. During this reporting period, **91** 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.

### **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 2008 to do an update of the FWMC strategic plan, which includes a formal community needs assessment and an evaluation of the program overall.

**Franklin Square Hospital Center**, a 357-bed community teaching hospital located in the Rosedale section of Eastern Baltimore County, Maryland, is committed to providing the highest quality healthcare and education to our communities based on SPIRIT values: Service, Patient first, Integrity, Respect, Innovation, and Teamwork. FSHC services are provided via six service lines including Medicine, Surgical Services, Women's and Children's Services, Behavioral Health, Oncology, and Community Medicine and Wellness, as well as a wide range of sub-specialty services. Comprehensive oncology services, including CyberKnife, are provided locally at our Harry & Jeannette Weinberg Cancer Institute. Affordable health care is made available through the Primary Care Center and the Family Health Center, both of which work collaboratively with our Residency programs in Family Practice, Internal Medicine and OB/GYN. Clinical sites, faculty, and workforce development support professional education for a wide range of healthcare providers – nursing, technicians, and support services.

The Community Service line coordinates all of the community programs the Hospital provides to the surrounding area including, but not limited to, health education and screenings, child abuse prevention, smoking cessation programs, and wellness activities. The Community Health Education department coordinates community education and involvement including over 1000 health and wellness events for more than 30,000 participants each year. These activities were taken into the community at businesses, schools, faith communities, community centers, after school programs, Senior Centers, shelters, civic organizations, educational centers, malls, retail centers, and health departments.

**Demographics** Franklin Square Hospital Center's primary service area includes sixteen zip codes from eastern Baltimore City thru eastern Baltimore County and extending up to southern Harford County, adjacent to the Chesapeake Bay. This area has a large base population of approximately 518,000, and is projected to grow by 3.6% in the next five years, to about 537,000. Baltimore County has become a much more diverse community over the past few decades. The area can be described as blue-collar, high-school educated, and economically depressed, with a diverse population consisting of Caucasians (83.8%), African-Americans (11.8%), Asian/Pacific Islanders (2.0%) and Hispanics/Latinos (1.5%). Half of the population is either very young or senior with 25% children under eighteen years old and 17% over 60 years old.

Poverty is a significant problem in Eastern Baltimore County. County statistics show that the median income in the Essex Middle River area of \$36,439 is much lower than the county average of \$50,667. 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.

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

**East Baltimore Assessment Coalition** Franklin Square has led, and financially supported, the Southeast Area Network of providers in conducting a community needs assessment of the health and well-being in the southeastern portion of Baltimore County. The purpose of this project was threefold: (1) assess current health and well-being in the southeast area; (2) identify discrepancies in service needs and outcomes among area residents; and (3) devise a strategic plan for correcting

these discrepancies. In 2007, we will publish the resulting action plan for developing coordinated and collaborative efforts and investing in economic and social resources in ways that improve the health and well-being for all of southeast Baltimore County's residents now and in the future.

**Child Abuse Prevention Services** Franklin Square Hospital evaluates over 300 children who have been suspected of being abused each year. Children in Eastern Baltimore County are almost 50% more likely as children in the rest of the county to be abuse victims. After reviewing cases of children who were injured and treated in the Emergency Department (ED), it appeared that many were not receiving complete evaluations and cases of child abuse were possibly being missed. Additionally, in a two-year period from 1998-2000, five children who were born at Franklin Square returned severely injured from Abusive Head Trauma (AHT). In response to the increased incidence of abuse, the Department of Pediatrics developed a comprehensive approach to diagnose and prevent child abuse. The Franklin Square Hospital Child Protection Team (CPT) began to function in November 2000. The leaders of the CPT are a Social Worker Coordinator, the Medical Director, and on-call social work and medical staff. The team provides 24/7 coverage to the Hospital and evaluates any child who is suspected of being physically or sexually abused. In 2002, a three-pronged prevention program began. The primary focus for the prevention of AHT includes educating all newborn parents about the dangers of shaking infants and giving them strategies to cope with a crying infant. Each parent of a newborn receives a brochure and signs a statement acknowledging the dangers of shaking infants. They are encouraged to watch a video on coping with a crying infant. The other two programs include parent education classes and daycare provider education classes that focus on discipline techniques without the use of violence. These programs are done in collaboration with local non-profit organizations (The Family Tree and Child Care Links).

**Impact:** The child abuse programs have served thousands of children and parents since its inception in 2000. The CPT has evaluated 1500 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.

**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 nearly 13% of all principle diagnoses at Franklin Square Hospital in 2005.

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

**Impact:** In FY 2006, over 2000 people were screened at more than 100 events. At each event, an average of half of the participants are identified as hypertensive; a few are advised to take urgent action. For those who do take action, stroke, heart attack and renal failure may be prevented. In addition to avoiding the toll of human suffering, thousands of dollars in emergency and rehabilitative care may be saved.

*Per Halstead Academy Nurse: "Last year, when you screened one of our Teacher Assistants, her blood pressure was high. You counseled her about monitoring her BP and signs to contact her doctor. One day, she came to me with a headache. I took her BP and found that she was in hypertensive crisis. She went to her doctor and is now under control. Thanks for being here to help."*

**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 adults), and Stop Smoking Today (adult smoking cessation). Additionally, we provide Hospital staff training in tobacco cessation counseling.

**Impact:** Tobacco education programs, sponsored by Franklin Square, directly influenced over 2200 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). 95% of these "Tourists" 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.

54% of all youth found smoking on school property who participated in Tobacco Choices, an after-school tobacco intervention program stated that they learned something new about tobacco use. All (100%) the teens in the ALAM Not On Tobacco (NOT) programs to provide youth with the skills to stop smoking. found the program helpful in quitting smoking.

The adult cessation program, Stop Smoking Today, is a three or four session series that combines acupuncture, Shiatsu massage, Deep Relaxation with Guided Imagery and traditional behavioral modification. These classes reached 100 adult participants of diverse backgrounds and medical issues including pregnancy at local sites (a long-term homeless men's shelter, Nehemiah House, a large retirement complex, Oakcrest Village, and Chase Elementary School) with a last class quit rate of 49% for 2005-6 year. Ongoing quit rates 1-month post classes are 28%. *Joan O., class*

participant, "This past July 5 was one year that I am smoke free; just wanted to let you know how much you helped me."

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.

**Gaps in the availability of specialist providers to serve the uninsured in the hospital**

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

<b>Major HSCRC Category</b>	<b># Served</b>	<b>Net Benefit</b>
Community Health Services	234,902	1,616,979
Health Professions Education	168	10,967,570
Mission Driven Health Services		6,211,334
Research		813,687
Financial Contributions	355	557,368
Community Building Activities	1,356	61,116
Community Benefit Operations		280,796
Charity Care		7,760,000
<b>Total</b>	<b>236,781</b>	<b>28,268,849</b>

# FRANKLIN SQUARE HOSPITAL CENTER

## Community Benefit Report 2007

### Subsidies Narrative

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The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses to hospitals for services defined as subsidized care. They are defined broadly 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.”

The HSCRC has addressed how these types of services should be treated requiring that hospitals clearly explain the subsidies included within the report.

Included the Hospital’s 2007 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, OB Physician and Breast Surgery subsidies provides community services ensures adequate women’s services and primary coverage coverage for our community. Likewise, the amount in Emergency and Trauma ensures that the Hospital maintains adequate surgical call coverage for the emergency department. The subsidy makes up for the shortfall in payments in relation to the cost of providing 24/7 coverage. The Anesthesia Coverage subsidy amount in the report is associated with anesthesia services.

# Frederick Memorial Healthcare System Community Benefits Report FY 2007



## Frederick Memorial Healthcare System Community Benefits Report 2007



“I hereby declare “Project 2000” to be officially complete. We dedicate these buildings, and the healing, comfort and compassion that occurs within, to the memory of our founder Emma Smith, as a place to care for the sick, comfort the injured and provide peace of mind. May our second century of caring be guided by Emma’s principles, and may all who enter our facility be welcomed with the dignity and respect they so deserve.” With those words, Thomas A. Kleinhanzl, President and CEO of the Frederick

Memorial Healthcare System ushered in a new era of health care for the residents of Frederick County, and for the population of the entire region the Healthcare System serves.

After nearly 6 years of construction and renovation, the new Frederick Memorial Hospital stands in tribute to the dedicated men and women who enter everyday to care for their friends and neighbors; and to the \$30 million the community contributed to make the new facility a reality. The result is a brand new hospital, built to accommodate the ever increasing demand for hospital services and care, and the advanced technology and equipment that new procedures will surely demand in the 21<sup>st</sup> century.

The George L. Shields Emergency Department – three times the size of the old ED – was built to keep up with the 65,000 patients treated at FMH every year. The Billy Miller Neonatal Intensive Care Unit offers an environment in which our Johns Hopkins Neonatologists can care for newborns of only 28 weeks gestational age using the latest technology and instrumentation. The hospital’s all-private rooms provide the comfort, privacy and peace of mind that fosters recovery and recuperation. And the new operating room suites were built to house the equipment and technology necessary to perform advanced vascular and cardiac surgical procedures.

Now that the facility is complete, the Healthcare System is turning its attention to expansion of services and provision of care. The results of Frederick County’s first-ever Community Health Assessment clearly indicate that there are areas in the spectrum of service provision that must be addressed in relatively short order. The need for immediate intervention for patients presenting in the Emergency Department with a heart attack is of primary importance. The Maryland Health Care Commission has given permission to begin performing primary angioplasty – the emergency procedure performed to immediately restore blood flow to the heart muscle. The Healthcare System will partner with a group of Interventional Cardiologists – physicians who perform the life-saving angioplasty procedure – to bring this capability to the citizens of Frederick County in 2008.

The incidence of strokes, and other neurological disorders and disease, in our community is also on the rise. FMH will address these issues by establishing a Stroke Center of Excellence. Providing emergency intervention dramatically reduces the degree of motor and cognitive disability that often results from the effects of a stroke. Having on-site Neurologists to manage the early administration of clot-busting drugs, and to provide oversight of the rehabilitation process, will significantly improve stroke patient outcomes in our community. A primary function of the Stroke Center will be to provide stroke prevention education, and support for the victims of stroke and their family caregivers.

In the years to come, our community will face a number of healthcare challenges. FMH will step up to meet and address these community needs in cancer care, prenatal and childrens' health, heart disease, joint replacement, spinal surgery, mental health; and continue to provide wellness interventions in nutrition and weight management, diabetes education, and alternative therapies.

FMH will continue to seek opportunities to bring healthcare beyond the walls of the hospital and into the communities it serves. Free standing facilities offering rehabilitative services, imaging, and laboratory services; or clinics offering immediate care for non-life-threatening injuries or illness are just some of the service provision opportunities we continue to investigate. Whatever challenges the future of healthcare may present, FMH is equal to the task; confident that our community will continue to support our efforts with their generous gifts, valuable time, and remarkable talents.

Today's healthcare is more a collaborative effort between doctor and patient, community and hospital, than it has ever been before. Working together, as partners in the new millennium, we are poised to provide the latest technology medical science has to offer. As a healthcare institution, Frederick Memorial Hospital pledges to remain forever dedicated to providing that cutting-edge care with dignity, respect, and the kind of compassion that can only be delivered by the gentle touch of a neighbor's hand.

### **Our 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 and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

## **Community Health Assessment**

For the first time – ever – a community wide Health Assessment was performed for the Frederick community. 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. 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 will 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;
2. To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
3. To increase accessibility to preventive services for all community residents.

Areas of opportunity for community health improvement identified through the survey's data include:

### Access to Healthcare Services:

- Routine Medical Care
- Availability (Inconvenient Office Hours)
- Health Disparities (Low income and Minorities)

### Death, Disease & Disability:

- Heart Disease & Stroke
- Cancer
  - Colorectal Cancer (Deaths)
  - Prostate Cancer (Screening)
- Respiratory Disease
  - Asthma
  - Chronic Lower Respiratory Disease

Maternal, Infant & Child Health:

- Prenatal Care

Mental & Emotional Health:

- Alzheimer's Disease
- Emotional Wellness
  - Stress
  - Suicide

Modifiable Health Risks:

- Overweight & Obesity
- Alcohol Abuse
- Tobacco Use

## *The FMH Wellness Center*



The Frederick Memorial Healthcare System established The FMH Wellness Center in 1986 as a focused venue through which the hospital could partner with the community in a meaningful way to help maintain health, prevent disease, and facilitate access to treatment and care. What began as a simple community-outreach program focusing upon diabetes education and prevention, has grown into a freestanding Wellness Center that participates in health screening events, and initiates many community outreach educational programs, classes and seminars. The FMH Wellness center provides nutritional counseling, childbirth, parenting and sibling classes, safety and injury prevention programs, health education and complementary therapies such as acupuncture, massage, reflexology, yoga, pilates and tai chi.

### 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 the number one killer of kids age 0-14 years - unintentional injury. The FMH Wellness Center and the Frederick County Health Department are the co-lead agencies in Frederick County's Safe Kids efforts. The co-lead agencies conduct 10 annual meetings with representatives from all of the following 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.

- American Red Cross
- Child Care Choices
- Families Plus!
- Family Partnership
- Fitzgerald Auto Mall
- Frederick County Dept. of Fire & Rescue
- Frederick County Head Start
- 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.
- Frederick Peddlers
- Frederick Police Department
- Ft. Detrick First Steps Program
- Healthy Families Frederick
- Heartly House
- Kiwanis Club-Suburban Frederick
- Maryland Poison Center
- Maryland State Police
- Optimist Club
- Parent Power (Mental Health Association)
- State Farm Insurance
- US Fire Administration
- Volunteer Frederick!
- YMCA

In 2007, the following services were provided for the benefit of our community:

- **783** telephone consultations educating parents and caretakers about child safety issues
- **103** car seats rented to low income families or individuals having out of town guests with small children
- **662** individual car safety seat checks
- **37** law enforcement officers, firefighters & EMTs, and individuals from community agencies trained as child passenger safety technicians
- **32** child passenger safety technicians updated prior to their re-certification
- **2,581** residents reached including high school students in Highway Traffic Safety Programs
- **98** bicycle helmets distributed and fitted properly
- **67** children participated in 2 bicycle rodeos
- **188** children taught airway obstruction relief at 4 summer camp locations
- **800** elementary school students attended water safety assemblies
- **1,886** residents attended 10 community events about Injury Prevention. Three (3) of these events were held for ESL residents.
- **69** children received photo and fingerprint child identification packets
- **322** residents instructed in CPR and first aid courses

## **Cancer Prevention**

In FY 2007, the FMH Wellness Center was the recipient of two grants: The **Minority Outreach Technical Assistance grant (MOTA)**, and the Cigarette Restitution Fund Tobacco Cessation Grant.

The MOTA grant was used to coordinate and deliver outreach activities targeted to the African-American, Latino, Native American, and Asian Communities. MOTA programs reached a total of **4,525** people through attendance at **22** cultural events, and helped to provide **28** educational programs. Cultural events included:

- the open house of the Centra Hispano,
- the Asian New Year Event, and
- the African American honors program.

Educational programs focused on:

- prostate cancer,
- breast cancer,
- skin cancer,
- tobacco cessation, and
- general health for the targeted minority communities.

The Cigarette Restitution Fund Tobacco Cessation grant monies allowed 111 people to participate in smoking cessation classes, and helped to provide 103 smokers with one on one appointments with a Nurse Practitioner. Additionally, cessation material was provided to **90** Frederick County physicians, and **150** packets of cessation materials were provided to CorpOHS.

Community education efforts included participation in 3 major tobacco events:

- Kick Butt's Day,
- Great American Smoke-Out,
- World No Tobacco Day,
- 33 health fairs, and
- 16 minority health events.

Additionally:

- 266 participants in CPR classes and injury prevention programs received cessation materials, and
- 1,000 children and their family members received information at a bike safety fair.
- 3,000 brochures in Spanish and English were produced, and
- 2,000 magnets were distributed to the FMH Birthplace and Special Care Nursery addressing the hazards of second-hand smoke.

Total community events = **52**; total potential community members reached = **6,266**.

## **Medical Fitness**

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 disease states miss out on the healthy benefits of routine exercise because of the fears associated with the cardiovascular workouts. The staff at Medical Fitness consist 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

There are patients who have participated in the Cardiac and Pulmonary Rehabilitation program who cannot afford to continue to exercise in a medically supervised facility. The Medical Fitness program was provided free of charge to 21 patients in FY 07. These patients must attend the fitness programs regularly and be willing to make positive - and measurable - lifestyle modifications such as smoking cessation, weight loss, etc..

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.

## The FMH Emergency Department



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 106 years. The department and new facility were officially dedicated to the memory of George L. Shields in May of 2004. Generous support from the George L. Shields Foundation helped the hospital realize its ambitious construction and renovation goals for the new Emergency Department, which will provide care to over 67,000 patients this year alone.

The Shields Emergency Department is one of the largest emergency departments in the region. With over 24,000 square feet, the ED houses:

- 52 beds and treatments rooms
- 14 general-purpose rooms
- 9 Fast Track rooms
- 8 Kids Zone rooms
- 5 Crisis rooms
- 1 SAFE Room
- 15 Acute care beds (Includes 2 Trauma/Resuscitation Rooms)
- 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 six 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 Safe Coordinator, Kim Day, Rebecca Marrone, Tina Veith, Michelle Seavolt, & Kara Linthicum. 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. In response to a recent Sexual Assault in a Frederick county high school, our SAFE program coordinator was asked to be a featured presenter in a video about the program that will be shown to all the county high schools.

At the request of the Frederick County Sheriff, and the Brunswick and Frederick City Police Academies, this 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

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. 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:

- Camp David                      80 personnel
- Fort Detrick                      200 personnel
- Fort Meade                      50 recruits

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.

## **Clinical Pathology Laboratory**

Frederick Memorial Healthcare System's Clinical Laboratory provides FREE laboratory specimen testing and surgical pathology services to the Frederick County Mission of Mercy, and the Frederick County Health Department. Both of these organizations provide health care services to many citizens of Frederick County who are uninsured or under-insured. The clinical laboratory provides all of the instrumentation, reagents, and expertise necessary to analyze blood, urine, sputum – and other specimens as submitted.



## **FMH Oncology Services**

The Regional Cancer Therapy Center at Frederick Memorial Hospital has been treating patients in a comfortable and caring environment since 1989. The 26,000 square foot facility houses chemotherapy and radiation therapy programs as well as meeting rooms for community outreach, patient education and support. The Regional Cancer Therapy Center has been ranked in the top 100 in the United States by *Coping Magazine*. In 2006, the American College of Surgeons Commissions on Cancer awarded The Oncology Service program a three-year commendation approval. The award was for exceptional program performance that exceeded 36 standards set forth by the Commission on Cancer.

The Regional Cancer Therapy Center began providing Intensity Modulated Radiation Therapy (IMRT) treatments in 2005. The new technology has dramatically affected the lives of patients in our community by markedly decreasing the adverse effects of radiation on healthy tissues surrounding malignant tumors, and concentrating its destructive radiant energy beam only upon the cancer cells.

The Multidisciplinary Lung Cancer Clinic (MLCC), located in the FMH Regional Cancer Therapy Center, has been treating patients with suspected or newly diagnosed lung cancer since opening in February of 2004. The goal of the Multidisciplinary Lung Cancer Clinic was to reduce the amount of time between diagnosis and treatment from two to three months – the national average - to no longer than two weeks. Since the clinic has been in operation, we have met – and in most cases – exceeded that goal. We are one of only a handful of lung cancer clinics presently operating in the United States. We are very proud of what we have been able to accomplish, and how dramatically we have been able to enhance the quality of life for our patients.

The Regional Cancer Therapy Center's Coordinated Breast Services is a program that is approximately one year old. The goal of the program was to do for breast cancer what the Multidisciplinary Lung Cancer Clinic did for lung cancer. A dedicated breast surgeon, and a patient navigator have worked together to significantly reduce the amount of time from diagnosis to treatment. The diagnosis and treatment of the breast is managed with state-of-the-art technology, and compassionate, personalized care.

In 2008 FMH will bring on-line the newest, most advanced radiosurgery available: CyberKnife. The CyberKnife center is scheduled to begin treating patients in late February. CyberKnife radiosurgery is a radiation treatment that can be an alternative to open surgery in many cases. The CyberKnife System uses image-guided robotics to precisely and non-invasively destroy tumors and other lesions with multiple beams of high-energy radiation. CyberKnife radiosurgery is so precise that radiation can be matched to the shape of small complex tumors located near critical structures. This ability allows CyberKnife to treat many lesions that may be considered inoperable or untreatable with other radiosurgery systems.

## Support Groups

The Oncology Services program provides a wide variety of support groups for member of the community who are either being treated for cancer, or who are family members or close friends of our patients. The support groups are facilitated by the staff members of the Regional Cancer Therapy Center. The clinicians, nurses, technicians and social workers share their clinical expertise, offer suggestions for managing the disease and the treatment protocols, and encourage patients through the months of therapy and treatments by offering a forum for sharing common experiences and individual tips.

The support groups provide printed materials for the participants such as: brochures, pamphlets and fliers. Some are produced by the Regional Cancer Therapy Center, while others are purchased for distribution from national agencies and organizations.

## Community Benefit Programs

- |  |                                     |
|--|-------------------------------------|
| <b>1. Horizons Breast Cancer Support Group,</b>      | Monthly – 3 <sup>rd</sup> Thursday  |
| <b>2. Man To Man – Prostate Cancer Support Group</b> | Monthly – 4 <sup>th</sup> Wednesday |
| <b>3. Look Good Feel Better</b>                      | Quarterly                           |
| <b>4. Caregivers' Support Group</b>                  | Monthly – 3 <sup>rd</sup> Thursday  |

## **Training & Organizational Development Department**

### **Overview**

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.

### **Needs Assessment**

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. In FY07, FMH continued its partnership with the new nuclear medicine course at Frederick Community College, helping to fund the second year of this program. 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 experience 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 by regular contact with school faculty, the completion of a student evaluation, and 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 100 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.

## **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.
- **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.

Net Community Benefit figures include direct and indirect costs and are offset by related revenues.

Total Net Community Benefits for FY 2007, by category, are as follows:

<b>Community Benefit</b>	<b>Net Community Benefit</b>
Community Health Services	\$1,446,478
Health Professions Education	364,815
Mission Driven Health Care Services	5,145,276
Financial Contributions	14,400
Charity Care	3,178,400
<b>Total Hospital Community Benefit</b>	<b>\$10,149,369</b>

**Frederick Memorial Hospital  
HSCRC – Community Benefit Report  
Gaps in the Availability of Specialists to Care for the Uninsured  
FY 2007**

Frederick Memorial Hospital is challenged, along with all other Maryland hospitals, to provide care to the uninsured patient. As part of Frederick Memorial's mission to provide services to all patients regardless of their ability to pay, the hospital provided \$3,178,440 in charity care services to patients in fiscal year 2007.

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

Frederick Memorial Hospital has initiated programs to provide specialists care for both the uninsured and insured patients within our facility. The hospital contracts with over 100 physician specialists to provide ED coverage 24 hours, 7 days a week. Specialists include, cardiologists, orthopedics, GI, neurology, pulmonary, ENT, urology, hematology, vascular and thoracic. The total cost of this program for 2007 was \$1.1 million dollars.

Other programs include an in-house Hospitalist program, where care is provided for inpatients by physicians trained in the care of hospitalized patients. Total costs of this program for 2007 were \$1.8 million dollars. Obstetric and Anesthesia coverage is also provided 24/7 at a combined cost of \$2.0 million dollars.

Frederick Memorial Hospital has strived to bridge the gap of availability of Specialists care by providing a full range of specialists care coverage for both the inpatient and Emergency Department sector ranging from numerous specialists in the ED, inpatient care coverage, Obstetrical and Anesthesia coverage on a 24 hour, seven day week coverage. The total costs of these programs for 2007 totaled \$5.1 million dollars.

Garrett County Memorial Hospital  
Community Benefits Reporting  
Fiscal Year 2007  
Evaluation Framework

Garrett County Memorial Hospital is a rural facility nestled in the mountains of Western Maryland. We pride ourselves in being a non-profit hospital whose mission is “To promote the health of our regional community and to provide safe, high-quality care and health services to our patients.” The activities stated in our Fiscal Year 2007 Community Benefits Report illustrate our commitment to the general public of Garrett County and the mission of this hospital.

In Fiscal Year 2006, Community Benefits was officially incorporated into the Strategic Plan with the addition of a strategic initiative to develop a Community Benefits Action Plan. The goal of this initiative is to identify the community’s health care needs. The last community needs assessment was completed by the Garrett County Health Department (GCHD) in 1993. Therefore, the hospital, as a member of the Garrett County Health Planning Council, in conjunction with the GCHD, decided to initiate the Mobilizing for Action through Planning and Partnerships (MAPP) program. MAPP is a community-wide strategic planning tool for improving community health. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them.

MAPP is a community-driven initiative that brings community members and public health leaders together for the benefit of the community as a whole. Seeing the value of this initiative, the hospital has enlisted several members of our staff to be involved in the MAPP process. They include two wellness coordinators, the director of public relations, the education coordinator, the director of social services, the vice president of clinical services, and the chief executive officer. Broad community participation is essential because a wide range of organizations and individuals contribute to the public’s health. Additional organizations involved in the MAPP process include the Garrett County Board of Education, Community Action, the Federally Qualified Health Center (FQHC), Social Services, Gosnell Construction, Inc., First United Bank & Trust, Wellspring Family Medicine, Cornerstone Family Medicine, Partnership for Children, Youth and Families, and the Emergency Management Services, as well as many other public and private individuals.

The first MAPP meeting was held in August 2006. The goal of the MAPP process was to identify public health issues and solutions for addressing them. Residents of Garrett County were asked to complete a three-page Community Health Survey consisting of ninety-seven items during the winter of 2007. The survey respondents consisted of a “convenience sample” recruited from friends, family, and coworkers known to various MAPP committee members. The 1,324 completed surveys represent about 5% of the adult population of the county. Over ninety percent of respondents stated access to healthcare (family doctor, hospital, etc.) as well as healthy behaviors and lifestyles to be very important factors in a healthy community. However, ten percent of the respondents felt Garrett County was doing very poorly in these areas. The MAPP committee used the survey results to plan their next course of action.

The assessment and strategic planning phases were completed in November 2007. An action-goal-setting session in December 2007 implemented the following goals:

- Motivate individuals to take responsibility for leading a healthy lifestyle
- Identify actions people can take to lead a healthy lifestyle

- Focus on the community health system's key problems over the next ten years - especially the lack of physicians in the area due to the aging physician population.

The expected completion date for the MAPP process continues to be April 2008.

As part of its Community Based Initiatives, Garrett County Memorial Hospital proudly anticipates playing a role in the opening of a comprehensive care center in the community. The possible services to be provided at the center include wound care, infusion therapy and cardiac rehab. Currently, some of these services are not offered in the area and residents of the county need to travel to receive the necessary care based on their medical condition.

Another example of the hospital's community benefit initiatives reflecting evidence-based needs is the Community Blood Screening Program, which is offered once a year, to benefit those individuals who are uninsured or underinsured. The program offers a comprehensive series of blood tests to the participant at a substantially lower cost than a laboratory's rates. This year, participants were asked to answer a survey regarding the program. Of the 514 participants in the program, 101 completed the survey and returned it to the hospital. Of the respondents, forty-five percent were not covered by health insurance at the time of the screening. Of the respondents with health insurance, sixty-two percent had a deductible of \$100.00 or more. These statistics prove the blood screening service is used mostly by individuals that are uninsured or underinsured. Of the participants, fifty-two percent received at least one abnormal lab result. Thirty-seven percent required physician follow-up. Thirty percent had a new condition or diagnosis identified. Due to the results of the testing, fifty-one percent of the participants reported they made a lifestyle change.

In addition to the Community Blood Screening Program, GCMH is expanding its screening services to the work place. First United National Bank & Trust has contracted with the Wellness department of Garrett County Memorial Hospital to provide blood screening services for all of its employees. This is the purpose of all community benefit activities. We want to improve our community's health one person at a time.

To insure the progress of community benefit initiatives, the bi-monthly Strategic Planning Committee has listed Community Benefits as a standing agenda item. In addition, the management of the hospital is informed on a routine basis of Community Benefit activities. Both the Accounting and Wellness departments will be responsible for monitoring how the hospital's activities fulfill the goals identified in the plan through regular progress reporting. At this time, programs are enhanced, revised, discontinued or repeated based on levels of interest, participation and outcomes. The community is kept informed of activities provided by the hospital through press releases and promotional efforts.

With the MAPP process in motion, Garrett County Memorial Hospital and all Garrett County organizations promise to work together to improve the overall health of Garrett County residents. We look forward to many positive results.

Garrett County Memorial Hospital  
Fiscal Year 2007

Community Benefit Report

Written Description of Gaps in the Availability of Specialist Providers to Serve the Uninsured in  
the Hospital

Garrett County Memorial Hospital (GCMH) is a small acute care hospital located in Garrett County, Maryland. The county has been designated a federal medically underserved area. In addition, the county has a “low income” designation as a Health Professional Shortage Area (HPSA) for primary care as well as a HPSA designation for dental and mental health. Approximately 18% of the population has no form of health care coverage. In the past, most underinsured residents of the area came to the Emergency Room at GCMH for treatment of minor illnesses since we provide care regardless of ability to pay. Recently, GCMH along with the local health department actively pursued the construction and development of a Federally Qualified Health Center (FQHC) in Garrett County. This facility provides primary care to low income individuals in Garrett County regardless of their ability to pay. The facility opened for business in October 2006.

The Independent Dialysis Center opened November 2006 in the Oakland area to provide dialysis services to the residents of Garrett County. In the past, GCMH could not accept patients on dialysis. These patients were transferred to another facility. Now, the dialysis center will also provide dialysis to inpatients of GCMH regardless of their ability to pay.

GCMH does not employ any physicians for specialty care. All patients requiring Neurology, Pulmonology, and Cardiology as well as major trauma patients are transferred to another facility. Although we are able to provide basic care, we do not have physicians to provide these specialty services.

## Evaluation Framework Proposal

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Yes, each year GBMC's Community Relations Coordinator works to establish activities that are consistent with both the strategic programs of GBMC and the community's needs.

In addition, GBMC's Community Needs Advisory Committee (a formal community benefits committee established that reports directly to the President/CEO and includes Board oversight) oversees GBMC's community based activities, as well as evaluates prospective new activities, to ensure that activities are aligned with the Mission, Vision and Values of GBMC.

2. Were hospital staff and leadership involved in developing the plan?

Yes, various hospital staff and departmental leadership are involved in selecting and providing community activities on behalf of GBMC.

(Currently the Community Needs Advisory Committee is developing a new community benefits strategic plan that is intended to outline activities over a three-to-five year period).

- Community Needs Assessment

3. Does the hospital's plan target specific areas of community need?

GBMC has struggled to formulate its community benefit activities using specific demographic and incidence rate data due to the absence of a prepared Community Needs Assessment in Baltimore County.

GBMC approached the Baltimore County Department of Health to initiate dialogue on the feasibility of creating a partnership that would develop a Community Needs Assessment.

While the process with the Baltimore County Department of Health may continue, GBMC is also evaluating other alternatives for developing a statistically-based Community Needs Assessment.

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.

Given the absence of a Baltimore County Needs Assessment, GBMC has accessed information prepared by Carroll County. However, to date the Carroll County assessment has not resulted in specifically designed community benefit activities provided by GBMC.

- Community Benefits Initiatives

5. Does the hospital identify its Community Based Initiatives?

Yes. GBMC has identified select initiatives as being primarily community based, such as the Weinberg Family Community Care clinic.

GBMC also completed a GAP Assessment to help identify areas of prospective community need.

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

Yes. Based in part on the GBMC GAP assessment, as well as other health issues well supported by national evidence-based data, GBMC has approved implementation (beginning in FY 2008) of two new community based initiatives directed at the geriatric and youth populations.

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

Both initiatives referenced above have been established as performance-based and involve reporting of outcome measures to the Community Needs Advisory Committee in order to receive continued financial support.

- 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?

Yes. One of the community initiatives approved for FY 2008 involves partnership with an outside agency. In addition, the Community Needs Advisory Committee is designed to include membership from external agencies/interests.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

Yes. See response in #8.

- 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?

An objective of the Community Needs Advisory Committee is to routinely collect and report progress data to evaluate the effectiveness of community benefit activities undertaken by GBMC and determine the appropriateness of continued support.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

Hospital leadership, through the functions of the Community Needs Advisory Committee is kept informed of all activities and results regarding the community benefit activities of GBMC. In addition, the Community Needs Advisory Committee has established within its strategic plan specific steps to better inform the community of community-based activities provided by GBMC.

### **Gaps in Availability of Specialist Providers**

GBMC's current experience has identified a shortage related to psychiatric evaluations performed in the emergency department. Similarly, coverage for orthopedic and anesthesia services have also become increasingly harder to provide in the emergency department setting. As a result, GBMC contracts with several physician specialty groups to provide on-call emergency room coverage for these services.

GBMC has also established an OB/GYN physician practice specifically designed to meet the needs of underserved patients.

# Good Samaritan Hospital

Community Benefit Report

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## 1. Brief Description – Hospital and Services

### **Hospital Mission, Key Services, and Programs**

The Mission of Good Samaritan Hospital is, “To be Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.” Our vision is, “To be the trusted leader in caring for people and advancing health.” Since opening its doors in 1968 the hospital has been striving to make a difference in the health of our community. The board and senior management of the hospital fully supports the variety of programs that address the needs of the community.

Long known as a specialty center for rehabilitation and orthopedics, we take a comprehensive approach to caring for our patients that 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 adding a 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.

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. One 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 and other wellness programs as well as health screenings.

The Community Outreach Department and Parish Nurse Program serve the needs of the community by providing health education, seminars, screenings, senior programs and referral services. These services are provided through partnerships with several Baltimore City and Baltimore County senior centers, approximately 40 local churches and schools, and other various community organizations.

### **Primary Geographic Area Served**

The primary service areas include the Northeast section of Baltimore City as well as parts of the Towson, Parkville and Dundalk areas of Baltimore County. The population served by the hospital is primarily adults.

### **Key Community Health Needs**

The needs of the community are assessed on information provided by the Baltimore City and County Health Departments, and also from working closely with community partners such as local schools, and the Northeast Development Alliance (NEDA), a community development corporation with the goal of fostering a healthy and vibrant environment for

resident in the northern neighborhoods of Baltimore City, to further assess the community's needs. Based on this evaluation, many of the community programs that have been developed target and aging population, the uninsured, elementary school children and cancer awareness for early detection.

## **2. Featured Community Programs**

- ✓ To address the needs of the community's growing senior population the VintAGE program was implemented in 2005 through the community outreach department and now has over 600 members. The goal of this program is to provide classes, seminars referral resources and other services to help seniors age actively and independently and improve and maintain a good quality of life. This past year's programs and seminars were focused on nurturing body, mind and spirit. Approximately 400 participants attended programs led by physicians and other healthcare professionals that provide a variety of topics which included nutrition, various forms of exercise, general health information, cognitive vitality, and spirituality. Speakers included a psychiatrist, geriatrician, nurse practitioner, social worker, fitness experts and a representative from Bon Secours Spiritual Center. Evaluations of these programs were rated as excellent by the participants.
- ✓ The Community Outreach and Parish Nurse Program in partnership with the American Cancer Society implemented a breast cancer awareness program. Educational seminars, literature, and breast cancer awareness necklaces were presented to approximately 1,800 women in local churches, schools, senior centers and senior residence buildings. Women were educated on the importance of early detection by yearly mammograms and visits to their health care professionals.
- ✓ Five local Catholic schools were provided vision and hearing screening by the hospital's Community Outreach Department in partnership with Loyola College's Speech and Hearing Department. Approximately 585 children from Pre-K to 8<sup>th</sup> grade were screened for vision and hearing problems. Eighty-six were identified as needing follow-up for vision and 45 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 that they were planning to have further evaluation done by either the pediatrician or a specialist.
- ✓ The Nursing Education Department coordinates the hospital's pipeline education programs. The goal of these workforce enhancement programs is to address the nursing and respiratory therapist shortages in health care. The Nursing Assistant Program has graduated 126 students since its beginning. The LPN to RN Program has 75 enrolled and is planning the first graduation in fall of 08. The Respiratory Therapist Program will be graduating 3 students from its first class in fall 07.

# **Good Samaritan Hospital**

## **Gaps In Availability Of Specialist Providers To Serve The Uninsured**

This information has remained consistent with the MedStar Health fiscal year 2006 report. 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 inpatient and outpatient substance abuse treatment
- Limited availability of inpatient and outpatient surgical coverage, including general surgery, ENT, oral surgery, neurosurgery, and GYN
- Medication assistance

GOOD SAMARITAN HOSPITAL

**Community Benefit Report 2007**

**Subsidies Narrative**

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The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses to hospital for services defined as subsidized care. They are defined broadly 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.”

The HSCRC has addressed how these types of services should be treated requiring that hospitals clearly explain the subsidies included within the report.

Included the Hospital’s 2007 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 section C1 subsidizes the only hospital based gynecological practice that ensures adequate women’s services coverage for our community. Likewise, the amount in section C3 ensures that the Hospital maintains adequate gynecological call coverage for the emergency department. The last physician subsidy amount included in section C5 of the report is associated with anesthesia services.

## **FY07 Community Benefit Evaluation**

### **Community Benefits Planning and Needs Assessment**

Planning is an essential element for every business entity. Harbor Hospital is no different. The hospital engages in regular strategic planning and has an annual planning process, involving both our executive team and our hospital leadership team, to identify our priorities for each fiscal year and from longer-term perspectives. In our planning process, clinical and operational goals are addressed at various levels. As part of this, we factor in community needs, both current and projected, into all our planning.

The community planning aspect of our organizational assessment is equally important to its business planning counterpart. Our community relations team has an annual planning process. Since the AVP for community relations reports to the hospital president and is a member of the executive team, the highest levels of leadership are engaged in the discussion. In addition, we involve peers in physician relations and nursing to help ensure that we are identifying key areas for outreach to meet our community's needs.

We also work closely with our planning team; our clinical specialists who focus on the community; our parish nurses; and with area health departments. In particular, we seek input and feedback from Baltimore City, Anne Arundel County and Baltimore County departments of health. This enables us to continue to assess community health needs, and identify potential roles for Harbor to play in meeting those needs.

This is a dynamic and ongoing process. Through this dialogue, we form the framework of our community outreach. Then, the community relations team, and any appropriate member of our Harbor family, meet regularly to plan and implement our activities. Underpinning all of this is Harbor's mission: we are committed to quality, caring and service for our patients and our communities.

### **Community Benefits Initiatives**

Through our planning process, Harbor Hospital identifies various community benefits initiatives. Harbor Hospital, through our own funding and regional and national grants, is able to work closely with our local health departments and community partners to offer free colon, breast and cervical cancer screenings; low-cost lung scans; free smoking cessation classes; and a strong "Parish Nurse" program that provides key outreach to our patient population.

The smoking cessation classes, for example, are a direct result of the higher-than-average rate of lung cancer in this region. Harbor Hospital has worked with Anne Arundel County Department of Health for years to offer both the classes and free nicotine replacement therapy. We have a parish nurse who also offers ongoing one-on-one counseling for those who are struggling with the habit.

Our parish nurses also regularly act as health care navigators for residents of the local communities we serve. They hold office hours at local organizations, offer blood

pressure screenings, and guide their “clients” toward any health care referrals they may need. This is a free service, and our nurses touch many lives each year.

As the average age of Americans increases, Harbor also is ahead of the curve in identifying and developing programs to continue to help seniors navigate the ever-changing world of modern health care. Our Harbor Seniors is a free program for people ages 55 and older that, provides free health screenings, educations seminars and opportunities to socialize. Members also get a discount at our Harbor Fitness gym, and many also participate in our free mall-walking program offered at two area malls.

We track and assess all our programs. Some of our outreach is funded by local, regional or national grants. Through those requirements, we track usage rates and outcomes. For example, we can provide exact counts on the number of Baltimore City women who have had free mammograms and Pap smears through our grant with the city, as well as results (number of cancers and precancers 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 administrator 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. We also attend a number of other community meetings, including the Southern Police Station Community meeting and the South Baltimore Community Advisory Panel. We strive to be engaged members of our communities, where every level of interaction provides stronger ties with, and the creation of more meaningful services for our neighbors.

### **Community Benefits Collaboration and Implementation**

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. For example, our smoking cessation, lung cancer screenings and teen pregnancy programs each address community health priorities identified by Baltimore City and Anne Arundel County. 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 service. Harbor Hospital’s *LifeResource* Center is the bricks and mortar centerpiece of our community outreach program. Located on the Harbor campus, it is a spacious facility where community members can learn more about health topics and practice healthy lifestyles. Each month, Harbor offers an assortment of free and low-cost education programs and lectures for every member of the

family. Presenters include our physicians and other health care experts, who discuss a variety of diagnosis, diabetes and wound care, and stress relief – just to name a few. We also offer free health seminars in our waterfront Baum auditorium, as well as at convenient locations in Baltimore, Howard and Anne Arundel counties.

This past year, we have begun to work more closely with an exciting collaboration in south Baltimore called The Cherry Hill Learning Zone (CHLZ). This is an advocacy group comprised of representatives of the city school system, Towson University, community groups, and other key stakeholders in the business community. Harbor is proud to be the health partner. This past year, we worked with our CHLZ partners to offer free flu vaccinations to teachers in Cherry Hill public schools. Then, later in the school year, Harbor hosted an essay contest for middle and high school students in Cherry Hill. The goal was to get them thinking about healthy lifestyles, so they answered the question, “What can I do to stay healthy?” Two first place and two second place winners received a total of \$3000 in prize money, courtesy of Harbor Hospital and the Harbor Hospital Foundation.

Our community outreach also includes other layers of service. From the GED program that regularly meets, free of charge, in our *LifeResource* Center and our comprehensive annual flu vaccination clinics that result in 2000+ free and low-cost vaccinations to our attendance at health fairs and other community events, Harbor remains focused on the inherent value of a hospital providing a continuum of care.

## **Harbor Hospital**

### **Gaps In Availability of Specialist Providers to Serve The Uninsured**

This information has remained consistent with the MedStar Health fiscal year 2006 report. Physician leadership and case management staff continued to identify several areas of concern:

- Timely placement of patient 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

## Community Benefits Evaluation

- Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

*Yes. The community benefit plan is a separate key planning document, with particular emphasis on our mission commitments of access and health status improvements and tied directly to our strategic plan. Community benefit is one of the four major strategies outlined in our strategic plan. Our strategy is to keep our community in the forefront of everything we do through playing a lead role in building a better system of care for the uninsured, targeting at-risk populations for special outreach, maintaining a leadership position in community benefit and advocating for expanded commitment from other hospitals, and evaluating our programs and outcomes.*

2. Were hospital staff and leadership involved in developing the plan?

*Yes. The community benefit plan is developed and monitored by a management review team that includes the CEO, senior managers, and leaders of various initiatives throughout the hospital. The Mission and Planning Committee of the Board of Trustees and the full Board of Trustees provide annual approval of the community benefit plan and quarterly governance oversight of progress toward the plan.*

- Community Needs Assessment

3. Does the hospital's plan target specific areas of community need?

*Yes. The community benefit plan targets access to healthcare and community health improvement especially for women and children; seniors; and racial, ethnic and linguistic minorities.*

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.

*Yes. Specifically, community needs were identified using the following needs assessments and reports.*

- *American Hospital Association May 2007, "When I'm 64" How Boomers Will Change Health Care*
- *Montgomery County Area Agency on Aging, Area Plan FY2008-2011, Comprehensive Plan of Service*
- *Imagining an Aging Future for Montgomery County (May 2007), Phase 1 Towson University Center on Productive Aging*
- *Promoting a national Falls Prevention Action Plan, Archstone Foundation, NCOA, 2005*

- *National “Listening to Mothers Survey II” by the Childbirth Connection, January-February 2006*
- *Montgomery County Department of Health and Human Services, Strategic Plan 2006-2011*
- *Health Insurance Coverage in Maryland Through 2003, Maryland Health Care Commission, 2004*
- *The Children’s Agenda 2004 Data Book, Montgomery County Collaborative Council*
- *Faith-based Communities Study, 2004*
- *Community Ministries of Rockville Report, 2004*
- *Program Prioritization to Control Chronic Diseases in African American Faith-Based Communities, April 2004*
- *Community Ministries of Rockville Health Project Focus Groups Report, April 2004*
- *National Healthcare Disparities Report, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, July 2003*
- *Blueprint for Latino Health in Montgomery County Maryland, 2002-2006*
- *Improving the Health of Our Community, Montgomery County, Maryland, 2002 Progress Report*
- *A Report on the Needs of Low Income Seniors, Montgomery County, Maryland, June 2002*
- *Institute of Medicine Report, Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Health Care, March 2002*
- *Montgomery County Community Health Improvement Plan, July 2001*
- *Community Health Indicators for the Washington Metropolitan Region, June 2001 (A Regional Report from the Metropolitan Washington Public Health Assessment Center)*
- *Primary Care Coalition Enhancement of Safety Net Providers Final Report (December 12, 2000)*

- Community Benefits Initiatives

5. Does the hospital identify its Community Based Initiatives?

*Yes. Examples of major community benefit initiatives are:*

*Silver Spring Senior Source – providing health and wellness programs for seniors in partnership with Housing Opportunities Commission of Montgomery County, Montgomery County Department of Health and Human Services, and the State of Maryland’s Department of Aging*

*Faith Community Nursing – providing health promotion programs and activities within 54 faith communities with 95,000 members*

*Senior Fit program – providing exercise to persons 55 and older in partnership with Kaiser Permanente, Montgomery County*

*Department of Recreation, Maryland National Capital parks and Planning Commission and churches*

*Maternity Partnership program in partnership with Montgomery County Department of Health and Human Services*

*Minority Outreach and Technical Assistance program in partnership with the State of Maryland's Minority Outreach and Technical Assistance Cigarette Restitution Fund, two Montgomery County minority health initiatives (African American Health Program and Asian American Health Initiative), three community-based organizations (African Women's Cancer Awareness Association, Community Ministries of Rockville, and CASA of Maryland) and the Maryland Commission on Indian Affairs*

*Holy Cross Hospital Health Center at Montgomery College providing primary care to uninsured adults*

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

*Yes. Examples of community benefits initiatives developed in response to evidence based needs are:*

*The Maternity Partnership was developed in partnership with the Montgomery County Department of Health and Human Services in response to infant mortality statistics in Montgomery County.*

*The Holy Cross Health Center at Montgomery College was developed in partnership with Montgomery College in response to the high number of uninsured adults in Montgomery County, inappropriate use of emergency department facilities by uninsured adults and a documented need for additional training facilities for nurses and other healthcare providers and participates in the Montgomery Cares program in Montgomery County*

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

*Performance in community benefit initiatives is monitored regularly; process and outcome measures are used as appropriate. For example:*

*For the Maternity Partnership Program, we measure the number of low birth weight newborns and compare the percent of all newborns to the percentage for our overall hospital and the state of Maryland. In FY07, in our ob/gyn clinic, 4.1 percent of newborns were low birth weight newborns, compared to 8.9 percent for Holy Cross Hospital and 9.0% in the state of Maryland.*

*For management of diabetes, we measure eight performance indicators, including percent of HbA1c less than 7.0 percent and greater than*

***9.0 percent; percent with HbA1c test every six months; percent with LDL less than 100 mg/dl; percent with annual retinal or diabetic eye exam; percent with annual microalbumin test; and percent with blood pressure less than 130/80.***

- 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?

***Yes. Each year the hospital convenes a discussion group of outside participants to review our community benefit plan and provide input into future plans.***

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

***Yes. Holy Cross Hospital collaborates with more than 100 community partners including churches, payers, local and state government agencies, other hospitals, community-based organizations, and colleges in planning and implementing its community benefit activities. Community partners include such entities as Montgomery County Health and Human Services, the State of Maryland's Department of Aging, the Archdiocese of Washington, Montgomery College and Kaiser Permanente.***

- 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?

***Yes. Management meets quarterly to review community benefits activities. The Senior Vice President Corporate Development and the Vice President Mission Services, both direct reports to the President and CEO, are charged with monitoring and reporting on community benefit activities. The Mission and Strategy Committee of the Board of Trustees provides quarterly governance oversight, and the full board of trustees receives quarterly performance indicators for community benefit. The full board of trustees annually approves the plan within the context of accomplishment toward the prior year's community benefit plan.***

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

***Yes. Management reports community benefit activity quarterly to the Mission and Planning Committee of the Board of Trustees and the full Board of Trustees reviews and approves the community benefit plan on an annual basis. The hospital publishes an annual report of its community benefit activities that is distributed to key stake holders, government officials, employees and households within its service area. A copy of the report is attached.***

**GAPS IN THE AVAILABILITY OF SPECIALIST PROVIDERS TO SERVE THE  
UNINSURED IN THE HOSPITAL**

During fiscal year 2007, the following specialty services would not have been readily available to uninsured patients at Holy Cross Hospital were it not for the hospital's decision to subsidize these services.

- General Surgery
- Orthopedic Surgery
- Neurosurgery

**Otolaryngology/Oral Surgery**

- Plastic Surgery
- Urology
- Neonatology

**Ophthalmology**

- Pathology
- Perinatology
- Vascular Surgery
- Thoracic Surgery
- Psychiatry

**Physician Subsidies**

In fiscal year 2007, Holy Cross Hospital incurred expenses of \$1,209,655 in order to induce certain physician specialists to provide emergency room on-call services to uninsured patients. In addition the hospital incurred expenses of \$331,785 in order to induce certain hospital based physician practices to provide care to the hospital's uninsured patients. Holy Cross Hospital has elected to include this amount in its community benefit inventory.

Subsidies were paid to obtain services in the following specialty areas:

- General Surgery
- Orthopedic Surgery
- Neurosurgery

**Otolaryngology/Oral Surgery**

- Plastic Surgery
- Urology
- Neonatology

**Ophthalmology**

- Pathology
- Perinatology
- Vascular Surgery
- Thoracic Surgery
- Psychiatry

# *Opening Doors*

Fulfilling Our Mission to Improve Our Community's Health



**HOLY CROSS HOSPITAL**

Experts in Medicine, Specialists in Caring.™



*October 2007*

When Holy Cross Hospital opened its doors in 1963, it began a tradition of opening doors to health care for our community.

At our founding, the Congregation of the Sisters of the Holy Cross established a commitment to meeting community need and to improving the health of all those we serve, with particular emphasis on the poor and vulnerable. This commitment is brought to life through our community benefit ministry. Our community benefit efforts include all of the services we provide to community members at no cost or subsidize as part of our mission to be the most trusted provider of health care services in our area.

In meeting this commitment, we focus our efforts on improving health care access. Our proven approach is to systematically identify significant health care needs in our evolving community that are not adequately met because of financial, geographic, racial or cultural barriers. Then we propose and develop innovative solutions to address these needs in ways that can be sustained in the future.

One of our strengths is our ability to collaborate with other organizations to maximize our collective positive impact. We continuously bring together resources toward shared goals by partnering with local, state and federal government agencies; associations; community-based social service organizations; faith communities; charities and others.

As the second largest hospital in Maryland and the leader in community benefit in Montgomery County, we take seriously our responsibility as a not-for-profit health care provider to steward the resources entrusted to us and to invest in our community benefit efforts. In the past four years, we provided more than \$76 million in community benefit including more than \$32 million in financial assistance, according to reporting guidelines of the State of Maryland Health Services Cost Review Commission.

Our efforts have touched community members millions of times in our history. The individuals highlighted in this report are only a few of the many people who have contributed to or benefited from our community benefit activities. Going forward, we will remain committed to programmatic and financial investments that will continue to open doors to health care.

A handwritten signature in white ink, appearing to read "K. Sexton", written in a cursive style.

Kevin J. Sexton  
President and CEO  
Holy Cross Hospital

# Opening Doors to Financial Assistance

More than 740,000 people in Maryland 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 2007, we provided nearly \$9 million in financial assistance through 28,000 encounters with community members.



*“I got the coverage I needed*

*and follow-up care for my truly miraculous recovery from a stroke.”*

..... Bob Creecy

## » Helping the Uninsured Get Full Coverage

“We thought we would lose everything – our house and all of our possessions – when my brother suffered a massive stroke,” said Sandy Creecy.

Bob Creecy had recently lost his job and his health insurance. He didn’t qualify financially for Medicaid and at age 54 he was too young to qualify for Medicare. He would likely not be able to get traditional insurance because of his stroke. Sandy didn’t know where to turn.

“As the bills mounted, like a gift from heaven the Holy Cross Hospital financial counselors introduced us to MHIP,” said Sandy. The Maryland Health Insurance Plan (MHIP) is state-administered health insurance that makes coverage available to residents who do not otherwise have access to health insurance.

Holy Cross Hospital embraces this alternative to traditional insurance. Our financial

counselors identify patients who may be eligible and work with them toward enrollment.

Holy Cross Hospital is a member of Trinity Health, one of the largest health systems in the country. With support from Trinity Health, Holy Cross Hospital created an innovative premium assistance program that pays half or the full premium for people who are financially eligible.

“MHIP provided Bob with the insurance he needed and the hospital covered half of the premium cost,” said Sandy. By becoming insured, Bob could be referred to private physicians and receive the follow-up care he needed after his hospital stay.

“We can’t thank Holy Cross Hospital enough,” said Sandy.

# Opening Doors to Unique Services

Holy Cross Hospital offers a wide range of services that are a direct result of our commitment to our mission. Many of these programs are unique in the community and would not otherwise be available. These programs meet important community needs and are not expected to generate a positive financial return.

- The **Caregiver Resource Center** offers free classes, support groups and a resource library for family members, friends and professionals who are involved in the physical, emotional, spiritual or social care of someone who is medically challenged or facing lifestyle changes as a result of aging or illness. *3,771 encounters\**
- The **Medical Adult Day Center** provides social, recreational and rehabilitative services for medically disabled or older adults who are socially isolated, need supervision or want to participate in group activities. *5,392 encounters\**
- The **Faith Community Nurse Program** supports 54 congregational health ministries in educating, empowering and equipping members of their faith communities in the pursuit of health, healing and wholeness. *95,000 encounters\**
- The **Holy Cross Hospital Health Center at Montgomery College** provides affordable primary health care and education to low-income, uninsured adults. *6,181 encounters\**
- The **Holy Cross Hospital OB/GYN Clinic** provides prenatal, obstetric and gynecologic services to uninsured women in partnership with the Montgomery County Department of Health and Human Services. *19,816 encounters\**
- **Palliative care** provides total active care for people with advanced medical illness. The program helps patients and their families consider all available options and cope with difficult treatment and end-of-life issues. *1,021 encounters\**
- Home care nurses provide **postnatal home visits to uninsured mothers**, creating a bridge from birthing care to pediatric care. *1,219 encounters\**
- Pharmacy programs provide **prescriptions at discharge** to low-income inpatients as well as outpatients of the OB/GYN Clinic. *3,392 encounters\**

*\*Fiscal 2007*



## » Health and Hope from the Start

*More babies are born at Holy Cross Hospital than any other hospital in Maryland or the District of Columbia. We have provided prenatal, obstetric and gynecologic care to women regardless of their ability to pay for those services since 1963. Today Holy Cross Hospital remains Montgomery County's leading provider of prenatal, obstetric and gynecologic services for uninsured women.*

In 1999, our commitment to obstetric and gynecologic care grew dramatically through the expansion of the Maternity Partnership with the Montgomery County Department of Health and Human Services. To accommodate the growing need for prenatal, obstetric and gynecologic services and to provide a single standard of care for all women, Holy Cross Hospital built a new onsite OB/GYN Clinic, 68 private maternity suites and nine new labor and delivery rooms for a total of 24 rooms.

Patients served by the Maternity Partnership lack the ability to obtain health insurance. If not for the OB/GYN Clinic, many women might

not receive the appropriate care needed to ensure a healthy mother and child. Women enter the OB/GYN Clinic for prenatal care at any point during pregnancy, though most have nine visits leading up to their delivery.

Many patients are not native English speakers, therefore staff members are bilingual to provide culturally competent quality care. "The Spanish-speaking nurses answered all my questions and made sure I understood," said Dorinda Salazar-Duque, an OB/GYN Clinic patient.

Women with complications such as HIV, diabetes, premature labor and hypertension are followed closely during their pregnancy and delivery.

"The staff at the OB/GYN Clinic found the right medication levels to control my

epilepsy and diabetes during my pregnancy," said Dorinda. "They explained how to take the medications and even arranged for me to purchase them at a price I could afford."

Holy Cross Hospital also offers an extensive perinatal education program that includes classes in Spanish, as well as home care follow-up programs for uninsured women.

Weight at birth is a good indicator of a newborn's general health. The percentage of newborns born at the OB/GYN Clinic with low birth weight is half of the state average, demonstrating the clinic's success in contributing to healthy starts in life.



*"My baby and I are healthy because of the excellent care we received from the OB/GYN Clinic."*

..... *Dorinda Salazar-Duque*

# Opening Doors for *At-risk Populations*

*As the health and life expectancy of many in our community is improving, certain populations continue to experience poorer health and disproportionate rates of illness and death.*

*That is why Holy Cross Hospital has pioneered innovative efforts that are tailored to meet the unique needs of vulnerable or underserved populations, including women, infants, seniors, and racial, ethnic and linguistic minorities.*

## **»» Faith Community Nurse Program**

### *Caring for Body, Mind and Spirit*

“Health is created in communities, not in medical settings,” said Carmella Jones, RN, FCN, manager of the Holy Cross Hospital Faith Community Nurse Program. “Building on that belief, faith community nursing has a broad vision of ‘whole health’ that focuses on the connection between spirituality and health.”

By integrating body, mind and spirit, faith community nursing creates an opportunity for

intervention that can lead to prevention, wellness and more effective coping strategies for dealing with a diagnosed disease. 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.

More than 50 faith communities partner with our Faith Community Nurse Program. These congregations are diverse in denomination, size, race and ethnicity. “We assist each congregation in developing their unique vision for health and wellness and we provide support for implementing and sustaining that vision,” said Carmella.

Faith community nursing programs include health education programs, preventive screening, chronic disease management education, wellness counseling, patient advocacy, resource referral, support group development, services and prayers for healing, and home and hospital visitation programs.

As a local, regional and national model, our Faith Community Nurse Program offers members educational conferences, networking meetings, a newsletter, regular emails, and a spirituality and health lending library.



## » *Primary Care for Those Who Need it Most*

*The Holy Cross Hospital Health Center at Montgomery College opened in 2004 to bring affordable primary health care to those who needed it most – low-income, uninsured adults. Now this unique center accommodates more than 6,000 patient visits per year. More than 10,000 patient visits per year are anticipated by 2010.*

This state-of-the-art center is a “medical home” for adults in Silver Spring and surrounding areas who are not able to access primary care elsewhere. Skilled clinicians provide emergency room follow-up, physical exams, chronic disease management and care for patients discharged from the hospital. The staff speaks English, French and Spanish, and offers interpretation in other languages.

Some Health Center patients have never before received care for their

simple or complex health problems. Others have not maintained their health because they lack the money or insurance needed to consistently afford medications. The center’s most common diagnosis is high blood pressure, which can increase a person’s risk for heart attack and stroke if it is not well managed.

“There is nothing more heartbreaking than seeing a patient with high blood pressure suffer a stroke because she was unable to access follow-up care or pay for her medication,” said Elise C. Riley, MD, medical director of the Holy Cross Hospital Health Center. “Here we can help prevent the consequences of untreated disease.”

The center offers various educational programs and resources to help patients

manage high blood pressure, diabetes and other chronic conditions. Individual instruction, group education, and low-literacy, culturally competent written materials are available onsite.

As a collaborative effort between Holy Cross Hospital and Montgomery College, the center also offers a unique learning opportunity for students working toward or considering careers in medicine, nursing, health information and pharmacy. Students regularly rotate through the clinic, contributing to the care of patients and receiving first-hand experience that prepares them for a future in health care.



*“We can prevent future health problems by providing primary health care today. Our outpatient setting serves people who may not otherwise have access to care.”*

..... *Elise C. Riley, MD, Medical Director, Holy Cross Hospital Health Center*

## »» Senior Fit Exercise Program

When Theresa Woo was 62, her son told her, “Mom, I don’t want to lose you. You need to take better care of yourself.” He sent her to a nutritionist for dietary counseling. But the nutritionist said she didn’t need to change her diet. Instead, she needed exercise.

“So I enrolled in the Senior Fit program,” said Theresa. “That was eight years ago. Today I still participate in the class about four or five days a week.”

In 1995, Holy Cross Hospital created Senior Fit, an innovative 45-minute multicomponent exercise program for adults ages 55 and older. Offered free of charge, the program removes participation barriers to senior exercise presented by most fitness facilities, such as youth-oriented activities and high expense.

With this program, seniors can access safe exercise classes specifically designed for them



*“I want to enjoy many more years*

*laughing and having fun with my family. Senior Fit classes make me stronger and help me maintain my health so I can stay independent.”*

..... Theresa Woo

according to American College of Sports Medicine guidelines.

“The instructors are great at tailoring exercises to each student’s comfort level,” said Theresa. “My 90-year-old mother loves the classes just as much as I do.” The activity promotes health and flexibility, prevents disease and helps maintain independence.

Over 12 years, the program has grown steadily and now 1,750 seniors are enrolled in the classes and participate more than 56,000 times each year. The classes are offered at 17 locations throughout Montgomery and Prince George’s counties and the District of Columbia, through a partnership among Holy Cross Hospital, Kaiser Permanente, Maryland National Capital Parks and Planning Commission, Montgomery County Department of Recreation and local churches.

A National Council on Aging impact study concluded that Senior Fit participants experienced measurable improvement in upper and lower extremity strength as well as several measures of self-efficacy. “I always leave feeling better than when I walked in,” said Theresa.

## Exercise for Older Adults

*As people age, their risk for illness and injury naturally increases. But exercise can slow the aging process and help people become stronger and more resilient. As part of our commitment to older adults, we host exercise classes designed for seniors at convenient settings throughout the area that help participants maintain independence and prevent disease.*

- *Senior Fit is a free 45-minute multicomponent exercise program offered at 17 locations.*
- *Better Bones is a free program focused on reducing the rate of bone loss and enhancing balance, flexibility and strength.*
- *Holy Cross Hospital Senior Source, a vital aging program, offers physical activity, education and information for health and wellness. Physical activity programs include yoga, tai chi and Pilates.*

## » Eliminating Health Care Disparities

As communities nationwide grow more diverse, health care providers must tailor the way they deliver care to meet the needs of changing patient populations.

“We are taking responsibility for understanding cultures and providing care that is sensitive to the beliefs, customs and behaviors of the populations we serve,” said Wendy Friar, RN, director of Holy Cross Hospital Community Health. “We are committed to doing everything possible to ensure that disparities in care do not occur.”

Recognizing the link between the shortage of minority health care providers and poorer health for minority communities, Holy Cross Hospital established the Ethnic Health Promoter program in 2001. Begun as a collaborative effort with the Montgomery County Cancer Crusade, the program trains ethnic health promoters. Their outreach efforts target 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 country’s health care system.

“Our health promoters are African-American, Asian-American, Latino-American and Russian-

American. They are culturally and linguistically competent and they live in the communities where they provide outreach,” said Wendy. The ethnic health promoters are uniquely qualified to provide effective, understandable and respectful care that is compatible with cultural beliefs and practices. Ethnic health promoters work in community settings such as churches, senior and community centers, private homes, Montgomery County Public Schools and ethnic markets.

Holy Cross Hospital continues to fund this program, and it has received subsequent community support from the Asian American Health Initiative, CASA of Maryland, Community Ministries of Rockville, Kaiser Permanente, Montgomery County African American Health Program and the Susan G. Komen Breast Cancer Foundation. In fiscal 2007, Holy Cross Hospital Ethnic Health Promoters had 21,638 encounters with the community.



*Holy Cross Hospital’s ethnic health promoters provide vital 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.*

- **Mammogram Assistance Program Services** *increase access to early breast cancer education, screening, diagnosis, treatment and support services for low-income, minority women over age 20.*
- **The Colorectal Cancer Early Detection Program** *refers hard-to-reach Black and African-American populations to the Montgomery County Department of Health and Human Services for colonoscopies.*
- **The Minority Communities Empowerment Project** *is a collaborative effort to reduce health disparities in cancer mortality and morbidity and tobacco use among minorities through community and organizational capacity building.*

# Opening Doors to Professional Education

Holy Cross Hospital is the second largest hospital in Maryland and is the only Montgomery County hospital that is a member of the Association of American Medical Colleges' Council of Teaching Hospitals and Health Systems. We host physician residency programs affiliated with George Washington University, Children's National Medical Center and Howard University. We also educate students from 13 nursing programs, operate our own School of Radiologic Technology and train students in other health care professions.



*“Now I’m a licensed nurse  
in Holy Cross Hospital’s surgical intensive care unit.”*

..... Ana Ramirez, RN

## » Welcoming Foreign-Trained Nurses Back to Their Profession

“It was frustrating to be a professional nurse in my home country of Colombia but not have the professional knowledge of English to pass the licensing exam in the United States,” said Ana Ramirez, RN. Like many immigrants, Ana came to America from her native country seeking new opportunities. But she found it harder than expected to pursue a nursing career here.

To assist Ana and others in rejoining the nursing profession for which they were trained in their home countries, and to increase the number of culturally and linguistically competent nurses in Montgomery County, Holy Cross Hospital

helped to develop and launch a collaborative pilot program for licensure of foreign-trained nursing professionals. The pilot program is part of the Latino Health Initiative of the Montgomery County Department of Health and Human Services.

The pilot program helps foreign-trained nurses who meet specific selection criteria navigate the state's registered nursing licensure process, participate in college courses to prepare for licensure and gain clinical exposure to the U.S. health care system through placements in hospitals. There are no other known local or national programs that offer these program components. Holy Cross Hospital employed and mentored seven nurses in training while they completed the program. Six participants passed the

state's registered nursing licensing exam. “I was encouraged every step of the way and got the educational, financial and moral support I needed to earn my license in this country,” said Ana.

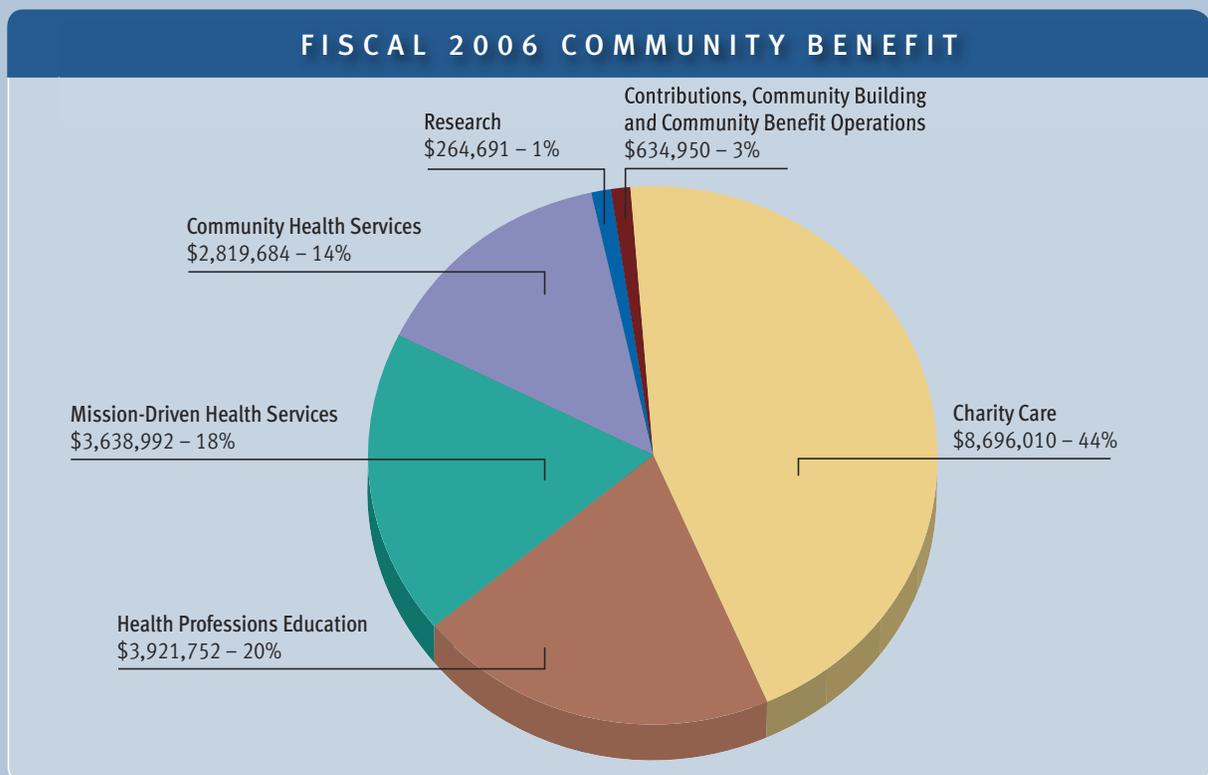
The goal moving forward is to continue to grow the program over five years. Partners include the Latino Health Initiative; Montgomery College; Montgomery County Department of Health and Human Services; Montgomery County Workforce Investment Board/MontgomeryWorks One-Stop Career Development Center; Career Transition Center, Inc.; and Welcome Back Initiative. The program also is expanding to other community hospitals.

# Our Commitment to the Community

In fiscal 2006, Holy Cross Hospital dedicated nearly \$20 million to community benefit, more than any other hospital in Montgomery County according to the most recent publicly reported data available from the State of Maryland Health Services Cost Review Commission.

Holy Cross Hospital provided nearly \$9 million in financial assistance, representing one-third of the county's total hospital charity care.

In total, the community benefit program had more than 320,000 encounters with community members.



## Planning and Oversight

The State of Maryland Health Services Cost Review Commission establishes the definition of community benefit and the reporting categories.

Holy Cross Hospital's interdepartmental leadership and its board of trustees plan, monitor and evaluate the hospital's community benefit efforts. Initiatives are thoughtfully planned to ensure links between the

hospital's clinical expertise and unmet community needs identified in local needs assessments.

Our activities focus on positively impacting the health of our community with programs tailored to the unique needs of women, infants and seniors, and racial, ethnic and linguistic minorities.

## Our History

Holy Cross Hospital was founded by the Sisters of the Congregation of the Holy Cross in 1963 and is a member of Trinity Health, one of the largest health systems in the United States.

## Trinity Health's Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us. Our core values are respect, social justice, compassion, care of the poor and underserved, and excellence.

## Holy Cross Hospital's Role

Holy Cross Hospital exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area. Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

*For additional information about Holy Cross Hospital Community Benefit, contact John M. Pollack, M. Div., at 301.754.7391 or [pollaj@holycrosshealth.org](mailto:pollaj@holycrosshealth.org).*



**HOLY CROSS HOSPITAL**

Experts in Medicine, Specialists in Caring.™

A MEMBER OF  TRINITY HEALTH

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Silver Spring, MD 20910  
301.754.7000

[www.holycrosshealth.org](http://www.holycrosshealth.org)

## **HSCRC EVALUATION FRAMEWORK PROPOSAL:**

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

### *Community benefits planning*

Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Were hospital staff and leadership involved in developing the plan?

### *Community needs assessment*

Does the hospital's plan target specific areas of community need?

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.

### *Community benefits initiatives*

Does the hospital identify its community-based initiatives?

Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

Were the initiatives performance-based and did they involve process and/or outcome measures?

### *Community collaboration*

Did the hospital involve other community participants in planning and/or implementing its community benefit activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?

Did the hospital participate in any community organizations, partnerships or efforts to plan and/or implement its community benefits activities?

### *Community benefits implementation*

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?

Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

## **Howard County General Hospital Response:**

### **Community Benefits Planning**

Howard County General Hospital (“HCGH” or “Hospital”) conducts community benefit planning through both its strategic planning process as well as its annual operating planning and budgeting process. The Hospital’s strategic plan, updated approximately every four years, outlines broad areas of strategic focus. The current plan, adopted by the Board of Trustees in June 2006, identifies access to and provision of services to HCGH’s increasingly diverse population as a strategic priority that is rooted in increasing community benefit. The strategic plan is developed by the Board of Trustees’ Strategic Planning Committee, comprised of trustees, senior hospital staff and selected community leadership, and includes input from physician, hospital staff and community leadership. The plan is ultimately approved by the Board of Trustees. Execution of the strategic plan is the responsibility of hospital management.

The annual operating plan and hospital budget incorporate near-term community benefit planning along with other hospital activity and program planning. The hospital budget includes a line item that specifically designates HCGH financial resources to support targeted initiatives of community based non-profit agencies. Furthermore, all managers are required to support local not-for-profit health and human service agencies with volunteer service in leadership or other roles.

### **Community Needs Assessment**

HCGH last conducted a comprehensive community health needs assessment in 1997. In 2001 the Hospital participated in and supported a comprehensive community health needs assessment sponsored by the Howard County Health Department (“HCHD”). Each needs 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.

As a result of the 2001 HCHD Health Improvement Planning initiative, eight focus areas were identified:

- Cancer
- Asthma
- Mental health
- Injury and violence prevention
- Smoking cessation
- Diabetes
- Health of seniors
- Nutrition and physical activity

A coalition of community providers and other interested parties was formed to develop and execute health improvement plans around each focus area. Following the 2001

County Health Department Survey, a Health Improvement Plan (“HIP”) Steering Committee was established to monitor progress of health improvement priorities. Chaired by the County Health Officer, the HIP Steering Committee includes key leadership from HCGH, the county health department, police, fire & rescue, public schools, the Association of Community Services and the Horizon Foundation, a \$90 million private foundation funded and established by HCGH in 1998 to improve community health in Howard County. The HIP Steering Committee meets quarterly to monitor progress of coalitions established to develop and execute strategies to improve health in the above-mentioned focus areas.

### **Community Benefits Initiatives and Community Collaboration**

HCGH directs its community health improvement initiatives out of its Community Health Education Department, which has a mission “to provide health education and wellness programming to the community which focuses on prevention and early detection.” Programming addresses physical, mental, emotional and spiritual aspects of wellness. Priority is given to identified community health needs. In addition, the department serves as a health referral and networking center for the community. In FY 2007 over 34,000 persons were served

HCGH publishes a quarterly community health newsletter, *Wellness Matters*, which is mailed to over 175,000 households and includes articles about health improvement and listings of health education and fitness programs, health screenings, and support groups offered by the hospital and other community not-for-profit health and human service providers. Most support groups are co-sponsored with other community-based organizations, including the American Cancer Society, the Crohns and Colitis Foundation, etc.

Hospital community benefits programming does indeed reflect evidence based needs. In 2004 the Horizon Foundation commissioned a study on access to health care in Howard County. The study, performed by John Snow Inc. (“JSI”), identified numerous barriers to health care for a burgeoning foreign born population in Howard County, particularly the Latino and Korean segments of this population. Using the results of this study as a starting point, Hospital leadership engaged Latino community leaders from Alianza de la Comunidad – a Latino support and referral group, and St. John the Evangelist Catholic Church – a Catholic church in Columbia with a large Latino population, to plan outreach initiatives to break down barriers to care. As a result, two annual Howard County Latino Health Fairs have been held in March 2005, 2006 and 2007, each drawing over 400 Latinos to events featuring screenings and health education provided by more than 30 HCGH and community based health and human service providers. In 2007 HCGH sponsored its first Korean Health Fair, held on April 29<sup>th</sup> at Centennial High School, which featured more than 40 community organizations that offered health screenings and education, as well as information about community resources. Over 200 Korean residents attended.

More broadly, HCGH recognized from the JSI report that the indigent populations residing in the Oakland Mills village of Columbia as well as the neighborhood

immediately north of the Hospital faced barriers to care. In response the Hospital has worked closely with the Horizon Foundation to facilitate the establishment of the Chase Brexton Community Health Center- Columbia (“Center”) which opened in the Oakland Mills section of Columbia in September 2006. The hospital provides both direct financial support to the Center as well as in-kind health care services free of charge to certain uninsured Chase Brexton patients.

Additionally, the Hospital participates in other community partnerships to promote health improvement in the community. HCGH has entered into sixteen partnerships with various schools throughout Howard County as well as a general partnership with the Howard County Public School System to promote health education, health career awareness, and generally support the education system’s contributions to overall good health.

Finally, HCGH supports local health and human service programs with both financial grants and in-kind support through its managerial staff, all of whom are evaluated on their personal support of these organizations through volunteer participation.

### **Community Benefits Implementation**

The Hospital monitors and evaluates its community benefit activities by regularly reporting such activities through the strategic plan monitoring program. In addition, reports of extraordinary activities are included in a report provided to the Board of Trustees at its monthly meeting. The Senior Vice President for Planning and Marketing has responsibility for reporting progress on these initiatives to the board.

To date, such reporting has largely been process based (e.g. number of attendees at a particular program) rather than outcome based (e.g. reduction in incidence of a particular illness or condition). As models and measures get more sophisticated we hope to better capture outcomes data that can be directly linked to HCGH community benefit programming.

Annually the Hospital produces a community benefit report which is published in the winter edition of *Wellness Matters*. In addition, specific initiatives are highlighted to the community in the quarterly *Wellness Matters*.

**HSCRC Community Benefit Report – The Johns Hopkins Health System Access to Specialist Providers for the Uninsured – FY 2007 Report Submission**

This section of the report responds to the new HSCRC requirement for hospitals to include a “written description of gaps in the availability of specialist providers to serve the uninsured in the hospital.”

Johns Hopkins Hospital provides a full range of specialty care by leading physicians in their disciplines, and does so without regard for the health insurance status of the patient. Johns Hopkins Hospital also works in cooperation with Johns Hopkins Bayview Medical Center and Howard County General Hospital to meet the specialty care needs in a timely fashion for all individuals seeking specialty care. These approaches eliminate any gaps in the availability of specialist providers to serve the uninsured in the hospital.

## EVALUATION FRAMEWORK PROPOSAL

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

### *Community benefits planning*

Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Were hospital staff and leadership involved in developing the plan?

### *Community needs assessment*

Does the hospital's plan target specific areas of community need?

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.

### *Community benefits initiatives*

Does the hospital identify its community-based initiatives?

Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

Were the initiatives performance-based and did they involve process and/or outcome measures?

### *Community collaboration*

Did the hospital involve other community participants in planning and/or implementing its community benefit activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?

Did the hospital participate in any community organizations, partnerships or efforts to plan and/or implement its community benefits activities?

### *Community benefits implementation*

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?

Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

## Johns Hopkins Bayview Medical Center FY07 Community Benefits Plan Evaluation

### Community Benefits Planning

Johns Hopkins Bayview Medical Center (JHBMC) solicits input from staff and leadership annually to develop management objectives. One of those objectives for FY07 pertains to JHBMC's organized and measured approach to participating in and meeting identified community health needs. The objective is to:

- Improve organizational diversity, in terms of representation of under-represented minorities.

The recruitment and retention of Spanish-speaking employees is an important initiative at JHBMC. The Director of Employment Services remains an active member of the Maryland Hispanic Workforce Council and attends meetings regularly. JHBMC also continued to offer a GNA training class for Spanish-speaking students, partnering with Global Tech Bilingual Institute to assist with the recruitment and assessment of the participants. In FY07, thirty-three Spanish speaking employees were hired.

In an effort to address the broader need for a diverse and inclusive employee base, the medical center hired a full time diversity specialist and organized a Diversity Leadership Council. The council oversees the work of several Diversity Committees, one of which is Recruiting & Community Partnerships. The Council and its committees were being formed and beginning to meet at the end of the fiscal year.

Another related objective is to:

- Develop and implement a community relations improvement plan.

This plan includes the following:

*Share information with the community advisory board and seek feedback from board members.*

*Seek community support for internal and external medical center expansions (i.e. new buildings, operating room expansion).*

*Sustain communication with key community leaders.*

*Address individual concerns and questions as they arise.*

### Community Needs Assessment

The most recent community needs assessment was completed in FY05 and described in the FY05 evaluation component of the community benefit report. The assessment was a follow-up to a 1996 needs assessment that spearheaded JHBMC's Community Health Action Project (CHAP), the goal of which is 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 FY07, a representative from JHBMC worked with a group of service providers from the southeast portion of Baltimore County to conduct a needs assessment specific to that area of the county. The Baltimore County Office of Community Conservation and Franklin Square Hospital Center paid for a consultant to conduct the assessment. The final product will be finalized in FY08 and shared by all of the stakeholders.

### **Community Benefits Initiatives**

On July 8, 2002, JHBMC opened its community health library for the public's use. The library was created to offer the community a resource for reliable health information, via access to the Internet, educational videos and publications. When the library first opened, the hours of operation were limited to 10 a.m. – 2 p.m. daily and volunteers staffed it. This changed in FY07, however, when the staff of the medical library assumed responsibility for this community resource. The hours were expanded to 9 a.m. – 4 p.m. and a librarian now staffs this library. Nearly \$7,000 worth of journals, books, media equipment (i.e. a DVD player, headphones) and office supplies was purchased to enhance the library. As a result, there was an increase of over 700 encounters for the community health library in FY07.

The staff of the medical library appreciates the ease with which the general public is able to locate seemingly reliable health information using the Internet. However, more often than not, people access *unreliable* information. To counter this likelihood, the librarians offer courses in the community that teach people how to find reliable health information online. They also created a reference guide (in Spanish and English) that is available at health fairs and as requested.

JHBMC offers a variety of support groups that are open for the public to attend. One example is the Seeds of Hope Bereavement Support Group, which provides education and support for people who are dealing with grief and loss. This group is new in FY07 and is offered by the palliative care providers at JHBMC. This group reported forty-two encounters in FY07.

The Caregivers Support Group has been offered for just over two years and serves as a safe haven for caregivers to share frustrations, fears and growth in caring for their loved ones. This group has proven to be a valuable resource for caregivers in that group members took the initiative to create a phone tree to call one another in times of need. A survey by the Alzheimer's Association about this group revealed that members feel the group is worthy and that it has made a good impact on their lives. This group had a total of one hundred encounters in FY07.

### **Community Collaboration**

JHBMC is able to impact community health on a broader scale by being an active member of several local and state coalitions. Examples include:

- JHBMC's Maryland Safe Kids Coalition representative is a certified car safety seat technician who is available to help anyone in the community safely install an infant or toddler car seat upon request.
- JHBMC's Maryland Healthy Eating and Active Lifestyle Coalition representative is helping with the implementation phase of the state's Nutrition and Physical Activity Plan, which is part of a Centers for Disease Control and Prevention (CDC) grant.
- JHBMC's Maryland Health Disparities Coalition representative attends meetings regularly and helped coordinate a town hall meeting at the medical center to help get the word out to health care providers and clients alike about health disparities.
- JHBMC's Tobacco-free Baltimore County Community Coalition representative attends monthly meetings on behalf of the medical center and shares coalition updates.

JHBMC continues to sustain positive relationships with over thirty different community associations by attending their meetings on a regular basis. This allows JHBMC to:

- Inform area residents of community benefit activities
- Seek information and opportunities to improve the community's health status
- Address any questions or concerns that residents may have about activities on our campus and
- Identify opportunities to focus hospital resources to meet community needs

Additionally, JHBMC participated in 86 fairs, festivals and special events in the communities it serves. Upon completion of each event, we solicit feedback from the sponsors to ensure that we have met their specific needs. Some of the comments from FY07 include:

- "The staff was friendly and knowledgeable. The doctor discussed issues in depth and the membership enjoyed the program very much."
- "Your display provides essential information to the O'Donnell Heights community."
- "Many visitors to our event were eager to receive the blood pressure screening."
- "Everything was well done and professional. Thank you again and hope to work with you again."

### **Community Benefits Implementation**

The community continues to play a role in planning and implementing some of the medical center's community benefit activities. On a large scale, community benefit report information is included in the medical center's newsletter, which reaches over

130,000 homes. On a very local level, a community advisory board consisting of business partners and residents of the communities JHBMC serves meets six times a year. In addition to learning about campus development, the board has a vested interest in hearing about and recommending community outreach activities. Input is solicited regularly at meetings. It is not uncommon to request and obtain letters of support from this board for many of JHBMC's initiatives.

The Community Relations department has primary responsibility for the day-to-day oversight of community benefit activities as they relate to the community. The staff is responsible for providing regular blood pressure screenings in the community, staffing health fairs, coordinating informational talks when requested and providing a variety of wellness-based education that otherwise would not be offered.

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Johns Hopkins Hospital provides a full range of specialty care by leading physicians in their disciplines, and does so without regard for the health insurance status of the patient. Johns Hopkins Hospital also works in cooperation with Johns Hopkins Bayview Medical Center and Howard County General Hospital to meet the specialty care needs in a timely fashion for all individuals seeking specialty care. These approaches eliminate any gaps in the availability of specialist providers to serve the uninsured in the hospital.

**Johns Hopkins Hospital – FY07 HSCRC Community Benefit Report**  
**Section M – Community Benefits Evaluation**

**HSCRC EVALUATION FRAMEWORK PROPOSAL:**

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

*Community Benefits Planning*

Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

Were hospital staff and leadership involved in developing the plan?

*Community Needs Assessment*

Does the hospital's plan target specific areas of community need?

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.

*Community Benefits Initiatives*

Does the hospital identify its community-based initiatives?

Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

Were the initiatives performance-based and did they involve process and/or outcome measures?

*Community Collaboration*

Did the hospital involve other community participants in planning and/or implementing its community benefit activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?

Did the hospital participate in any community organizations, partnerships or efforts to plan and/or implement its community benefits activities?

*Community Benefits Implementation*

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?

Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

**Johns Hopkins Hospital Response:**

Community Benefits Planning

As part of the strategic planning process, clinical departments of The Johns Hopkins Hospital (JHH) are required to present their annual plan to Johns Hopkins Medicine (JHM) leadership. Relationships between the community and JHM were taken into account in the development of the FY07 Management Objectives. Under the strategic priority "Redevelopment & Innovation" was the JHM management objective, "Achieve campus and community redevelopment plans on budget and on schedule." As part of the management objective process JHM entities and clinical departments were asked to develop tactics, metrics and targets to achieve this objective.

Community Needs Assessment

In 1997 JHH contracted with Holleran Consulting to conduct a Community Health Needs Assessment of East Baltimore.

In 2000 the Johns Hopkins Urban Health Institute (UHI) was developed. 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. One of the goals of the UHI is to provide 100% Access to Health Care with No Disparities.

Beginning in 2003 the JHH/Johns Hopkins University (JHU)/UHI began a collaborative effort to construct a database of research activities that involve the community of East Baltimore. The primary objective of this database is to match the research capabilities of the JHU and JHH to the needs and aspirations of the community. This database is now in prototype form.

The most recent community needs assessment that includes the community around JHH, and positions both JHH and JHBMC to better understand the needs of the community and target initiatives that are most likely to have a positive impact on improving the health of residents was completed 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 is to reduce the incidence of heart disease in the medical center's catchment area by ten percent over ten years.

## Community Benefits Initiatives

JHH has recently updated its campus-wide Community Services Directory. The directory enhances the Hospital's ability to track its community-based initiatives and improve the accessibility of services to the community. The directory identifies current Hospital sponsored community-based initiatives with a description of services and contact information. The directory has allowed JHH to track and remain aware of its community-based initiatives.

A significant number of JHH's community benefit initiatives continue to reflect evidence-based needs, to include evaluations based on performance and to include outcome and process measures. Some examples of these initiatives include the Department of Psychiatry's Case Management and Mobile Treatment programs. The Case Management Program has been in existence for over ten years providing support services for individuals with chronic mental illness. There are many sources of evidence that support the need for case management services focused on chronic mentally ill individuals. They include the incidence and prevalence rates of chronic mental illness, the rate of homelessness among individuals with mental illness and JHH psychiatric re-admission rates. The Case Management Program services include housing, employment and social services to help support individuals in the community.

The Mobile Treatment Program was the first of its kind in Baltimore City that provided intensive psychiatric treatment within the home. The program is also based on several sources of evidence including incidence rates of chronic mental illness in the community, as well as JHH psychiatric admission and re-admission rates. Intensive psychiatric services are provided in the home of individuals not able to attend traditional treatment in an outpatient setting. The main goal of the Mobile Treatment Program is to help prevent mentally ill individuals from being re-admitted to the hospital.

Other community benefit initiatives included in previous reports are the Comprehensive Women's Program which is based on multiple sources of evidence that support the need for substance abuse services particularly focused on women. Supporting evidence includes drug related arrest rates, JHH admissions with a drug diagnosis, rates of delivery for drug affected infants and the volume of individuals seeking treatment. The program provides specialized treatment for drug dependent women. Services are designed to address the special needs of women in addition to providing more standard substance abuse education and relapse prevention therapy.

Several Comprehensive Women's Program components address family system needs including therapists who have received special training in family therapy, a parenting skills program, and substance abuse prevention groups for the children of program clients. This initiative is performance-based and involves both process and outcome measures. Process measures include the number of admissions/discharges, visit volume per month and medical record audits of clinical documentation. Patient outcome measures include retention in treatment, number of arrests during treatment and

participation in vocational/educational activities. These measures are monitored by the funding agency and the JHH. The program had 2,672 client encounters during FY2007.

The Dunbar Hopkins Health Partnership assists Baltimore City's Paul Lawrence Dunbar High School in preparing its students to pursue careers in the health care industry through school-to-career transition initiatives. The program provides students' exposure to JHH through tours, lectures, seminars, job shadowing, and paid work experience. Students also are provided health-related educational opportunities and reinforced college preparatory learning, as well as relevant career development skills. Approximately 120 students participate in the Dunbar Hopkins Health Partnership annually with a significant number going on to attend college and pursue health careers. The need for career transition initiatives to guide young students has been documented.

The Dunbar Hopkins Health Partnership was established to meet this documented need at the Paul Lawrence Dunbar High School. In order to track outcomes, performance-based evaluations are also conducted.

The PATCH (Psychogeriatric Assessment and Treatment in City Housing) Program remains an important component in meeting the needs of local residents. The program provides psychiatric care to severely mentally ill older individuals living in Baltimore City Housing and a community-based mobile psychiatric treatment service outreach to residents in need of treatment. The program does contain an evaluative component that is performance-based.

### Community Collaboration

JHH remains committed to actively involving community participation in its community benefit activities. A number of community initiatives have included community involvement in their development and implementation. Community initiatives such as Basic and Cancer Science Days were developed with community participation. During these activities elementary school students are exposed to science by observing scientific experiments, interacting with researchers and participating in a science learning show.

Other examples of initiatives that involve community participation include The East Baltimore Technology Center (EBTC) which provides computer literacy training and refurbished computers to community residents. The EBTC was developed with input from local community organizations and residents. Unified Voices, a JHH sponsored choir involving staff and community members, was also created with significant input from community members. Additional initiatives such as the Dr. Bernard Harris Elementary School Summer Tutorial Program, Operation PULSE, Martin Luther King Jr. Early Head Start and the Dunbar Hopkins Health Partnership have included community representatives in their planning and development activities.

During the year, JHH participated in several community partnerships including the East Baltimore Development, Inc. (EBDI) and the Historic East Baltimore Community Action Coalition (HEBCAC). EBDI is a non-profit organization responsible for leading and

managing the revitalization of an 80 acre portion of East Baltimore north of the JHH campus. The organization is supported by a partnership including the community, City of Baltimore, State of Maryland, local civic groups, charitable foundations, JHH and the Johns Hopkins University. The partnership is significantly involved with redevelopment efforts to create a life science and technology center, new business activity, new housing, green space, jobs and human services.

HEBCAC is a community-based partnership organization created by the community, City of Baltimore, State of Maryland, businesses, JHH and the Johns Hopkins University to revitalize and redevelop local neighborhoods. JHH plays a significant role in the partnership by providing leadership in the organization's governance, actively participating in redevelopment projects and providing financial support.

### Community Benefit Implementation

Due to the vast array of continuously developing community benefit initiatives and the Hopkins spirit of entrepreneurship, JHH departments are individually responsible for monitoring and fulfilling the goals outlined in their community benefit activity strategic plans. JHH senior leadership is responsible for overseeing the attainment of departmental goals through the annual strategic planning process and periodic reports on major projects.

A continuing primary function of the JHH Office of Community Services is to plan, implement and monitor community benefit activities. The monitoring of community benefit activities is conducted throughout the year. The JHH Office of Community Health is also responsible for monitoring initiatives that address the health status of the community. JHH leadership is constantly informed regarding the type and progress of the institution's community benefit activities.

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**University of Maryland Medical System  
(UMMC and J. Lawrence Kernan Hospital)**

**HSCRC Community Benefit Report  
FY 2007  
Summary of Evaluation Process**

Each of the eight hospitals in the University of Maryland Medical System (UMMS) enjoys a long history of working within the communities it serves. Each hospital's mission includes providing services to the community for the benefit of its residents, often on a reduced or no cost basis.

UMMS hospitals are committed to strengthening their neighboring communities. In doing so, each hospital often provides support, financial and otherwise, to various community-based organizations and partners. For many years, the hospitals in the University of Maryland Medical System have internally coordinated and conducted community health, outreach, education and screening activities with various community partners.

**Community Health, Outreach and Advocacy Strategic Plan**

A Community Health, Outreach and Advocacy Strategic Plan was developed in FY2006 as an effort to better coordinate and direct member hospitals' work moving forward. A System-wide team (the "UMMS Community Health Coalition") of 20 individuals was established to construct this plan and an UMMS community health, outreach and advocacy program.

The scope of work for the UMMS Community Health Coalition centered on creating a "two-way dialogue with the community, faith-based organizations, senior centers, community organizations....and other key, established community partners". To effectuate this work, the Coalition adopted a multi-faceted approach to "listening" to and soliciting community needs and concerns. Members of the Coalition interviewed several elected and appointed officials as well as other community leaders to seek their input, ideas concerns and suggestions on how UMMS could best reach, meet and address the needs of the community.

The Coalition concluded in this Plan that community work should include: (1) effective and efficient delivery of community services, (2) system integration of these services, where appropriate, (3) effective utilization and deployment of resources for community-based activities, (4) effective communication of efforts in order to maximize awareness of community activities, and (5) meet specific targeted community needs within defined geographic area(s).

## **Ongoing Evaluation**

It is important that UMMS member hospitals periodically evaluate the success of any program(s) implemented as a result of the Strategic Plan or initiatives of the Coalition. The means for doing so require that member hospitals and the Coalition:

- Create a baseline of patients educated and screened each year;
- Set goals for increasing these numbers annually;
- Measure/track the number of patients who seek follow up from education or screening results;
- Set goals for increasing these numbers annually;
- Measure community health outcomes in targeted areas, i.e., cardiac-related diseases and diabetes;
- Continue follow up with patients in the target group; and
- Measure health improvements in the target disease areas.

## **Member Hospital Evaluation Processes**

Each of the member hospital of UMMS continually evaluates clinical programs and services based on adherence to its mission and strategic goals and objectives. Community health and educational based initiatives and actions are evaluated based upon:

- clinical quality – how the service improves patient outcomes and quality indicators
- customer satisfaction – how it improves patient and family satisfaction and meets the needs of diverse patient populations
- financial performance – what is the contribution margin and how does it position us to increase revenue
- operational effectiveness – how does it enhance staff productivity, patient flow and cost effectiveness
- workforce development – how does it impact morale, culture, skill development, recruitment and retention of staff

Health outcomes and impact on the community is a consideration in the development of clinical program plans and is measured in terms of clinical effectiveness and quality (length of stay, morbidity, complications, re-admissions, etc.), customer satisfaction (patient satisfaction surveys), and access to services (measures of time to next appointment, focused discussions with community leaders and consumers, etc.)

Each of the member hospitals utilize available community health assessment reports from area health departments in the development of clinical program plans for selected service lines. In addition, the UMMC strategic planning department consistently tracks clinical

and community program demands and supply in conjunction with the Maryland Health Care Commission (MHCC).

When seeking information on specific community health and access issues, each of the hospitals use a variety of methods to obtain community input including community focus groups, participation on area elementary school community committees, and ongoing dialogue with the Farmer Mitchell Board (UMMC) that serves as a resource for the Medical Center's primary health activities. Kernan Hospital administrators have gone to the Franklinton community association for input regarding community issues.

Each of the member hospitals' Community Outreach Manager develops and implements community health screenings, educational lectures, health fairs and various other outreach programs throughout the year. Each of the hospitals' participation at these community and employer-sponsored health fairs provides continuing opportunities to learn what community residents need and desire in terms of access to health screenings, diagnostic and treatment modalities, and clinical research. UMMC maintains an information kiosk at Lexington Market that has free health information and brochures and a calendar of local health events.



## **Kernan Hospital FY 2007 Specialty Gap Statement**

### **(Part of the University of Maryland Medical System)**

Kernan Orthopaedics and Rehabilitation is licensed as an acute hospital without an emergency room. Any patients presenting at the hospital, 911 is called and they are transferred to the most appropriate hospital by the Baltimore Fire Department's EMS. Patients in need of services other than orthopaedics, rehabilitation and dental are referred to another hospital within the University of Maryland Medical System.

Kernan has been meeting the special needs of the Baltimore Metropolitan Community for over 100 years. During this period of time, the hospital has transitioned and evolved from a children's orthopaedic hospital, meeting the unique needs of disabled children and those inflicted with polio, to a University of Maryland Medical System Hospital dedicated to adult and pediatric orthopaedics and multidisciplinary adult rehabilitation services. This transition and mission of Kernan has embraced the changing needs of the community it serves. In the 1990's Kernan merged with Montebello, one of three chronic hospitals built in the 1950's, to meet the statewide need for comprehensive rehabilitation care. Today, the hospital continues to evolve and modify its services based on the needs of the community.

Kernan provides statewide leadership for rehabilitation and serves as the State's rehabilitation hospital (William Donald Shaffer Rehabilitation Center). As the patient census at the Shock Trauma Center at the University of Maryland Medical Center grew, it was recognized that there was a need to provide streamlined, diversified rehabilitation services for the many survivors of these complex catastrophic accidents and illnesses. This stimulated the evolution of the rehabilitation program at Kernan which has continued to evolve and grow based on the needs of the citizens of the State of Maryland. These programs have been modified and enhanced over the years to meet the most significant needs - especially in the area of brain injury, stroke, orthopaedics and other neurological conditions. Kernan accepts all patients in need of rehabilitation services regardless of their financial status or potential discharge challenges.

As the rehabilitation programs have grown at Kernan, the need was identified to provide other services on an outpatient basis to assist the patient in their reintegration back into their community. Working with various groups such as the Brain Injury Association, Arthritis Foundation and the Active Survivors Network, Kernan continues their support to these organizations to facilitate the fulfillment of their mission goals and to assist patients in their reintegration back into their communities in the face of potential life-long challenges. These programs includes out-patient therapy services (physical therapy, occupational therapy, speech therapy) as well as the development of a multiple sclerosis (MS) day program which provides support and a learning environment for patients and families affected by MS. Kernan also offers multiple support groups including: stroke, brain injury, spinal cord, parkinson's, amputee, and one for caregivers. The financial resources of these programs are limited and Kernan provides ongoing support for office/meeting space and through other contributions.

Recognizing the importance of leisure interests, Kernan has partnered with a number community organizations. These organizations include: Baltimore Municipal Golf Corporation, BARS (Baltimore Adaptive Recreation and Sports), and Baltimore City Department of Recreation. Kernan has purchased adaptive golf carts for local golf courses, and constructed an adaptive putting green and sports court for individuals with physical limitations on the Kernan campus.

One highly recognized area of need is access to dental services for children, adults, and the physically and mentally challenged. Recognizing this need, Kernan added a Dentistry Service in 1996 to serve this population. Since that time, the hospital has significantly expanded this program. The target population consists of low income families and adults and children with special needs, including those on waiting lists for treatment and those who have been turned away from routine care providers. This program addresses problems from three perspectives. First, from the clinical perspective, Kernan Dental Service is continually increasing its services to meet the growing demands of these target populations, which exceeds our current capacity. Second, from a standpoint of improving oral health infrastructure in Maryland, the hospital helps to ease the burden on emergency room care by providing treatment to patients before symptoms become acute/emergent to avoid the complications brought on by an absence or delay in treatment of complex needs. Third, from the patient's perspective, it improves patient health outcomes by avoiding the complications brought about by delays in treatment for complex dental needs and providing a dental home for these patients.

According to the Health Care Access and Safety Net Act of 2005, one of the most underserved, under resourced and under accessed medical specialties is dental care. The Children's Dental Health Care Project (2000) indicated that 80% of children covered by Medicaid have modest dental needs, 15% have moderate needs and 5% have catastrophic needs. A 2006 evaluation of dental health in Maryland conducted by the Office of Oral Health identified several populations having the most difficulty accessing care including, low-income families, children under the age of three, foster children, immigrants (both documented and undocumented) and patients with special needs and/or disabilities. These are all patient populations that Kernan targets and serves.

The founder's mission for Kernan's role as an Orthopaedic Pediatric hospital remains an integral component to this day. Kernan employs two active Pediatric Orthopaedic surgeons to meet the needs of the community and is currently recruiting another Pediatric Orthopaedic surgeon in collaboration with the University of Maryland School of Medicine's Department of Orthopaedics.

As the Maryland population continues to grow and age, it is recognized that the hospital industry will continue to grow and require replacement of its workforce. Considering this, the hospital has identified and worked with several universities and colleges to provide access to training opportunities at Kernan for nursing and allied health professionals at the Associates, Bachelors and Masters levels. These opportunities include internship programs for physical therapy, occupational therapy and speech & language. Recognizing the need of expanding the educational opportunities for preparing the next generation of healthcare providers, Kernan offers scholarships, paid externships and tuition reimbursement. Given the current healthcare environment, there will continue to be gaps between the needed professionals and the number of persons we are able to support and train.

Lastly, as an Institution, the hospital reaches out to its local community to work with them to meet not only their healthcare needs, but also to support community efforts to improve the surrounding environment. Working with Dickeyville and Franklinton Community Associations, we have identified and participated in a number projects to improve the quality of life in the community and provide support for local schools to promote an enriching learning environment for their students.

Services which can not be provided by Kernan are referred to our UMMS Hospitals (primarily UMMC, Maryland General, Mt. Washington Pediatric Hospital and University Specialty Hospital).

**Community Benefits Reporting  
Fiscal Year 2007**

**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 620 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?
  2. Were hospital staff and leadership involved in developing the 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.

- Community Needs Assessment
  3. Does the hospital's plan target specific areas of community need?
  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.

Not at the present time, we hope to in the future.
  7. Were the initiatives performance-based and did they involve process and/or outcome measures?

Not at the present time, we hope to in the future.

- 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?

Not in any of this year's community benefit activities, but we did participate in a seminar on building community connections in which we learned what other hospitals are doing to benefit the community through various collaborations with local businesses and organizations. In the near future, we plan to build similar community connections.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

Not at the present time, we hope to in the future.

- 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.

## **Maryland General Hospital Community Benefits Evaluation FY 2007**

### **General Statement:**

UMMS hospitals are committed to strengthening their neighboring communities. In doing so, each hospital often provides support, financial and otherwise, to various community-based organizations and partners. For many years, the hospitals in the University of Maryland Medical System have internally coordinated and conducted community health, outreach, education and screening activities with various community partners. Examples of several effective partners with whom relationships have been formed include: Frederick and Calvin Rodwell Elementary schools, the Commission on Aging and Retirement Education, The American Heart Association, The American Cancer Society, The Skin Cancer Coalition, Action for Community Enrichment, Bethel AME and St. Bernadine's Church.

Until recently, each UMMS hospital worked independently to address an array of community health concerns or requests. As a System, member hospitals had not previously coordinated activities or pooled resources. A few individuals have devoted full or nearly full-time efforts to community-based activities, and their work has been wide-ranging. Hundreds of education seminars and screening activities occur across the System each year. Although excellent, these efforts have often been scattered and reactive to community demands rather than specifically focused in accordance with pre-determined strategies or goals.

### **Maryland General Hospital:**

For the past fifteen years, Maryland General Hospital has made a long-term investment into our community by way of the Community Health Education Center (CHEC). CHEC assesses the health education and health screening needs of the community by responding to specific requests by organizations and community leaders. In FY 2007, CHEC attended nearly 100 events in Baltimore City at the request of these leaders, during which 11,528 people participated and 13,901 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.

Currently, CHEC is providing free screening tests for blood pressure, cholesterol, diabetes, tuberculosis, pregnancy, cervical cancer and vascular disease. Blood pressure and vascular disease results are given to the participant by a qualified healthcare professional, trained to answer questions specific to the individuals results. Tuberculosis testing results are obtained during a second visit to CHEC, 48 to 72 hours after testing. Recommendations are given to the individual according to their individual results. Results of the other tests are provided later, usually by mail, complete with explanations, guidelines and other basic information pertaining to the test. All participants are encouraged to call the HealthLink 2000 line with questions and assistance is offered, when necessary, to refer an individual to a healthcare provider for follow-up.

## **Maryland General Hospital Community Benefits Evaluation FY 2007**

The positive impact the program has had on the community is undeniable. During fiscal year 2007, CHEC identified 321 who required follow-up on their blood pressure, 260 who required follow-up with their cholesterol level, 73 who needed to follow-up on their blood sugars, 162 who were reactive on the PPD test for tuberculosis, and 2,255 who had a positive pregnancy test.

**Maryland General Hospital  
Community Benefits Report, FY 2007  
Gaps in Coverage-Specialist Availability**

Maryland General Hospital provides medical care in more than 30 specialties. We have over 500 doctors and more than 1,500 employees. Our services cover education, prevention, and treatment of illness, injury and other sickness.

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.

**MARYLAND GENERAL HOSPITAL**  
**Community Benefits Report, FY2007**  
**Physician Subsidy Detail**

Maryland General Hospital developed and operates a “Surgeons-On-Call” program in order to subsidize a portion of their practice that treats patients without insurance. These surgeons, on a rotating basis, are called in to perform emergency surgery on patients who present to our emergency room for which they would not be compensated. As a subsidy, they are paid the Medicare allowed amount directly by the Hospital.

During fiscal year 2007, a total of \$151,340 was paid to our roster of physicians who provided surgical services to approximately 300 patients.

McCready Memorial Hospital is a very small, rural hospital providing only basic services. The hospital offers general surgeries, diagnostic testing, emergency services, minimal inpatient services and an outpatient clinic.

When specialists or specialty diagnostics are needed, we have sophisticated referral and air/ground transportation services for those patients needing additional treatment or diagnosis from larger facilities where such services are supported.

**Mercy Medical Center**  
**Evaluating the Effectiveness of Mercy's Community Benefit Efforts—**  
**Process, Reporting Structure and Examples**  
**December 2006**

Mercy Medical Center utilizes a clearly defined Board evaluation and reporting process to discuss its community benefit efforts. This process is outlined in several forums which discuss how Mercy is attempting to address the needs of its community as identified in Mercy's core mission—to serve the poor and underserved—and in Mercy's clinical programs and services identified in our strategic plan. When possible, Mercy utilizes data that is uniformly reported to allow Mercy to evaluate the success of our efforts. These data allow Mercy to focus on evidence-based needs. Two areas are highlighted below.

**The Mercy Strategic Plan & Its Commitment to Our Community**

Mercy's 132 year commitment to serving the poor of Baltimore is well known. One of the conclusions from the most recent Strategic Plan<sup>1</sup> (completed in June of 2004) called for Mercy to "...sustain the traditional commitment to the poor and underserved in Baltimore City through the provision of substantive services..."

To accomplish this, The Plan called for Mercy to:

- Assess current programs to determine if they are properly targeted to contribute to the medical needs of the community
- Work collaboratively to address these needs with those in our community who share our commitment (e.g., community health centers)

What is less well known is Mercy's commitment to providing clinical programs targeted to address the healthcare needs of the Region (not just Baltimore City). In this regard, Mercy's most recent Strategic Plan called for Mercy to "...strengthen Mercy's regional programs in women's health, vascular surgery, orthopedics and colon-rectal disease..."

**Assessing Programs Targeted to Benefit the Community**

Assessment of Mercy's programs targeted to benefit its Baltimore City community and the Region is done through the Board of Trustees Mission & Corporate Ethics Committee. A copy of the May 25, 2005 Presentation to the Mission & Corporate Ethics Committee is appended to this document. Two examples of community needs are cited below, one relating to Mercy's commitment to the poor & underserved in Baltimore City and the other relating to a specific medical need of the Region.

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<sup>1</sup> The Mercy Strategic Plan was a nine month effort that include members of Mercy's Board of Trustees, Management, Medical Staff, its Women's Advisory Board and other community leaders.

Mercy looks at both national statistics and State of Maryland statistics in evaluating the effectiveness of its SAFE Program. Nationally, between 1992 and 2000, the average annual sexual assaults were 152,680<sup>2</sup>. In 2003, there were 1,188 rapes reported in Maryland. Mercy's SAFE Center treated 26% (or 305) of the State's victims. These victims were from Baltimore City, Baltimore County and Anne Arundel County. Mercy is also working to train SAFE nurses for positions in other hospitals serving other parts of the State of Maryland.

### *Mercy's Hoffberger Breast Center & Its Center for Women's Imaging*

Mercy initiated The Hoffberger Breast Center in 1997 as part of its commitment to the women of Baltimore City and the Central Maryland Region. Mercy's focus is in early detection, state of the art clinical treatment and in clinical research. Incidence rates in Maryland for breast cancer by geography are as follows:

Maryland:	133:100,000
Central Maryland:	131:100,000
Baltimore City:	115:100,000 <sup>3</sup>

Discussions at the Board's Mission & Corporate Ethics Committee centered around Mercy's belief that the incidence rate for those in Baltimore City may be under-reported, largely as a result of inadequate screening. Mercy is Baltimore's largest hospital provider for screening mammography and as such has a responsibility for working to improve screening for the poor and underserved. This will be discussed later in the collaboration section. Mercy will track both the incidence rate for women in Baltimore City and their corresponding mortality rate.

### **Community Collaboration**

Mercy is a strong believer in community collaboration. Mercy has developed a strong relationship with some of Baltimore's Federally-Qualified Health Centers (FQHC's). They include Family Health Centers of Baltimore (formerly known as South Baltimore Family Health Center), Healthcare for the Homeless and Park West Medical Centers. The collaboration with these FQHC's has allowed Mercy to improve implementation of some of the community need-based initiatives. For example, to improve mammography screening and/or diabetes education, Mercy works with the FQHC physicians to be sure that each patient history and physical includes this component. From the appendix, you will see the "Clinical Indicator Report" given by the Medical Director of Family Health Centers of Baltimore.

Also appended is a November 20, 2006 letter noting Mercy's collaborative partnership with the Family Health Centers of Baltimore (FHCB) in the area of emergency preparedness. The FHCB Emergency Preparedness Management Coordinator works closely with the Mercy Director of Emergency Preparedness and participates as a member of Mercy's Emergency Management Committee.

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<sup>2</sup> United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, August 2002 "Rape and Sexual Assault: Reporting to Police and Medical Attention 1992-2000.

<sup>3</sup> Maryland Cancer Registry, Department of Health & Mental Hygiene.

## **Mercy Medical Center**

### **Description of Gaps in the Availability of Specialist Providers to Serve the Uninsured**

As a major provider of medical services in Center City Baltimore, Mercy is vital to the provision of a safety net for the medically underserved. This safety net is most severely tested in provision of services to Emergency Department patients.

- **Emergency Department:** 27% 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 three physicians who have accepted the responsibility for providing coverage in Mercy's ED, an area where a significant number of uninsured patients are cared for.
  - Mercy supports a weekly Orthopedic Clinic which follows up patients seen in the Emergency Department and other outpatient sites, as most patients are underinsured. Although originally designed to manage the 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 downtown.
- **Otolaryngology:** again, this is especially 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.
- **Dentistry:** Mercy is the major community hospital based dental program in Baltimore, and provides services for adult and pediatric patients seen in the Emergency Department and local clinics.
- **Substance Abuse and Medical Detoxification:** Mercy is the only inpatient detoxification provider in Baltimore City. As 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 overrepresented in patients with substance abuse (e.g. Otolaryngology, Gastroenterology). Substance abuse

Mercy Medical Center  
Description of Gaps in the Availability of Specialist Providers to Serve the  
Uninsured

rates are higher in Baltimore City, and associated with higher rates of inadequate insured patients.

- **General Surgery:** Mercy provides higher levels of uncompensated care to patients in this discipline than any other community hospital in Baltimore.
- **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 2005, the Center for Women's Imaging provided almost 13,000 imaging exams. Due in large part to a shortage in mammographers, Mercy is currently unable to increase services in this area.
- **Gastroenterology:** Coverage remains problematic primarily for inpatients because of Mercy's payor mix. (Emergent gastroenterologic problems involve higher proportions of inadequately insured patients.)
- **Other specialties with challenges in providing services for uninsured patients**
  - **Anesthesia**
  - **Pulmonary and Critical Care Medicine**
  - **Neonatology**
  - **Endocrinology**
  - **Infectious Disease**
  - **Neurosurgery**

2007

# COMMUNITY BENEFIT REPORT



Montgomery  
General Hospital

*Close to our patients*



*A message from our*  
**CHIEF EXECUTIVE OFFICER**

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*Dear Neighbors and Friends,*

On behalf of Montgomery General Hospital, I am honored to share with you our Community Benefit Report for 2007. MGH continues to be committed to improving the health and welfare of the communities we serve and, we pledge to provide high quality care.

Montgomery General Hospital is a 149-bed, not-for-profit community hospital. Founded in 1920 by Jacob Wheeler Bird, MD the original hospital had 28 beds and was the first acute care hospital in Montgomery County. Montgomery General Hospital serves the greater Baltimore and Washington metro areas. The majority of our patients live in Montgomery, Frederick, Howard, and Carroll counties.

Throughout the year, a number of MGH faculty and staff become very involved in projects that improve and help our community. Our devotion to healthcare involves much more than providing high quality, personalized health care services on our hospital grounds. We take great pride in our dedication to improving community health through our outreach efforts and collaboration with community organizations.

Montgomery County is a wonderful place to work and live. The special people in this community make our jobs very rewarding. We would like to thank you for entrusting your healthcare needs in us. We look forward to serving our community for many years to come.

Best wishes for a wonderful new year.

Sincerely,

# COMMITTED TO OUR COMMUNITY



## MISSION:

*We help you feel better*

Montgomery General Hospital is an independent community hospital dedicated to serving the citizens of Montgomery and surrounding counties by providing high quality, personalized health care services.

## VISION:

*Working with our friends and neighbors to create Maryland's healthiest community*

Montgomery General Hospital's vision is to continually increase our value to the community by offering the best of modern medicine in a caring, professional and ethical environment to our:

- Patients and Their Families
- Professional Staff
- Employees and Volunteers

## CORE VALUES:

*We count. Therefore, we are accountable.*

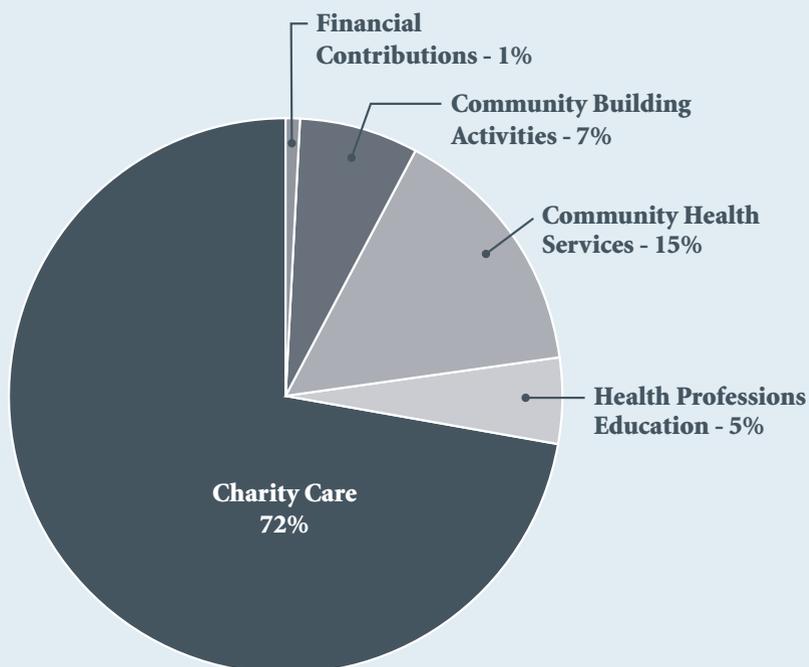
- Respect • Accountability • Integrity
- Teamwork • Excellence

*At Montgomery General Hospital, our vision is to increase our value to the community continuously by offering the best of modern medicine in a caring, professional and ethical environment to our patients and their families, professional staff, employees and volunteers.*

**Our community comes first.**

*As the community grows, so does our commitment to serving its diverse needs.*

**Community Benefit Support by category - FY2007**





## Promoting a **HEALTHIER COMMUNITY**

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Improving community health among our neighbors and friends is very important to Montgomery General Hospital. This year MGH contributed \$844,953 towards community education and outreach, health screenings, support groups, health fairs, counseling, and self-help and wellness programs.

### **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 were designed to educate the community on health related illnesses. Topics included: Addressing Drug Issues, Pan Flu, Smoking & Cancer, Positive Parenting, Stroke Support, Children's Mental Health Crisis Preparedness, Look Good and Feel Better for Cancer Survivors, Headaches, Sleep Apnea, Breast Reconstruction and Pulmonary Rehabilitation.

### **COMMUNITY EDUCATION PROGRAMS**

As a service of the hospital, health education and wellness programs are offered to all members of our community. Community education classes are designed for all members of our community – teens through seniors. Classes are conducted throughout the year. In 2007, classes included: AARP Driver Safety, ACLS for Healthcare Professionals, Babysitting plus CPR, Big Brother/Sister, Blood Drive, Cardiac Rehab, Caregivers Support Group, Childbirth Classes, First Aid, Heartsaver & AED, Home Alone, I Can Cope, Lamaze Techniques, Mommies with Muscle, Mommy & Me, SIDS, Smoking Cessation and Yoga.

### **HEALTH SCREENINGS**

Prevention is the key to a healthy community which is why MGH chooses to offer various free health screening programs throughout the year. To name a few...

*Men's Health Expo* offered free cancer screenings and up-to-date information on prevention, early detection, treatment, diagnosis, and care for several cancers and other diseases. Attendees enjoyed physician lectures by MGH Medical Staff, giveaways, and multiple interactive health booths.

*Dare to C.A.R.E.* offered 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. Included in Dare to C.A.R.E. was nutritional counseling, BP screenings, and podiatry evaluations.

**Women's Health Expo** offered free screenings for dental/oral cancer, cardiac risk factor assessments, blood glucose and cholesterol, skin cancer, hearing, blood pressure, vision and glaucoma.

**Cancer screening and treatment:** MGH continues to make great strides in educating the community about cancer prevention and treatment. Specifically, a full-time oncology nurse is employed to guide patient's families and physicians through the many facets of tests and treatments that often accompany a cancer diagnosis. This "Cancer Care Navigator" is a Registered Nurse certified in oncology with many years of experience in the care, treatment and education of cancer patients. The Cancer Care Navigator educates patients about cancer and treatments, but also provides emotional support and encouragement.

MGH is a proud member of the Montgomery County Cancer Crusade. Through this program, education and screening activities are offered for prostate, colorectal, and oral cancer. A special outreach program developed to raise awareness of prostate, colon and rectal cancer in the African American community was continued and expanded. To reach this underserved population the hospital employs a nurse to coordinate and deliver prostate cancer screenings and colorectal and oral cancer referrals, as well as to provide cancer education to this targeted community. This coordinator position is jointly funded by MGH and the Tobacco Restitution Fund. During the year this program distributed

information about prostate and colorectal screenings as well as general cancer care throughout the community, including barbershops, churches, restaurants and other places where men gather.

One of the largest screening events held during the year was the prostate cancer screening offered in September of 2006 as part of the Men's Health Expo. More than 200 men attended educational seminars about a wide variety of men's health topics and 99 of these men pre-registered and received a free prostate specific antigen (PSA) prostate screening test.

#### **ADDICTION AND MENTAL HEALTH SERVICES**

The Addiction and Mental Health Center (AMHC) is an integral component of Montgomery General Hospital and has earned an excellent reputation over the past 30 years for the delivery of a broad range of fully integrated inpatient, outpatient, crisis, 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 24 hour-a-day 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. During the reported fiscal year, staff spent over 1,800 hours on the phone. There is no charge for this service. •

## Teaching our COMMUNITY

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### MEDICAL EDUCATION

Montgomery General Hospital is committed to reducing the shortage of healthcare professionals in our community. In 2007 MGH invested \$228,229 in activities related to providing clinical settings for training students in medicine, nursing and other health fields.

MGH continued its sponsorship of the Medical Careers Program for students in the community who aspire to become nurses or other healthcare professionals in a hospital setting. The program addresses the growing shortage of health care professionals by offering young people an opportunity to experience what it is like to work in the medical field. MGH nurses and clinical support staff worked closely with these students to facilitate a hands-on learning experience. Approximately 300 students from several local colleges as well as public and private high schools participate in this program each year. Under the general supervision of the Human Resources Department, students do a full rotation in the hospital with on-site supervision by MGH nurses, radiology technicians, pharmacists, laboratory staff and physical therapists. In addition, the Hospital's Nursing Coordinator spends approximately 30 percent of her time supervising the nursing school students.

*Since 1996, the Women's Board has awarded 900 scholarships and provided a total of \$704,800 in financial assistance for our community students.*

Each year, the Women's Board of Montgomery General Hospital offers scholarships to qualified students wishing to pursue a nursing or Allied Health career. The scholarship fund was established to encourage and provide financial assistance to talented people interested in entering the medical field. Scholarships are awarded to students entering college and to those continuing or expanding their careers through advanced degrees.

The Women's Board of Montgomery General Hospital selected 111 students to receive 2007 scholarships. Scholarships were awarded for a total of \$64,500. •



# PROTECTING OUR COMMUNITY



*In 2007, Montgomery General Hospital invested \$415,145 and dedicated 7,999 staff hours to improve disaster preparedness 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 in an effort to help prepare Montgomery County healthcare providers to respond to large scale emergency events in a coordinated, collaborative manner. To this end, a Memorandum of Understanding was signed by the participating hospital 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 healthcare providers in the county on emergency preparedness. This allows MGH to provide better urgent care to the community in the event of a local, regional, and/or national disaster. MGH representatives met with other area hospitals and staff to assess the county's overall ability to handle a crisis situation.

## ENVIRONMENTAL IMPROVEMENTS

More than 5,772 hours of staff time were spent on Environmental Improvements during this reporting period. Efforts to reduce environmental hazards in the air, water and ground as well as reduce waste production occupied more than 2,184 hours of staff time during the fiscal year. Additionally, approximately 2,288 hours of staff time was spent on our recycling program. Environmental pollution prevention and a sharps disposal program also occupied staff time. •

## *Providing Charity Care* **TO OUR COMMUNITY**

A key element of MGH's clinical services is the charity care provided by our hospital. Charity care is the amount of free or discounted medically necessary care provided to patients unable to pay some or all of their bills. Charity care does not include bad debt arising from patients failing to pay medical bills.

At Montgomery General Hospital, our vision is to increase our value to the community continuously by offering the best of modern medicine in a caring, professional and ethical environment to our patients and their families, professional staff, employees and volunteers. Our community comes first. As the community grows, so does our commitment to serving its diverse needs.

*This year, Montgomery General Hospital provided \$3,950,000 in subsidized care to qualifying members of the community.*

*The Hospital provides access to urgent or emergent medically necessary health care services at a reduced or waived fee to all patients who meet criteria.*



# Montgomery General Hospital

*Close to our patients*

18101 Prince Philip Dr. • Olney, MD 20832 | [www.montgomerygeneral.com](http://www.montgomerygeneral.com)

# **Community Benefit Report 2007**

## *Montgomery General Hospital*

### *Gaps in the Availability of Specialist Providers for the Uninsured*

Montgomery General Hospital is dedicated to serving our community by providing high-quality, personalized healthcare services. That involves a pledge to offer accessible services to individuals who do not have the resources to pay for necessary medical care.

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 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 set by Montgomery General Hospital. Hospital financial aid is not a substitute for employer-sponsored, public or individually purchased insurance.

### *Gaps in specialty services*

#### Neurosurgery-

Montgomery General Hospital is occasionally challenged with a shortage of Neurosurgical resources. Neurosurgeons provide comprehensive services in general and specialty neurosurgery that affect the spine, brain, nervous system and peripheral nerves. This service is offered through MGH; however, we currently only have one surgeon who specializes in this field. This physician also covers other hospitals so, his availability is limited.

#### Orthopedic Hand-

In some instances, emergent orthopedic hand cases are transferred to other area hospitals. The current orthopedic demands of our patients sometimes require several weeks waiting time which makes it sometimes challenging to manage emergent cases.

#### Oral/Maxillary/Facial

Facial fractures or severe dental injuries are at times problematic in finding coverage.

### ***Resolution***

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to Montgomery General Hospital. In FY2008, MGH plans to join MedStar Health. By joining this hospital system, 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 will now gain access to the medical staff including specialty resources.

Substantial growth is expected over the next five years. MGH is currently working with a local developer to begin construction on 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.

## Community Benefit Evaluation for Fiscal Year 2007 Northwest Hospital

This report is prepared following the suggested guidelines provided at a workshop entitled “Evaluating Community Benefit Initiatives” presented by Maryland Partners in Community Health Improvement on November 9, 2005.

### **Community Benefits Planning**

Northwest Hospital does not currently have a specific community benefits plan for the hospital overall, however planning for initiatives that benefit the community as a whole or certain community constituencies occurs in several ways. The hospital’s executive staff develops strategic imperatives in response to assessed needs, Board directives, and identified business priorities.

For example, the Board of LifeBridge Health, Northwest’s parent corporation, charged the three hospitals comprising the health system each to identify a priority community health need and develop an intervention that could be implemented and show measurable results in a three to five year period. In response to that charge, a Community Mission Committee, consisting of Northwest board members and leadership staff was formed in March 2005. That committee is charged with advising and monitoring hospital staff in regard to community health and welfare initiatives.

### **Community Needs Assessment**

As with planning, community needs assessments are done in a variety of ways. One way we participate in community needs assessment is by hospital staff serving on community coalitions that perform a planning function. For example, the Coordinator of Community Health Education serves on local and regional coalitions including the Baltimore County Cancer Coalition, the Maryland Skin Cancer Prevention Coalition, and C.H.A.M.P (Community Health and Monitoring Program). All three groups utilize a planning process that identifies problems, substantiated by local or state data, researches best practices and identifies appropriate community partners to participate in the implementation and evaluation of planned activities.

Finally, on occasion the hospital commissions an external consultant to conduct a formal needs assessment on community health needs. We used this means to conduct the 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 representatives. The consultant also performed an extensive review of public health data from Baltimore County, and State health departments. In addition, she interviewed the Baltimore County Health Commissioner to determine the County’s priorities, existing programs, and potential for partnerships.

### **Community Benefits Initiatives**

Initiatives developed in response to identified needs may or may not be based on evidence-based outcome expectations. One example of a program that has a built in evaluation that tracks outcome measures is the Women's Heart Screening Program. One of the selected outcome measures is behavior change following the screening at both 1 month and 6 month post-screening intervals. We evaluate whether the screening participant has followed up with her physician, taken her medication and/or changed her behavior in regard to exercise and healthy eating.

In the community health initiative mandated by the LifeBridge Board, the charge was to identify and respond to an identified community health need. The process of selection of the specific need was based on an assessment of critical health problems through an analysis of need via key informant interviews, review of public health data, etc. Because the charge was to develop an intervention that could show measurable improvements in health status in three to five years, we researched best practices seeking evidence-based models.

The initiative that Northwest selected is an effort to reduce readmissions to the hospital for patients with Congestive Heart Failure. This health problem was selected as a result of the needs assessment. It is in alignment with the Clinical Quality Goal in Northwest's Performance Improvement goals. This initiative, is designed to identify patients admitted for Congestive Heart Failure and enroll them in an educational program that provides community health nurse visits, telephone monitoring and educational materials to assist patients and their families in monitoring and controlling their blood pressure, fluid status and medications. These services are provided free-of-charge to the enrollees.

### **Community Collaboration**

As noted above, the hospital regularly participates in various community planning efforts and also often collaborates with other community service providers or organizations to deliver some services. For example, the Community Health Education department partners with churches, senior centers, area malls and schools to help them identify health concerns and plan programs to address health needs. During FY 06 Northwest partnered with nearby churches and businesses to identify and address health needs both within the congregations and those businesses. These services may be open to the general public as well as the partner constituency.

### **Community Benefits Implementation**

Previously there has not been an overall plan for providing community benefits nor monitoring their progress and outcomes. Thus individual programs that provide a community benefit have been monitored by the responsible program director and reported to the appropriate Vice President, and funding agency, if grant-funded. Occasionally such programs are presented to the hospital's Board in an educational session. With the development of the Community Mission Committee, there is now a designated vehicle for regular, ongoing reporting for monitoring purposes to a committee consisting of Board members and leadership staff.

Reporting on community benefit programs to the community is done annually by a publication, *Reaching Out*, that provides a summary of free and low-cost health services for the communities served by LifeBridge Health. *Reaching Out* provides details of community health education, support groups, health screenings and community sponsorships provided to our community by Northwest Hospital.

## Community Benefit Report for Fiscal Year 2007

### Northwest Hospital

#### Description of Gaps in Availability of Specialist Providers for Uninsured

Northwest is a community hospital with an attending staff of approximately 700 physicians, including several specialties. Those specialties include Neurology, Neurosurgery and Infectious Disease. Gaps we have identified for all patients who live in the hospital's community, including the uninsured, include specialists in Endocrinology, Gynecology, Vascular, Colorectal, Orthopedic, and Breast Surgery. Because of these gaps, the hospital is actively recruiting such specialists to fill these service gaps.

When uninsured patients are admitted to the hospital without a primary care physician, their hospital care is managed by hospital-employed hospitalists. The physician fees for these inpatient services are absorbed by the hospital if the uninsured patient does not have resources to cover these costs.

## **Peninsula Regional Medical Center Evaluation Framework Proposal**

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- **Community Benefits Planning**
  1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?
    - Peninsula Regional completed its last organization-wide strategic plan in 2003. As a part of the 2003 strategic plan under Customer Relationships, the medical center identified the need to “formalize a process within Peninsula Regional Medical Center to develop programs, services, and measures for improving community health.” Additionally, one of the four strategic imperatives is for Peninsula Regional “to continue to be a leader in working collaboratively with other organizations in our region to ensure access to needed healthcare services for improving the health of the communities we serve.”
    - Peninsula Regional utilizes a community Health Council in support of activities to not only “evaluate more effective wellness and preventative service programs” within the community but to also “ensure a process is developed to document the results and outcomes of new community health services and programs.” An internal Health and Wellness committee evaluates current and ongoing community outreach efforts.
  2. Were hospital staff and leadership involved in developing the plan?
    - Hospital leadership including the Board of Trustees, physician leaders, hospital management staff, front-line hospital staff and various community groups were involved in developing the strategic and community outreach plans.
- **Community Needs Assessment**
  3. Does the hospital's plan target specific areas of community need?
    - The overall hospital strategic plan related to Community Benefit does not target specific areas of community need. This is done using a Community Health Assessment survey co-sponsored by Peninsula Regional and the Wicomico, Worcester, and Somerset County Health Departments. The plan reveals areas of need and the participants meet to choose an issue to work on collaboratively. (See response to Question #5)

4. Did the local health department/s provide current needs assessment information that was used by the hospital? Were other information sources used to identify community benefits needs? Please provide a description of these sources.
  - A Community Health Assessment (a self-report phone survey) was conducted by Peninsula Regional in cooperation with the Wicomico County, Worcester County, and Somerset County Health Departments. This needs assessment was completed at the end of October, 2004. Findings from this survey were immediately shared with leaders from Peninsula Regional Medical Center, Atlantic General Hospital, McCready Memorial Hospital, staff from the three local health departments, and area physician and community leaders. The next Community Health Assessment is scheduled for 2008.
  - In addition to the Community Health Assessment, Peninsula Regional uses input from its Health Council (community), local and national community health organizations such as the American Cancer Society, the March of Dimes, and American Diabetes Association, local health departments, and state and national data sources such as the CDC Health People 2010 when determining community health needs.
- Community Benefits Initiatives
  5. Does the hospital identify its Community Based Initiatives?
    - Currently, the medical center collaborates with numerous community organizations. The level of involvement is determined at a department level (i.e. decisions to work with the American Cancer Society on community initiatives are made by Peninsula Cancer Center staff).
    - A Community Health Assessment is conducted every 4-5 years. This survey is used to identify area needs. Recent example:
      - . A tri-county alliance targeting diabetes in Wicomico, Worcester, and Somerset Counties was formed in late January 2005. This alliance received a substantial grant July 1, 2006 using the money to develop a resource guide, establish a web site for both prevention and self-management information, and provide structured education and paper ADA screenings at local events and area employers. This group is currently working on monitoring program effectiveness including scheduled focus groups which will be used to develop more effective interventions for at-risk populations.
  6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.
    - The Tri-County Incidence of Self Reported Diabetes:
      - Tri-County (14.3%) area has a self-report of diabetes twice Maryland's rate (7.0%) and nearly twice U.S.'s rate (8.7%).

- Local (tri-county area) self report of diabetes has undergone a statistically significant increase from 8.5% in 1995 to 14.3% in 2004.
    - A community cancer cooperative consisting of representatives from Peninsula Regional, the local American Cancer Society, the Wellness Community, and Wicomico, Worcester, and Somerset County Health Departments developed an area Cancer Plan using several cancer data resources. .
- 7. Were the initiatives performance-based and did they involve process and/or outcome measures?
  - Measures for performance and/or outcomes from the Tri-County Diabetes Alliance are currently being developed. As a part of a recent grant local data tracking methods are being analyzed and a recommendation for an improved process in the tri-county area will be provided.
  - Department level initiatives vary depending on the initiative but most include a clinical outcome and/or specific performance measure.
- Community Collaboration
  - 8. Did the hospital involve other community participants in planning and/or implementing its community benefits activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?
    - The October 2004 Community Health Assessment was conducted for Peninsula Regional's entire five county service area and include input/survey responses from more than 800 community members. The results of the survey were shared with numerous community groups for the purpose of identifying area health needs.
    - Peninsula Regional currently utilizes a community Health Council in support of activities to not only "evaluate more effective wellness and preventative service programs" within the community but to also "ensure a process is developed to document the results and outcomes of new community health services and programs." An internal Health and Wellness committee has been formed to evaluate current and outgoing community outreach initiatives.
    - Members of Peninsula Regional's management team continue to work closely on area projects and are members of the Wicomico County Health Planning Board, the Worcester County Health Planning Board, the Worcester County Department Advisory Council, the Tri-County Health Planning Board, the Tri-County Healthcare Committee, and the Eastern Shore Oral Health Network (ESOHN).
    - Peninsula Regional's service line managers and executive team serve on the boards of many community health and healthy living organizations and well as community workforce enhancement coalitions.
  - 9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

- Peninsula Regional collaborates and partners with organizations on initiatives ranging from a co-sponsorship of a community Walk at Lunch program and the Tri-County Go Red women's heart check project to the support of community health initiatives such as ESOHN's dental health grant planning for the Lower Eastern Shore.
  - Peninsula Regional staff serves and supports and partners with numerous community health organizations including local chapters of the American Cancer Society, American Diabetes Associates, the March of Dimes, and United Way, Coastal Hospice, The Wellness Community, Healthy U, Lower Shore Enterprises, Women Supporting Women, and the Wicomico County Tobacco Coalition among others.
- Community Benefits Implementation
    10. Does the hospital monitor how its activities fulfill the goals identified in the plan such as through a regular progress reporting process, or by having a staff person assigned to monitor the plan?
      - The progress of individual department collaboration's is monitored through the individual staff members involved in specific projects.
      - 
      - An internal Health and Wellness committee evaluates community outreach efforts such as health fairs, free screenings, and free education and outreach sessions. This committee monitors the amount of community contact and the effectiveness of these activities.
      - Peninsula Regional recently conducted a community benefits audit to look at Peninsula Regional programs as well as those reported by other healthcare facilities in the state of Maryland.
    11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?
      - The Executive Team at Peninsula Regional meets regularly in regards to the current strategic plan and therefore regularly reviews and addresses community health needs.
      - Currently, the executive team and the medical center Board of Trustees are provided quarterly updates on the number of community outreach activities in which the medical center participated.
      - Community outreach activities are incorporated in the medical center's annual report provided to the community in January of each year.
      - As the newly assigned person becomes more familiar with activities and begins developing performance measures for community outreach activities, the depth and breadth of the information provided to the Board of Trustees and to the community through quarterly newsletters is expected to increase in the next 12-18 months.

## Peninsula Regional Medical Center

Peninsula Regional Medical Center conducted a Medical Staff Development Plan in the spring of 2003 and again in the fall of 2006. The plans (prepared by American Medical Consulting) are used to identify gaps/needs for all physician-types throughout the Medical Center's service area. The methodology employed in the plans include all persons residing within the primary and secondary service area of Peninsula Regional Medical Center. The plan is updated every 3 years by the Medical Center with the next planned update is scheduled to be complete sometime in late 2009. The following are data taken from the fall 2006 report.

With respect to low income and uninsured populations, the plan recognizes the following:

*Household income/economic factors can have a significant impact on the general health of a service area. Lower household income may reflect lower primary care utilization and higher critical care utilization. Various studies and articles also suggest greater reliance on hospital emergency rooms for non-emergency diagnosis and treatment in low-income areas. Estimated median household income in Peninsula Regional Medical Center's service area is \$44,507 which is lower than the national median income of \$48,713 and the Maryland median income of \$62,365.*

*American Medical Consulting feels that the Peninsula Regional Medical Center service area has some household income-related factors that would drive an additional need for physician services within portions of the community. Approximately 9,000 households (13.9%) within the service area earn less than \$15,000 per year. A lack of available resources to the indigent may increase volumes in the emergency room, as patients lacking primary care access often seek routine care through emergency services. Additional physician recruitment may be warranted to serve this population and will be further discussed in this plan.*

*American Medical Consulting concluded that the Peninsula Regional Medical Center service area would generate more physician visits than other similarly sized average communities nationally. In addition, the area is experiencing steady moderate growth and has an aging patient base. These two factors would suggest that the community should consider a physician population make-up similar to that of U.S. communities of a larger size and similar payor market mix.*

The plan identified a need for approximately 100 additional physicians over the next five years. The Medical Center has been aggressively recruiting in those specialties identified as being most needed. Additionally, the Medical Center works closely with T.L.C. (a federally qualified community health center) and the Public Health Departments to ensure all persons needing care are served regardless of their ability to pay.



Dimensions Healthcare System

**COMMUNITY BENEFITS REPORT  
FOR THE FISCAL YEAR  
JULY 1, 2006 – JUNE 30, 2007**

**Prince George's Hospital Center  
3001 Hospital Drive  
Cheverly, Maryland 20785  
301-618-2000**

## **INTRODUCTION:**

Prince George's Hospital Center 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 – Kirk Blackman  
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 beds: 265

No. of employees: 1,396

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 cath, 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 HOSPITAL CENTER  
CHEVERLY, MARYLAND  
HOSPITAL CENTER MEMORANDUM 1-1 JUNE 1, 2004**

**MISSION, VISION, VALUES AND  
PRINCIPLES OF SERVICE EXCELLENCE**

**MISSION**

The mission of Prince George's Hospital Center is to preserve, restore and improve the health status of members of our community by offering the highest quality health care services.

**VISION**

Our vision is to be the hospital of choice for our community.

**VALUES AND PRINCIPLES OF SERVICE EXCELLENCE**

Our actions are guided by the following values and principles:

- **COMPASSION**  
Compassion is reflected in our care, concern and consideration for our patients, their families and each other.
- **COURTESY**  
Courtesy is demonstrated by our ability to make every encounter a positive one. We treat everyone politely, making eye contact, using greetings and employing listening skills. We are forgiving of one another and treat everyone with dignity and respect.
- **COMMUNICATION**  
Communication is shown in our use of the written and spoken word. We strive to understand and appreciate each other's opinions and points of view. Communication is critical to everything we do.
- **COMPETENCE**  
Competency is reflected in our work. We show competence in excellent technical skills, and in our supervision, management and protection of hospital resources and personnel. Competence describes our employment standards. We promote a high level of performance by encouraging employee innovation and by fostering professional and personal growth for every member of our health team.
- **COLLABORATION**  
Collaboration is demonstrated by our commitment to working as a team. We work together to achieve an effective, efficient, accountable workforce. We will acknowledge the contribution of fellow employees and our medical staff to the team effort. We will support an open relationship among members of the health care team.

- **COMMITMENT**

Commitment is best shown by our pride in our organization, our work and each other. We actively pursue the goals and values of the hospital. We anticipate each other's needs. We promote excellence in our workplace by striving for excellence in ourselves.

**APPROVED:** Board of Directors, April 26, 2001

**DISTRIBUTION:** Hospital Policy Manual  
Vice Presidents  
Directors/Department Managers  
Medical Staff Office

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G.T. Dunlop Ecker  
President and CEO, Dimensions Healthcare System  
Mission, Vision, Values and Principles of Service Excellence 1-1  
(Reviewed 6/1/2004; Revised: 4/26/2001)

**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

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G. T. Dunlop Ecker,  
President and CEO, Dimensions Healthcare System  
Charity Care 5-5 (Revised: 6/21/2004, 1/28/2000, 3/1/1996)

# EVALUATION OF PRINCE GEORGE'S HOSPITAL CENTER'S COMMUNITY BENEFIT PROGRAM

**FY 2007**

Prince George's Hospital Center has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 60 years, PGHC has grown to become a major tertiary care center for the region and one of its largest employers. However, the greatest service to the community is that PGHC is a private not-for-profit hospital with a tremendous public mission. Providing community benefit is a major objective in PGHC's mission, vision and values, and is integrated into the hospital's policy and planning process.

PGHC was founded in 1944 and is an acute care teaching hospital and regional referral center located in Cheverly, Maryland. PGHC is a member of the Dimensions Healthcare System. The mission of PGHC is to preserve, restore and improve the health status of members of our community. PGHC does not satisfy this mission by just offering the highest quality health care services. It also strives to make a difference in the community. PGHC does it in many ways such as providing health education and screenings, support groups, and outings that complement hospital care and are designed to help many individuals including primarily at-risk and underserved populations. Prince George's Hospital Center also provides a high level of charity and indigent care and, therefore, subsidizes a significant amount of its physician cost. Employee benefits and the hospital's work environment also encourage employees to volunteer and care for the members of the community, as well as with other community-based organizations.

It should be noted that Dimensions Healthcare System is not and has not been financially viable without external grant support for nearly a decade. Despite its ongoing financial challenges, community benefit continues to play a significant role in Dimensions' strategic vision. In 2005, Dimensions' Board adopted a Strategic Vision that included four broad principles. Community benefit is evident in the first broad principle which is the need for a stable source of external funding to support indigent care. The other broad principles include the need for an affiliation with an academic medical center or larger healthcare system; the need for significant re-capitalization including a replacement facility for Prince George's Hospital Center; and the need for continued operational improvements. Hopefully, with the realization of this vision, Dimensions, and Prince George's Hospital Center, can continue its long established mission to serve the community.

## **Attachment M. Community Benefit Evaluation**

Shady Grove Adventist Hospital conducts a monthly evaluation of its community services. This evaluation examines the type and number of community services; the total number of times a program takes place; the number of people attending; the number of contacts occurring; and the predicted minimum attendance. By comparing predicted attendance to actual attendance, the hospital is able to gauge the community's demand for a program and adjust accordingly in subsequent months.

Programs are tracked according to which service lines they support: cardiovascular, cardiac, oncology, orthopedics, pediatrics, women and children, behavioral health, senior, and other. This tracking system allows the hospital to determine which service lines may need additional community programs. The monthly evaluation also includes anecdotal comments from employees involved in the community services programs. Many of these comments are evaluative in nature and further help to determine whether a program is effectively meeting the health care needs of the community.

At the end of each calendar year, the hospital compiles a summary report of all of its community services for the year. This report includes a written component highlighting resources dedicated to the program; what the program does to fulfill the hospital's mission; the direct products of program activities; and benefits for participants as tracked by participant responses to evaluation/survey forms and other measures. The year-end summary enables the hospital to plan its community services for the following year in response to identified community needs.

## **Gaps in Specialty Services - Community**

Adventist Health Care hospital facilities must compensate physicians to provide services due to gaps in availability of coverage in the following specialties to our underserved population:

### Washington Adventist Hospital

Family Practice  
Internal Medicine and certain subspecialties  
Obstetrics & Gynecology  
Orthopedics  
Urology

### Shady Grove Adventist Hospital

Critical Care  
ENT  
Neurology  
Neurosurgery  
Obstetrics & Gynecology  
Pediatrics  
Urology

We have further concluded that, due to the established community need, recruitment incentives such as relocation assistance and collection guarantees may be warranted to attract quality providers, so long as such incentives are provided in accordance with the applicable state and federal rules and regulations.

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

**Community Benefit Report  
Needs Assessment, Evaluation and Gaps In Specialty Coverage  
FY 2007**

Shore Health System (“SHS”) has a 3-year strategic plan and mission statement, which are tied to community benefit. The strategic plan is developed involving physicians, board members, Senior Leadership staff, management staff and other SHS employees.

Shore Health System serves a five county area, covering Caroline, Dorchester, Kent, Queen Anne, and Talbot counties. The local county health departments work closely with Shore Health System to identify community health needs within our service area. In addition, a quarterly Continuum of Care meeting involving directors and managers from local nursing homes also assists SHS in planning for community programs.

Shore Health System is committed to providing programs to satisfy unmet community needs and many are evidenced based. 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

As our Community Benefits Report indicates, Shore Health System has done a great deal in the communities to address many of these issues.

**Access to Care**

SHS has aided in obtaining medications or equipment needed for discharge for patients unable to pay. We have physicians who have participated in health fairs and that lecture in the community. SHS has been involved in numerous physician recruitment efforts over the last year, including orthopedics, physical medicine and rehabilitation, and endocrinology. Recruitment efforts continue for pediatrics, neurology, pulmonary, ob/gyn, anesthesia and numerous family practice physicians. We also pay a stipend to Tidewater Anesthesia to provide evening, weekend and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7 and a stipend to Maryland Emergency Medicine Network, Inc.

### **Gaps in Physician Coverage**

The SHS Medical Staff By-Laws require that physicians provide ten days of Emergency Department call. In those areas where we have 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, they are stabilized and then transferred to an appropriate facility that can treat their condition.

### **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 is committed to providing public education to the community on Stroke Prevention and Awareness. Sessions are conducted by the Neuroscience Specialist and include a presentation followed by a question and answer session.

### **Diabetes**

We have support groups for adult and juvenile diabetics. We have participated in numerous health fairs and screenings. We hold a week-long diabetic summer camp for juvenile diabetics and asthmatics. Nutrition is covered in all the diabetic information and at the health fairs.

### **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. We offer free of charge childbirth classes, infant CPR, Big Brother, Big Sister classes, breastfeeding classes, just to name a few.

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 in the five county areas.

### **Educational and Community-Based Programs**

Shore Health System has participated in a number of career and health fairs throughout the year. At the health fairs, attendees received information on topics such as the importance of keeping a current medication list, nutrition, smoking cessation, signs and symptoms of stroke, and diabetes. In addition, SHS has offered presentations to the community on living with arthritis, living well into your older years, and advance directives.

Our Community Benefits Plan will continue to work on addressing the community issues as listed above.

Please feel free to contact Linda Pittman at 410-822-1000, extension 5446 if you need additional information or have any questions. Frank Fields is the contact person for any financial questions and he can be reached at 410-822-1000, extension 5270.

Shore Health System  
Physician Subsidy Detail  
FY 2007

In order to keep the ED open 24/7 and to recruit board certified physicians, it is necessary to subsidize the ED physician's group to pay for their malpractice insurance, management and recruitment efforts. Anesthesia at Dorchester General Hospital is subsidized in order to provide call coverage so that we perform surgery 24/7 and patients do not have to be transferred elsewhere. The bottom line is the subsidies are necessary to maintain 24/7 coverage in a rural community.

## Community Benefit Evaluation for Fiscal Year 2007

### Sinai Hospital of Baltimore

This report is prepared following the suggested guidelines provided at a workshop entitled “Evaluating Community Benefit Initiatives” presented by Maryland Partners in Community Health Improvement on November 9, 2005.

#### Community Benefits Planning

Sinai Hospital does not currently have a specific community benefits plan for the hospital overall, however planning for initiatives that benefit the community as a whole or certain community constituencies occurs in several ways. The hospital’s executive staff develops strategic imperatives in response to assessed needs, Board directives, and identified business priorities.

For example, the strategic imperatives for 2005-2008 developed by the Planning Committee of LifeBridge Health, Sinai’s parent corporation, includes the following imperative: “*Continue LifeBridge’s focus on the health care and related needs of our core communities.*” An objective under that imperative is “*Identify and develop a plan that actively responds to unmet community health needs.*” In response to that objective, all three LifeBridge hospitals each mounted an extensive assessment and planning process to identify a specific community health need to which it could respond by creating an intervention that could show a measurable impact on that health need in a three to five year period.

Additionally, the executive staff of Sinai Hospital created a strategic imperative to “*create an advisory board to determine Sinai’s impact on the community’s health status.*” To meet this imperative, the Community Mission Committee, consisting of board members and leadership staff was formed in March 2005. That committee is charged with advising and monitoring hospital staff in regard to planning and implementing community health and welfare initiatives.

#### **Community Needs Assessment**

As with planning, community needs assessments are done in a variety of ways, according to the hospital departments involved and the constituencies they serve. 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. In response, the hospital provides free transportation and meals to patients enrolled in that program at a cost to the hospital of \$80,000 annually.

Another way of participating in community needs assessment is when hospital staff serve on community coalitions that perform a planning function. For example, the Chief of Medicine and the Director of Community Initiatives represented Sinai on the Associated Jewish Community Federation of Baltimore's (the Associated) Commission on Aging. This group performed a comprehensive needs assessment on the needs of Jewish seniors, a major component of which was health care needs. Sinai's participation on this coalition of service providers enables the hospital to partner with other organizations to assess needs and then design responsive services to a critical constituency for Sinai as an active service provider in the Jewish community.

Finally, on occasion the hospital commissions an external consultant to conduct a formal needs assessment on community health needs. We used this means to conduct the needs assessment necessary to identify a priority community health need discussed above 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 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.

### **Community Benefits Initiatives**

Depending on the way by which a community need is identified, initiatives developed in response to that need may or may not be based on evidence-based outcome expectations. For example in the first two needs assessment methods described above, those based on practice experience with a specific patient group or those based on community-based, shared assessments, the resulting initiative may not have an evidence-based outcome measure as its goal.

However, in the community health initiative mandated by the LifeBridge Board, the charge was to identify and respond to an identified community health need. The process of selection of the specific need was based on an assessment of critical health problems through an analysis of need via key informant interviews, review of public health data, etc. Because the charge was to develop an intervention that could show measurable improvements in health status in three to five years, we researched best practices seeking evidence-based models.

The initiative that Sinai selected, an effort to reduce obesity in children considered at risk for future cardiac disease, is designed to measure success by improvement on specific criteria related not only to weight, but also to measures such as physical activity, healthy eating, self-esteem and family involvement. This initiative was implemented in FY 06 and continued into FY07. Identified criteria are measured upon program enrollment and at specified intervals, in order to track change and determine whether targeted outcomes are achieved.

## **Community Collaboration**

The hospital regularly participates in various community planning efforts and often partners with other community service providers to deliver some services. In regard to service delivery, over the years, the hospital has developed programs that respond to the psychosocial aspects of health problems such as perinatal substance abuse, domestic violence, pediatric AIDS, infant mortality, breast cancer, postpartum depression and so forth. These programs typically work in partnership with other health and social service providers. For example, in FY 07 we provided institutional resources such as office space, administrative support and professional support group facilitation to women under 40 with breast cancer in partnership with the Susan G. Komen for the Cure, Maryland, a grassroots breast cancer advocacy organization.

Using the partnership model, we designed the pediatric obesity reduction project described above as a partnership with local schools and recreation facilities in both Baltimore City and County. This design is intentional in order to engage children, their families and teachers in this risk reduction and health improvement effort. We believe that this approach is more likely to be effective in children's natural community environment than in a hospital-based environment.

## **Community Benefits Implementation**

Previously there has not been an overall plan for providing community benefits nor monitoring their progress and outcomes. Thus individual programs that provide a community benefit have been monitored by the responsible program director and reported to the appropriate Vice President, and funding agency, if grant-funded. Occasionally such programs are presented to the hospital's Board in an educational session. With the development of the Community Mission Committee in FY 05, there is now a designated vehicle for regular, ongoing reporting for monitoring purposes to a committee consisting of Board members and leadership staff.

Reporting on community benefit programs to the community is done annually by a publication, *Reaching Out*, that provides a summary of free and low-cost health services for the communities served by LifeBridge Health. *Reaching Out* provides details of community health education, support groups, health screenings and community sponsorships provided to our community by Sinai Hospital.

## Community Benefit Report for Fiscal Year 2007

### Sinai Hospital of Baltimore

#### Description of Gaps in Availability of Specialist Providers for Uninsured

As a teaching hospital with its own accredited, non-university-affiliated residency training programs, Sinai Hospital employs a faculty of 140 physicians in several specialties including Ophthalmology, Cardiac Surgery, Obstetrics and Gynecology, Pediatrics, and so forth. Faculty physicians provide services to patients through a faculty practice plan. When patients request appointments in the faculty practice offices, they are not screened on their ability to pay for services. Physician fees for uninsured patients are determined on a sliding scale based on income. Fees may be waived if a patient has no financial resources nor health insurance.

Additionally, in those specialties in which the hospital does not have a faculty, such as Dentistry, Otolaryngology, Vascular and Neuro-surgery, we employ specialists in order to provide continuous care for patients admitted to the hospital through the Emergency Department. In these cases the hospital covers these specialists' consultation fees and fees for procedures for all indigent patients.

Because of these two arrangements for providing specialty care for uninsured patients, we are not able to document gaps in specialist care for uninsured patients.

## **Sinai Hospital of Baltimore FY2007**

### **C. Mission Driven Health Services**

- C1. Adult outpatient psychiatry clinic
- C2. Intensive outpatient program
- C3. Psychiatric ed consultation services
- C6. Park Heights Community-- Clinic
- C7. Behavioral Health Services – Inpatient Psychiatry

The above programs are paid for by Sinai which include taxi service, medication co-pays, administering medication, education, meals, and physical exams for the community.

- C8. OBGYN/, Internal Medicine, and Medicine Academic Hospitalists

OBGYN – We are the main provider for the community, this expense includes the primary care and maternal fetal high risk OB.

Internal Medicine- includes only primary care to the community.

Medicine Academic Hospitalists – providing care to patients admitted to the hospital.

SOUTHERN MARYLAND HOSPITAL CENTER

To: HSCRC

From: Southern Maryland Hospital

Subject: Community Benefits Inventory Spreadsheet

Date: December 2, 2008

**New CBR Requirement**

“Written Description of gaps in availability of specialist providers to serve the uninsured in the community”

Pursuant to this requirement, the following information is provided.

For the specialists OB/GYN, Peds/Neonatal, Hospitalist (unassigned ER patients), Anesthesia (obstetrical coverage 24/7), and Emergency Medicine, the hospital found that these independent medical groups encountered no or limited reimbursement for the services provided. Over a period of several years, various medical specialties and primary care physicians began to notify the hospital that they would not take emergency room call or continue to admit patient to the hospital.

The hospital found, through research with other hospital facilities, that our situation was not unique. We also found that the solution other facilities used was to “underwrite” the cost for these services. In essence, subsidize the medical specialist for the “no pay” or “limited pay” patients. The medical specialist we are reporting are also those areas in which there is a higher incidence of “no pay” or “limited pay” patients.

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 the full range of acute care services.

According to notice from Southern Maryland Hospital on February 5, 2008, the evaluation submitted on February 12, 2007 is to also apply to the FY 2007 CBR Report.



**SOUTHERN MARYLAND HOSPITAL CENTER**  
7503 SURRETT'S ROAD • CLINTON, MARYLAND 20735 • (301) 868-8000

February 12, 2007

Ms. Amanda Greene  
DP Programmer Analyst  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Amanda,

This is in response to your to your questions regarding the 2006 Community Benefits Worksheet:

- **Physician Subsidy:** This item consists of multiple physician specialties within the hospital and represents hospital-based providers. The compensation method consists primarily of employed personnel and occasionally contracted staff. The physicians specialties consist of:
  - Hospitalists & physiatrist
  - Obstetrics & Gynecology
  - Pediatrics / Neonatology
  - Emergency Medicine

The hospital has subsidized the expense associated with these services to insure that there is adequate physician coverage for the services these specialties provide. The subsidy represents the difference between physician salaries and third payor reimbursement.

- **Gaps In Specialty Providers:** The hospital has experienced difficulty in attracting sufficient physician coverage in the above specialties. Current trends would indicate that other hospital-based specialties might also experience the same difficulty in attracting adequate physician coverage. This would translate into the hospital being forced into an increased necessity to subsidize these specialties.

If there are any additional questions, please contact me at 301-877-5527

Sincerely,

A handwritten signature in black ink, appearing to read "Chuck", written over a white background.

Charles R. Stewart  
Vice President of Business, Finance and  
Corporate Compliance

**Southern Maryland's 358 Bed Full Service Hospital**  
*"Bringing Health Care Back to the Bedside"*

**SOUTHERN MARYLAND HOSPITAL CENTER  
DECEMBER 2005  
COMMUNITY BENEFITS EVALUATION QUESTIONNAIRE & RESPONSE**

**Community Benefits Planning**

1. ***Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?***

Yes, Southern Maryland Hospital's community benefit plan is an important part of the hospital's long-range strategic plan, and overall mission. For the entire 28 years of the hospital's existence, providing care to the uninsured, performing community health screenings, offering community health education and much more, has been planned and executed within the four counties constituting our service area.

2. ***Were hospital staff and leadership involved in developing the plan?***

Yes. Starting with the Board of Directors and inclusive of the CEO, Vice Presidents, and other executive level leaders, our strategic plan, including the community benefits aspect, is both "top down" and "bottom up".

**Community Needs Assessment**

3. ***Does the hospital's plan target specific areas of community need?***

Yes, a community needs assessment is periodically performed by an outside consultant together with the hospital's planning staff. Ideas are generated by operational staff (such as the health screening personnel) to specifically address the areas of greatest need. We customize our overall community giving to match a need in a specific geographic area. Because we service both urban and rural geographic areas, specific programming is necessary.

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.***

Several and varied sources are utilized to put together the entire picture of healthcare needs within our broad service area. Most pertinent is data gained through in-house work regarding use ~~of~~ rates of medical facilities and physicians, disease rates in underserved areas, education and income demographics (etc.). Added to that information is data from local health departments, such as Prince George's County and Charles County. Further, Medicare data and information from DelMarva Foundation has been useful. Perhaps, most important, though, is information gleaned from the community members themselves. Senior Center residents and management, folks who visit our screening vans or Mall Walkers programs provide critical information as to the individual needs of our neighbors.

## Community Benefits Initiatives

5. *Does the hospital identify its Community Based Initiatives?*

Yes, the initiatives have always been identified but not necessarily in the categories now required by the HSCRC.

6. *Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.*

A good example of SMHC's initiatives can be found in the design and creation of the Cardiac Risk Assessments that are done primarily through SMHC's Health Express Van. The creation of this service was based on cardiovascular statistics gathered by our hospital as part of its growth and investment in its cardiovascular service lines. For example, it has become quite clear through review of these data that folks in the Southern Maryland region suffer from significantly higher rates of heart disease and vascular disease, and exhibit high rates of related risk factors such as obesity, high cholesterol, and smoking. We have responded directly to the risk factors with exercise programs, blood pressure screenings, nutrition counseling, smoking cessation classes, and physician-presented education talks addressing these lifestyle choices. Another example can be found in the free Abdominal Aortic Aneurysm (AAA) screenings offered through the Health Express Van for individuals that meet specific criteria and may be at risk for an aneurysm.

7. *Were the initiatives performance-based and did they involve process and/or outcome measures?*

Yes, we follow many of our community members who have participated in one of our programs through questionnaire and a comprehensive database. Clinical information is gathered on these patients to ascertain our level of effectiveness particular to that individual. Advice is offered to patients, by an R.N., as to their progress or need for more action or education. Efforts are then made to match the individual with the program which will help them with their medical need.

## 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?*

SMHC routinely consults with community leaders, local churches, health centers, and other community organizations to determine the appropriate direction, need and resources for providing community-based services.

9. *Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?*

Yes, for each service provided, SMHC coordinated with the appropriate resource to ensure that the community's healthcare needs were being addressed. An example of this coordination can be found in SMHC's involvement in the Prince George's County Health Department's Flu Shot Program. SMHC acted as a host station to administer free flu shots for the Southern Prince George's region. As another example, the hospital has become quite close to a local organization called the Ministers Alliance, representing over 20 mostly African American churches. Through the ministers we have been able to reach church members and customize our program to their needs.

### **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?*

To some degree, but this is an area we can still improve upon. Feedback through our screening and effectiveness questionnaire (Cardiac Risk and Health Assessment Questionnaire) is helpful in directing and redirecting resources within the program.

11. *Are the community and the hospital leadership kept informed as the progress and results of the community benefits program?*

Yes, hospital management is kept aware of all activities and progress and routinely consulted on changes and adjustments that are made to the plan. Further, the Executive Vice President stays particularly involved in our outreach programs so top management is well integrated into the process.

## Evaluation Framework Proposal – St. Agnes Hospital FY 2007

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- **Community Benefits Planning**

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

- St. Agnes Hospital explicitly includes community benefit as a component of its strategic plan by policy of Ascension Health, corporate parent. Programmatic initiatives for addressing community benefits needs are incorporated into 5-year Integrated Strategic Financial Plan.

St. Agnes updated its 2003 Community Needs Assessment in Spring of 2007. The update included reexamination of community need priorities and action plans. This document is attached for the Commission's review.

2. Were hospital staff and leadership involved in developing the plan?

- With the incorporation of community benefits initiatives into the 5-year integrated strategic financial plan, members of hospital staff and leadership are involved in developing the plan. The medical staff leadership (medical staff officers and departmental chairs) in conjunction with executive team participate via management and Board committees to prioritize strategic priorities, including addressing identified community health needs.

- **Community Needs Assessment**

3. Does the hospital's plan target specific areas of community need?

Yes. 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 to that results in collaborative partnerships and networks to implement solutions.
  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.
    - St. Agnes used a wide variety of informational resources to identify community benefit needs as a component of its community health needs assessment. The information sources included the Maryland Inpatient Discharge Database, 2000 U.S. Census, Claritas Population Forecast among others. Data sources are appropriately footnoted in the Community Needs Assessment included in this submission. In addition to quantitative resources, the Community Needs Assessment Task Force members provided qualitative information on the community needs based on their knowledge and experience with identified communities.
  - **Community Benefits Initiatives**
    5. Does the hospital identify its Community Based Initiatives?
      - Yes. As a component of our community benefit financial report, St. Agnes identifies its Community Based initiatives. Many of these initiatives are long-standing programs that have been providing services to the community St. Agnes serves for many years.

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.

- In many cases, St. Agnes' health community benefit initiatives reflect evidence-based needs that were identified during the most recent community needs assessment and were included in response to Question 3 above. During FY06, St. Agnes completed a comprehensive assessment of all community benefit initiatives to determine if and how each program responds to identified community health needs.

Examples of existing initiatives include:

- 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.

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

- Given the long standing tenure of many of the community benefit initiatives they do not include performance-based process and/or outcome measures. However, with the FY 06 update of the community needs assessment St. Agnes established necessary infrastructure that will enable community benefit programs to track and monitor outcome measures for the community outreach initiatives.

- **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?

- Yes. St. Agnes has hired a Director for Community & Physician Outreach that maintains regular dialogue with community leaders regarding the needs of the communities and St. Agnes plans to address those needs.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

Yes. By way of example, as noted above, St. Agnes partnered with Baltimore Medical System, Inc. to operate its Community Care Center as a Federally Qualified Health Center (FQHC). This partnership preserved this health facility for the uninsured and underinsured in southwest Baltimore and assured continued access to primary care services in adult medicine, pediatrics and OB/GYN as well as subspecialty care clinics for many medical and surgical subspecialty services. Red Dress Sunday is a partnership with CareFirst, the largest insurer in Maryland, and multiple community churches. Also, as noted in response to Question 3, St. Agnes believes that in order to properly address identified community needs requires collaboration between multiple community agencies. As such, it is a strategic priority for St. Agnes to continue to be a catalyst in the community for collaborative dialog and partnerships.

- **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?

- Currently, there are limited reporting processes in place to monitor how community benefits initiatives are fulfilling organizational goals. A few initiatives monitor number of visits, but do not include specific process or outcome measures specific to overarching community benefit goals. However, as noted in Question 7, St. Agnes Hospital has developed a comprehensive infrastructure that will enable programs to track and report outcomes measures related to specific community health initiatives.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

- St. Agnes holds quarterly meetings with community leaders to provide updates on key programmatic initiatives and provide a forum for informational exchange. Annually, St. Agnes provides a reporting of the financial investments in community benefit initiatives through its Care of Persons Who Are Poor and Community Benefit. Other formal and informal communication with community leaders, local and state legislative representatives, and others is responsibility of the Director of Community and Physician Outreach.

**Physician ED Indigent Care Subsidy Summary – St. Agnes Hospital FY 2007**

St. Agnes Hospital currently has the 4<sup>th</sup>-busiest Emergency Department (ED) in the state. Like many urban-based hospitals with significant ED volumes, a large proportion of the indigent and charity care provided by the hospital overall is generated through the ED. The increasing community need for indigent care coverage through the ED, coupled with declining physician reimbursement and greater malpractice exposure, has created greater “gaps” in the availability of specialist physicians to treat these patients. Consequently, mission-based hospitals like St. Agnes, with an imperative to care for the poor and underserved, feel a duty to respond to fill in these gaps.

Specifically, various surgical sub-specialty physicians who are not being compensated for their services to this at-risk community have sought assistance from the hospital, which receives at least a portion of their uncompensated care in rates. For FY07, this subsidy paid by the hospital for this coverage amounted to nearly \$1 million, which was spread out over multiple physicians and specialties, including:

<b>Specialty</b>	<b>Daily/Annual Stipend</b>	<b>Fee For Service Comp.</b>
Hand Surgery	X	
Orthopedic Surgery	X	X
Thoracic Surgery	X	X
Vascular Surgery	X	X
Oral Surgery		X
ENT	X	
Plastic Surgery	X	
Urology	X	
Neurosurgery	X	
General Surgery	X	X
Surgical Oncology	X	
Pediatric Surgery	X	

All of the above costs have been included in line “C8 – Physician ED Indigent Care Subsidies”.

In addition, St. Agnes further compensates specialist physicians for serving poor and vulnerable populations in our FQHC-based Community Clinic. These specialists include OB/GYN, G.I., and Oncology physicians, as well as Family Practice physicians. These portions have been included in line “C7 – Community Care Center”.



# **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.

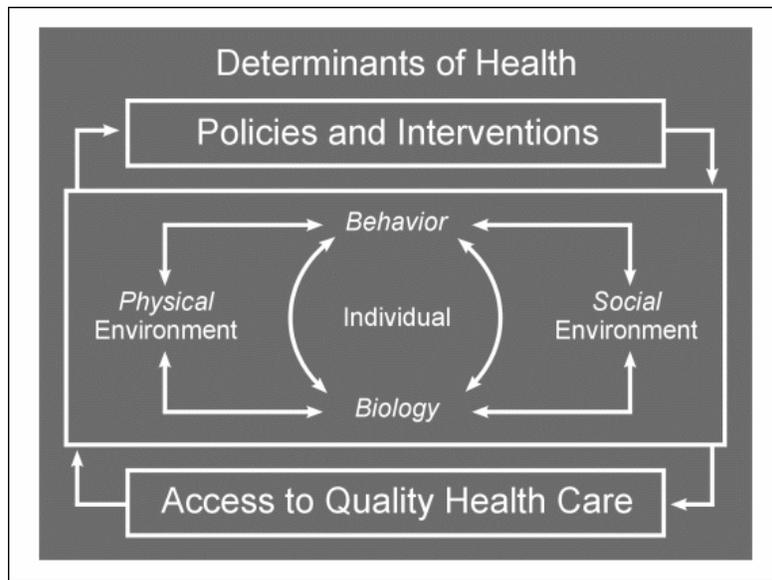
Rather, St. Agnes must recognize themselves as part of a larger, systematic approach to health improvement. Through this assessment process, St. Agnes must serve as a catalyst to encourage health care providers, local government, voluntary agencies, business leaders, and the community leaders of Southwest 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  $\leq 5$
  - Population Age  $\geq 65$
  - Female Population Age 15-44
  - Female Population Growth Age 15-44
  - Population Growth Age  $\geq 75$
  - 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**

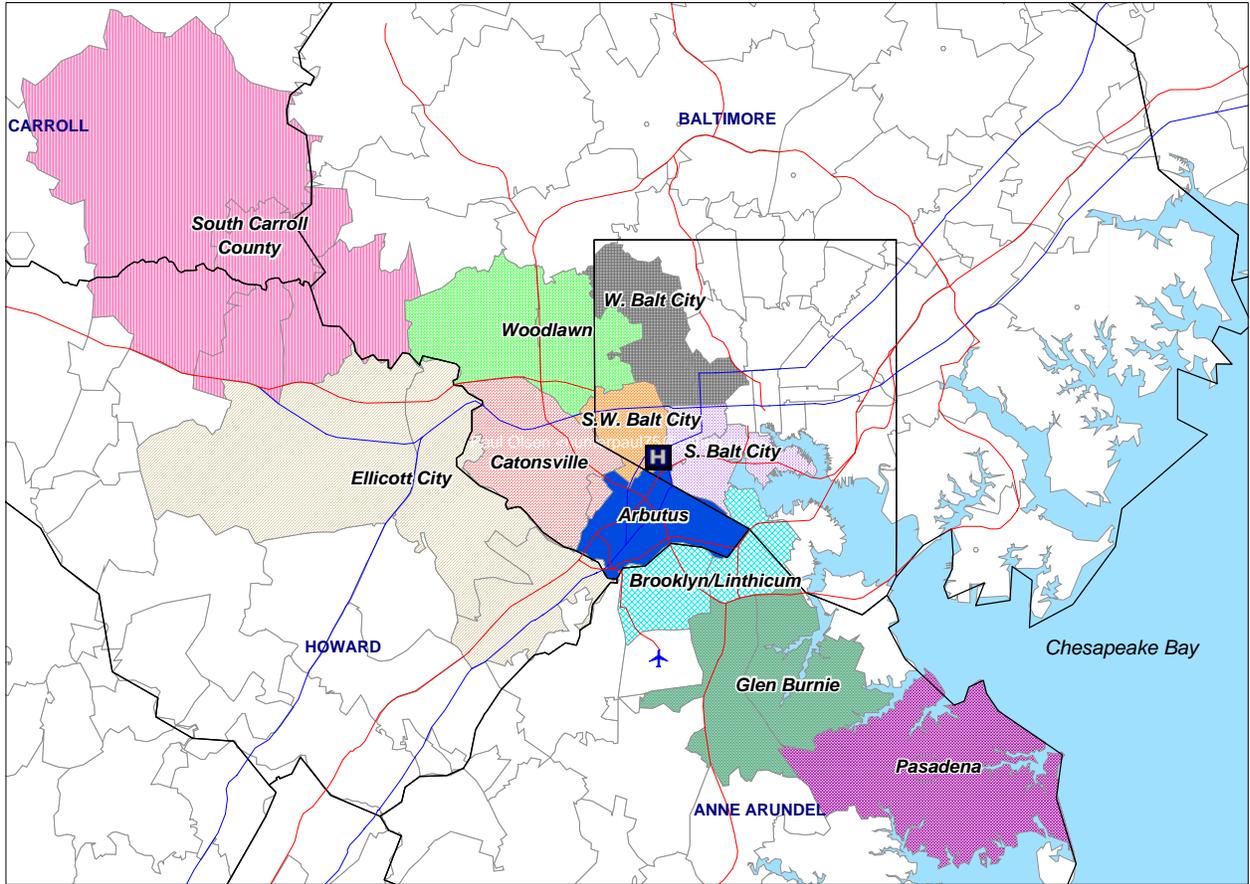
The areas surrounding St. Agnes have a diverse socioeconomic composition with a mix of urban and suburban communities that are consistent with the range of communities found in any large metropolitan region. For St. Agnes, the challenge of serving these communities lies in meeting the different needs 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**

<b>Community Name</b>	<b>Zip Code(s)</b>	<b>County</b>
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								
	Females 15-44	Index	Age >= 75	Index	All Ages	Index	% Racial Diversity	Index	Avg Demographic 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

SOCIAL & ECONOMIC CHARACTERISTICS	Education: Less than High School Diploma					Disability Index	Unemployment	
	Age 18-24		Age >= 25				% of Civilian Labor Force <sup>1</sup>	Index
	Population	% Less than High School Diploma <sup>1</sup>	Population	% Less than High School Diploma <sup>1</sup>	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.

<sup>1</sup> 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**

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	Acute Care Adms Rate*	Index	Acute Care Days Rate*	Index	ED Visits Rate*	Index	Physician Manpower Need**			Average 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.

<b>Figure 2: Study Area Overall Need and Health Status</b>			
<b>Overall need</b>	<b>Low</b>	<b>Medium</b>	<b>High</b>
<b>Health Status</b>			
<b>Poor</b>			S Baltimore City W Baltimore
<b>Fair</b>		SW Baltimore Brooklyn/ Linthicum	
<b>Good</b>	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 25<sup>th</sup> percentile and most favorable scores group representing the 75<sup>th</sup> 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.

<b>Figure 3: Socioeconomic Status and Health Status</b>			
<b>Socioeconomic</b>	<b>Low</b>	<b>Medium</b>	<b>High</b>
<b>Health Status</b>			
<b>Poor</b>	S Baltimore City W Baltimore		
<b>Fair</b>		SW Baltimore Brooklyn/ Linthicum	
<b>Good</b>			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.

## FY '07 COMMUNITY BENEFIT REPORT NARRATIVE

### ***Special Programs to Benefit the Community***

#### St. Clare Medical Outreach

St. Joseph Medical Center in Towson, Maryland, will project \$500,000 for operational expenses for the St. Clare Medical Outreach, a mobile primary care operation that provides free primary care to uninsured adults at two locations in Baltimore City. Based in a 38-foot recreational vehicle outfitted with two exam rooms, a medication room and a central area for laboratory draws and patient education, the staff of physician, nurse practitioners, registered nurses, and other ancillary staff provide free primary care to mainly Hispanic immigrants and the homeless. An average of 58 patients is seen in the three days a week the coach travels. On the remaining two days per week the staff schedule patients for necessary diagnostic testing, surgery, and specialty referrals at St. Joseph Medical Center. The inpatient and outpatient services which amount to approximately \$250,000 annually are provided to the St. Clare patients as part of the medical center's charity care program, while the specialists agreeing to provide consultation and treatment do so on a pro bono basis.

#### The Village Wellness Project – Tanzania, East Africa

A partnership with St. Joseph Medical Center

Since the year 2001, St. Joseph Medical Center has extended its hands and hearts from Towson to Tanzania to embrace and support the health status of the people of the Karatu District of Tanzania through the Village Wellness Project. More than 70,000 villagers have benefited from the Medical Center's presence in Karatu.

Recent health initiatives have included regular visits from teams of St. Joseph clinicians who provide health screenings and training in medical/surgical procedures, hygiene and malaria testing as well as HIV/AIDS prevention, education and counseling. In addition to medical assistance, we have worked with the villagers for the District on small loans and animal projects to ensure self-sufficiency. Capacity building has helped the villagers to acquire or build portable pit latrines, water collecting vessels and slow sand filters to purify water. Currently the repayment rates for small loans to women and youth exceed 80%.

In May 2007 St. Joseph Medical Center hosted Dr. Asanteli Makyao, Medical Director of the Karatu Hospital and one of the district's four physicians, for a working vacation. He observed procedures and practices at St. Joseph and will employ his findings at Karatu Hospital.

In 1864, when three Sisters of St. Francis left Philadelphia for Baltimore, they initiated a pattern of serving where needed despite few resources and a great deal of risk. Our outreach from Baltimore to Africa is farther in miles but the journey is the same: to go where there is a need, and where people from St. Joseph Medical Center can help to make a difference.

Good Afternoon Amanda,  
We believe that we do not have any gaps or deficiencies in the availability of specialist providers to serve uninsured patients at St Joseph Medical Center.

If you need anything else, please call.

Thanks!

Patrick O'Brien

Financial Planning

St Joseph Medical Center

7601 Osler Drive

Towson

MD, 21204-7578

410.337.1213

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

(1382)

**Gender:** Both Males and Females  
**Department:** 0 (Unknown)  
**Persons:** 4  
**Expenses:** 60  
**Revenues:** 0  
**Benefit:** 60

---

(1386)

**Gender:** Both Males and Females  
**Department:** 0 (Unknown)  
**Persons:** 4  
**Expenses:** 33  
**Revenues:** 0  
**Benefit:** 33

---

#### ANXIETY SCREENINGS

**Gender:** Both Males and Females  
**Department:** 0 (Unknown)  
**Persons:** Unknown  
**Expenses:** 45  
**Revenues:** 0  
**Benefit:** 45

---

#### AS PEDIATRIC SERVICE

**Gender:** Both Males and Females  
**Department:** 7470 (AS Pediatric Service)  
**Department Contact:** ()  
**Persons:** Unknown  
**Expenses:** 24,507  
**Revenues:** 0  
**Benefit:** 24,507

---

#### BALTIMORE CITY CATHOLIC SCHOOLS PREVENTIVE HEALTH INITIATIVE

**Description:** All collaborative effort between SJMC, other Catholic Hospitals within the City and the Baltimore City Catholic High Schools to improve preventive health initiatives within the schools.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Bernie White (410-337-1254)  
**Objective:** To improve preventive health initiatives within the Baltimore City Catholic Schools (BCCS)  
**Partners:** The Catholic Hospitals within the city will contribute personnel according to their expertise on a particular topic. St. Agnes Self Management Education, Good Samaritan personnel for vision and hearing screening.

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Baseline/Goal:** Improvement in the type and scope of preventive health initiatives within the BCCS.  
**Persons:** 22  
**Expenses:** 45  
**Revenues:** 0  
**Benefit:** 45

---

#### BALTIMORE COUNTY CANCER COALITION

**Description:** SPONSORED BY BALTIMORE COUNTY HEALTH DEPT., THE COALITION CONSISTS OF HEALTH CARE, FAITH-BASED, AND COMMUNITY PARTNERS WHO MEET BIMONTHLY TO PROMOTE CANCER PREVENTION, SCREENINGS, AND DETECTION.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** BERNIE WHITE (4103371254)

**Objective:** 1. INCREASE COMMUNITY AWARENESS OF CANCER PREVENTION AND IMPORTANCE OF SCREENING FOR EARLY DETECTION.  
2. PROVIDE SCREENING OPPORTUNITIES.  
3. PROMOTE COMMUNITY PARTICIPATION IN SCREENINGS.  
4. ESTABLISH EFFECTIVE COMMUNITY NETWORKS FOR CANCER EDUCATION, SCREENING AND EDUCATION.

**Partners:** BALTO CO HEALTH DEPT, FRANKLIN SQUARE HOSP CENTER, GBMC, SINAI-WELLBRIDGE, AMERICAN CANCER SOCIETY, PHILIPINO AMERICAN SOCIETY, BMS, AND VARIOUS CHURCH GROUPS.

**Baseline/Goal:** 1. COMMUNITY MEMBERS WILL PARTICIPATE IN SCREENINGS.  
2. COMMUNITY MEMBERS WILL RECEIVE INFORMATION ON CANCER PREVENTION, SCREENING AND EARLY DETECTION.

**Persons:** Unknown

**Expenses:** 222

**Revenues:** 0

**Benefit:** 222

---

#### BEAUTIFUL SKIN WORKSHOP

**Description:** A 6 hour workshop for girls age 13-15 to focus on healthy skin, safe sun practice to avoid skin cancer and premature aging, acne, avoid/discontinue smoking to promote healthy skin, nutrition, exercise and yoga to promote good health. The girls are also treated to facials, makeovers and consults with hair and manicure specialists. Beauty consults are donated by vendors.

**Gender:** Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Gloria Webster/Andrea Praskiev (410-37-1012)

**Objective:** To promote good skin care practices to prevent skin cancer, premature aging.

To provide nutritional information to promote a healthy complexion

To explore exercise and yoga as strategies for maintaining general wellness

To promote prevention of tobacco to molnitor health and appearance

**Partners:** Proctor & Gamble, Mary Kay Cosmetics, Sodexho Dietary and Nutritional Services, Professional Esthetics, CVFitness

**Baseline/Goal:** To promote good skin care practices to aid in a more positive self-image of oneself

**Persons:** 55

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Expenses:** 1,547  
**Revenues:** 800  
**Benefit:** 747

---

#### BONE DENSITY SCREENINGS

**Description:** Participants are screened using ultrasound heel measurement with Halogic somometer. Printed results are provided so that information can be shared with the participant's physician. Educational information is provided by a RN. Written material is provided.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To provide baseline BMD information

To provide educational information about Osteoporosis management and life style practices to facilitate bone health.

**Baseline/Goal:** Participants are provided with baseline information regarding bone density that they are encouraged to share with their physician. Referrals are made as necessary. Information and resources are provided.

**Persons:** 139

**Expenses:** 1,650

**Revenues:** 440

**Benefit:** 1,210

---

#### BREAST CANCER SCREENINGS

**Description:** Aimed at those women without insurance, living on a low income. Free self breast exam and screening mammogram

**Gender:** Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** Identify new cases of breast cancer as early as possible to provide referral information to those with psitive screening results.

**Baseline/Goal:** To help identify breast cancer in the early stages.

**Persons:** 32

**Expenses:** 5,079

**Revenues:** 0

**Benefit:** 5,079

---

#### BREAST SELF EXAM EDUCATION (BSE)

**Description:** Programs to teach the proper techniques for performance breast self-examinations.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Christine Duke (410-337-1555)

**Objective:**

1. Teach proper technique for prforming BSE.
2. Teach participants proper timing and expectations for a good breast health program including mammography, clinical breast exam, sonography, and BSE

**Partners:** ACS

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Baseline/Goal:** 1. Participants will demonstrate proper technique for performing BSE.  
2. Participants will know three components of a proper breast health program.  
**Persons:** 15  
**Expenses:** 47  
**Revenues:** 0  
**Benefit:** 47

---

#### **CAB SERVICES TO AND FROM MENTAL HEALTH TREATMENT**

**Description:** Provision of transportation for patients who cannot afford transportation or who do not have social support to provide transportation to and from for mental health services.  
**Gender:** Both Males and Females  
**Department:** 6220 (Acute Psych)  
**Department Contact:** Grace Serafini (410-337-1584)  
**Objective:** To facilitate treatment for mental health patients  
**Baseline/Goal:** Permit after care in partial hospitalization at St. Joseph Medical Center  
**Persons:** 323  
**Expenses:** 11,111  
**Revenues:** 0  
**Benefit:** 11,111

---

#### **CARDIAC SURGERY FOR INDIGENT PATIENTS (JAMAICA)**

**Description:** Provide cardiac surgery for indigent patients who do not have facility in their area to perform these services or provide treatment.  
**Gender:** Both Males and Females  
**Department:** 7011 (Cardic OR)  
**Department Contact:** ()  
**Objective:** Provide aortic valve replacement  
**Baseline/Goal:** Improved health for patient.  
Able to live "normal" life.  
**Persons:** 2  
**Expenses:** 360  
**Revenues:** 0  
**Benefit:** 360

---

#### **CATHOLIC HIGH SCHOOL LECTURES**

**Description:** Lectures by healthcare professionals to students to taking a required health course on a variety of topics relevant to adolescence.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Christine Duke (410-337-1555)  
**Objective:** 1. To provide students with accurate information about health topics relevant to their life.  
**Partners:** The Catholic High School of Baltimore

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Baseline/Goal:** Students will have factual information to help them make decisions.  
Students will recognize risky situations they or their friends may encounter.  
**Persons:** 520  
**Expenses:** 923  
**Revenues:** 0  
**Benefit:** 923

---

#### CENTER FOR HEALTH ENHANCEMENTS

**Description:** Health Enhancement Provider for massages for open heart, bi-lateral hip and knee surgery patients. Also included are NICU baby massages and expectant mother massages.  
**Gender:** Both Males and Females  
**Department:** 7752 (Center for Health Enhancements)  
**Department Contact:** Sister Anne Hefner (410-337-1646)  
**Persons:** 164  
**Expenses:** 190,813  
**Revenues:** 0  
**Benefit:** 190,813

---

#### CHILDBIRTH REVIEW CLASSES AT SJMC

**Description:** For couples who have given birth in the last four years. A review of the physiology of labor & delivery. Review and practice of coping techniques for childbirth.  
**Gender:** Both Males and Females  
**Department:** 8762 (Family Education)  
**Department Contact:** Marian Malinski (410-337-1682)  
**Objective:** Discuss anatomy and physiology of labor and birth. Demonstrate and have couples practice coping strategies for labor.  
Discuss sibling adjustment.  
**Baseline/Goal:** Expectant mothers and their coaches will be more comfortable with labor and delivery.  
**Persons:** 47  
**Expenses:** 540  
**Revenues:** 460  
**Benefit:** 80

---

#### CHOLESTEROL SCREENING

**Gender:** Both Males and Females  
**Department:** 7113 (CV Fitness)  
**Department Contact:** Ellen Gorman (410-337-1369)  
**Objective:** \*Provide the participant with the opportunity to evaluate one of the major coronary artery disease risk factors - elevated cholesterol.  
  
\*Provide participant with recommendations for further follow up and ways to reduce elevated cholesterol levels.  
**Partners:** SJMC laboratory - provides equipment and staff to conduct the actual test.  
**Baseline/Goal:** Early detection of potentially elevated cholesterol levels

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Persons:** 15  
**Expenses:** 682  
**Revenues:** 0  
**Benefit:** 682

---

#### CLINICAL STUDENTS

**Description:** ADMINISTER PLACEMENT OF CLINICAL AND NON-CLINICAL STUDENTS AT SJMC (NOT RESTRICTED TO RN'S)  
**Gender:** Both Males and Females  
**Department:** 8722 (CENTER FOR CLINICAL EXCELLENCE)  
**Department Contact:** BONNIE THOMSON (410-337-1335)  
**Objective:** TO PROVIDE PRACTICAL EXPERIENCE TO CLINICAL AND NON-CLINICAL STUDENTS, BEYOND THEIR CLASSROOM STUDIES.  
**Partners:** APPROXIMATELY 20 COLLEGES AND UNIVERSITIES  
**Baseline/Goal:** ASSIST STUDENTS IN LEARNING JOB APPROPRIATE SKILLS. PROVIDE OPPORTUNITY TO SEE SJMC AS AN OPTION FOR EMPLOYMENT WHEN EDUCATION IS COMPLETE.  
**Persons:** 265  
**Expenses:** 8,980  
**Revenues:** 0  
**Benefit:** 8,980

---

#### COMMUNITY BENEFIT PLANNING TIME (ADMINISTRATIVE)

**Description:** Time spent in planning, collaborating, implementing and evaluating community programs for services to the poor and community broader benefit by the VP of Mission/Ministry, Community Outreach/St. Clare Medical Outreach Director, Community Outreach Social Worker and other administrators.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Bernie White (410-337-1254)  
**Objective:** To develop health related programs benefiting the poor and the broader community.  
  
To maintain programs identified as benefiting the poor and broader community  
  
To research community resources that may benefit in the provision of healthcare needs of the poor  
**Partners:** Baltimore County and Baltimore City Departments of Health, MedBank  
**Baseline/Goal:** Improved access to health information and healthcare  
  
Programs which meet the health related needs of the poor and broader community.  
**Persons:** Unknown  
**Expenses:** 3,951  
**Revenues:** 0  
**Benefit:** 3,951

---

#### COMMUNITY REGISTRATION/SCHEDULING/INFORMATION WORK

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Description:** Time committed by Community Outreach Registration and Scheduling representative to take registrations and provide scheduling and information for community programs and prepare mailings for programs and events. Also, time devoted to inputting data to ensure continuation of program and event quality.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Bernie White (410-337-1254)

**Objective:** Provide information to community regarding community health programs and health screenings.

Facilitate attendance by community members at health programs, events, screenings.

Register community members at health programs, events, and screenings.

**Partners:** Public Relations/Marketing Department

**Baseline/Goal:** Appropriate participation in health screenings by community members who are appropriate for the screenings.

Adequate attendance by community members at health programs and events.

**Persons:** 4,340

**Expenses:** 11,086

**Revenues:** 0

**Benefit:** 11,086

---

#### DEPRESSION SCREENINGS

**Gender:** Both Males and Females

**Department:** 0 (Unknown)

**Persons:** 44

**Expenses:** 1,136

**Revenues:** 0

**Benefit:** 1,136

---

#### DONATIONS/CONTRIBUTIONS TO COMMUNITY ORGANIZATIONS

**Description:** Donations/contributions to community organizations

**Gender:** Both Males and Females

**Department:** 8670 (Mission/Ministry)

**Department Contact:** Angela Moralis (410-337-4872)

**Objective:** SJMCs participation in outside organization by donations/contributions

**Baseline/Goal:** Organizations are helped through donations/contributions.

**Persons:** Unknown

**Expenses:** 200,192

**Revenues:** 0

**Benefit:** 200,192

---

#### FETAL BURIAL

**Description:** Cemetery Service for pregnancy losses

**Gender:** Both Males and Females

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Department:** 8671 (Spiritual Care Department)  
**Department Contact:** Nancy Conner (410-337-1706)  
**Objective:** To help bring closure to parents of pregnancy loss  
**Baseline/Goal:** Parents are comforted.  
**Persons:** 340  
**Expenses:** 2,320  
**Revenues:** 0  
**Benefit:** 2,320

---

#### FLU IMMUNIZATIONS

**Description:** RNs will provide vaccination against influenza to senior citizens and other high risk individuals at no charge. The immunizations are given at churches, schools, senior community centers and homeless shelters.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)  
**Objective:** To provide influenza vaccine to senior citizens and other high risk individuals  
To provide education regarding the important of influenza and pneumococcal vaccination.  
**Partners:** Baltimore City Health Dept, ACE, MPP  
**Baseline/Goal:** To provide influenza vaccinations to free to those individuals who may not otherwise be able to be vaccinated.  
**Persons:** 3,327  
**Expenses:** 40,441  
**Revenues:** 0  
**Benefit:** 40,441

---

#### FRESH START CLASS

**Description:** 7 Smoking cessation programs held at community and business locations.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Christine Duke (410-337-1555)  
**Objective:** 1. Participants will devise a quit plan in conjunction with the class.  
2. Participants will change their tobacco use behaviors  
3. Participants will stop smoking.  
**Partners:** ACS  
**Baseline/Goal:** Decrease tobacco use in community members.  
Increase awareness of tobacco and health issues.  
**Persons:** 280  
**Expenses:** 1,058  
**Revenues:** 100  
**Benefit:** 958

---

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

### GRANDPARENTING CLASSES

**Description:** EDUCATIONAL EVENT FOR EXPECTANT GRANDPARENTS OFFERING UP-TO- DATE INFORMATION ON LABOR AND DELIVERY AND CHILDCARE.

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Objective:** GRANDPARENTS WILL BE ABLE TO DEMONSTRATE INFANT CPR AND HOW TO HANDLE A CHOKING BABY.  
GRANDPARENTS WILL HAVE KNOWLEDGE OF CURRENT CAR SEAT LAWS.  
GRANDPARENTS WILL HAVE A UNDERSTANDING OF THE USE OF THE EPIDURAL IN OB.  
GRANDPARENTS WILL HAVE AN UNDERSTANDING OF THE "BACK TO SLEEP" CAMPAIGN AND HOW THIS HAS LOWERED THE RATE OF SIDS IN THE USA.

**Baseline/Goal:** THE GRANDPARENTS WILL HAVE A BETTER UNDERSTANDING OF MATERNAL CHILD CARE.

**Persons:** 148

**Expenses:** 810

**Revenues:** 730

**Benefit:** 80

---

### GRANT WRITING

**Description:** Consultant paid to write grants for Community Outreach/Care for the Poor only.

**Gender:** Both Males and Females

**Department:** 8670 (Mission/Ministry)

**Department Contact:** Sister Anne Hefner (410-337-1646)

**Objective:** To attain funds for Care for the Poor and Community Outreach activities.

**Baseline/Goal:** Funding will be acquired to continue the Village Wellness Program in Tanzania.

**Persons:** Unknown

**Expenses:** 1,850

**Revenues:** 0

**Benefit:** 1,850

---

### HEAD & NECK CANCER SCREENINGS

**Description:** The screening, performed by a physician, consists of visual inspection and palpation of the head, neck, and mouth. Patient education, referral, and counseling are provided by RNs.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Mary Jo Huber (410-337-1960)

**Objective:** To identify early lesions/conditions of the head, neck, mouth, or throat that may be cancerous.

To provide education regarding the signs and symptoms of cancer in the head, neck, mouth, and throat.

To provide referral information to those individuals that require additional follow-up.

**Baseline/Goal:** To assist in the early detection of mouth, throat, and neck cancer.

**Persons:** 43

**Expenses:** 545

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Revenues:** 0  
**Benefit:** 545

---

#### HEALTH FAIRS

**Description:** Health events scheduled at churches, businesses or schools where staff present health information, education, counseling and/or screenings

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Bernadette White (410-337-1282)

**Objective:** To educate participants regarding health related topics

To provide health related screenings and counsel participants regarding their degree at risk for certain health problems and methods of prevention/treatment

To inform participants regarding relevant health resources

**Partners:** Churches, schools, businesses

**Baseline/Goal:** Participant will have increased health knowledge  
Participant will have knowledge of their relative risk for selected health problems and how to modify risk and/or seek treatment for further evaluation  
Participants will be more knowledgeable regarding health resources

**Persons:** 2,196

**Expenses:** 1,521

**Revenues:** 0

**Benefit:** 1,521

---

#### HEALTHY PREGNANCY CLASSES

**Description:** Education for expectant mothers and their partners focusing on healthy lifestyles

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Objective:** Discuss healthy lifestyles regarding food, exercise, sleep, toxics, and medical care for the expectant mother

**Baseline/Goal:** The client will be able to verbalize healthy eating habits and a healthy exercise plan for te expectant mother. The mothr will be mre aware of the effects of smoking, alcohol, drugs, and environmental changes on her and the fetus.

**Persons:** 39

**Expenses:** 382

**Revenues:** 50

**Benefit:** 332

---

#### HEARING SCREENINGS - PEDIATRICS

**Description:** Screening children PK-12 grade for hearing acuity. Children are screened according to the standards of the American Audiologic Society. Screening is conducted by RN, community health specialist, student interns, and volunteers.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To identify at an early age children at risk for hearing impairment.

To provide accuracy and consistency in the screening process for children.

To provide consistency in the referral process for children with possible hearing impairment.

**Persons:** 1,308

**Expenses:** 2,754

**Revenues:** 0

**Benefit:** 2,754

---

#### HEART RISK SCREENINGS

**Description:** Screenings provide an analysis of each participants modifiable risk factors including total cholesterol, HDL cholesterol and ratio; blood pressure; body weight; body comp; exercise status and smoking status. Participants receive results immediately and speak with a counselor who discusses results and recommendaion for follow-up

**Gender:** Both Males and Females

**Department:** 7113 (CV Fitness)

**Department Contact:** Ellen Gorman (410-337-1369)

**Objective:** Povidе community with means of evaluating modifiable risk factors so they can address any areas requiring attention, and therefore, reduce their risk for complications (or future compliations if already diagnosed) or heart disease.

**Partners:** SJMC's Lab and various other departments with the Medical Center.

**Baseline/Goal:** Early detection of heart disease

**Persons:** 280

**Expenses:** 8,406

**Revenues:** 210

**Benefit:** 8,196

---

#### HUMOR CART

**Description:** Provide entertainment to in-patients and their families while staying in the hospital - puzzles, games, crafts, dvd's, etc.

**Gender:** Both Males and Females

**Department:** 8660 (Volunteer Services)

**Department Contact:** Janet Streit (410-337-1492)

**Persons:** Unknown

**Expenses:** 503

**Revenues:** 0

**Benefit:** 503

---

#### KANGAROO KAPERS

**Description:** Class for expectant mothers and children who are expecting a new sibling. Introduces the child to the Medical Center and baby needs.

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Objective:** To prepare children for the birth of a sibling, the mother's hospital stay, and to familiarize the child with normal newborn behaviors.

**Baseline/Goal:** The older sibling will be more comfortable with the hospital setting. The child will view becoming an "older" sibling as a positive life change.

**Persons:** 142

**Expenses:** 902

**Revenues:** 580

**Benefit:** 322

---

#### LABOR & DELIVERY TOURS

**Description:** Walking tour of the Labor and Delivery Area and the Mother/Baby Unit

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Objective:** To allow expectant parents a chance to become familiar with SJMC

**Baseline/Goal:** Couples will be more comfortable with the environment of SJMC

**Persons:** 185

**Expenses:** 670

**Revenues:** 0

**Benefit:** 670

---

#### LACTATION CONSULT

**Description:** Meeting with mothers and infants regarding breastfeeding issues/problems. A consult may consist of a weight check, observation of a feeding, interventions, and education

**Gender:** Both Males and Females

**Department:** 6230 (Maternal Child Health)

**Department Contact:** Connie Getz (410-337-3994)

**Objective:** To assist mothers who are unable to pay our fee for an outpatient consult with breastfeeding issues/problems.

To improve a mother's breastfeeding relationship with her infant.

To support a mother's breastfeeding efforts.

**Partners:** Utilize the facility at Stevenson and York Road.

**Persons:** 36

**Expenses:** 508

**Revenues:** 0

**Benefit:** 508

---

#### LECTURES - HEALTH RELATED ISSUES

**Description:** Presentation of health related topics to members of the community

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Andrea Mocca (410-337-1473)

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Objective:** To increase community members' awareness of, knowledge of, or interest in health related topics

To motivate community members to maintain or improve their health status

**Partners:** Baltimore County Dept. of Aging for some lectures

**Baseline/Goal:** Community members will have increased awareness of health topics and will use it to maintain or improve their health.

**Persons:** 495

**Expenses:** 1,881

**Revenues:** 0

**Benefit:** 1,881

---

#### MEMORIAL SERVICE

**Description:** To invite families of deceased patients for comfort and support in a spiritual setting - Mass and Reception

**Gender:** Both Males and Females

**Department:** 8671 (Spiritual Care Department)

**Department Contact:** Nancy Conner (410-337-1706)

**Objective:** To bring closure to families who have lost loved ones.

**Baseline/Goal:** Families are able to express their sorrow and grief in a community setting.  
Better community relations  
Good communication with family members

**Persons:** 87

**Expenses:** 1,406

**Revenues:** 0

**Benefit:** 1,406

---

#### MUSIC THANATOLOGY

**Description:** Provide palliative care music to terminally ill patients through use of harp.

**Gender:** Both Males and Females

**Department:** 8670 (Mission/Ministry)

**Department Contact:** Angela Moralis (410-337-4872)

**Objective:** Provide therapeutic music to patients who are facing a terminal illness or are near end of life.

**Persons:** 409

**Expenses:** 20,244

**Revenues:** 0

**Benefit:** 20,244

---

#### MUSIC THERAPY - HARP

**Description:** Provide music therapy to patients to effect positive changes in emotional, physical, mental and/or spiritual functioning of individuals with health problems.

**Gender:** Both Males and Females

**Department:** 8670 (Mission/Ministry)

**Department Contact:** Angela Moralis (410-337-4872)

**Objective:** Provide harp therapy to TCU and NICU patients

**Persons:** 407

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Expenses:** 5,106  
**Revenues:** 0  
**Benefit:** 5,106

---

#### NATIONAL ACCESS TO HEALTHCARE GOAL

**Description:** Four focus groups to be conducted to identify issues related to health care access in the Fells Point community of Baltimore City. A plan to address issues will be developed, implemented, and evaluated over 3-5 years.

**Gender:** Both Males and Females

**Department:** 7756 (St. Clare Medical Outreach)

**Department Contact:** Bill Gough (410-337-1949)

**Objective:** Identify barriers to health care access in the Hispanic community in Fells Point.

**Partners:** Yes, Hispanic Apostolate, churches, employers, other health care providers. Presently, all collaborators are unknown.

**Persons:** Unknown

**Expenses:** 3,498

**Revenues:** 0

**Benefit:** 3,498

---

#### PARENTING 101

**Description:** Support group for new mothers and their infants

**Gender:** Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Objective:** To empower new mothers to feel confident to care for and make decisions in raising their child.

To educate the new Mom about infant and child growth and development.

To make the new Mom more aware of community resources.

**Baseline/Goal:** The new Mom will feel more confident in her role, more aware of community resources, and knowledgeable of infant growth and development.

**Persons:** 859

**Expenses:** 4,498

**Revenues:** 0

**Benefit:** 4,498

---

#### PAYING OF PRESCRIPTIONS, MEDICAL EXPENSES FOR INDIGENT PATIENTS

**Description:** SJMC, through its Mission/Ministry fund, agrees to assist in the payment of prescriptions, medical expenses, etc. for indigent patients.

**Gender:** Both Males and Females

**Department:** 8619 (INTEGRATED CARE MGMT)

**Department Contact:** DIANE SKILLE (1748)

**Objective:** To assist low income patients with their medical expenses

**Baseline/Goal:** Low income patients are able to receive medical treatment that they could not ordinarily afford.

**Persons:** 195

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Expenses:** 65,425  
**Revenues:** 0  
**Benefit:** 65,425

---

#### PERIPHERAL VASCULAR SCREENINGS

**Description:** Participants will be evaluated for PVD by Vascular physicians using Dopler studies and pressure readings. Education and counseling will also be provided.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To identify new cases of PVD

To provide education and counseling regarding PVD prevention

To provide referral information as needed

**Baseline/Goal:** Participants are referred for futher evaluation as a result of the PVD screening.

Education provided regarding way to promote better health

**Persons:** 66  
**Expenses:** 1,761  
**Revenues:** 0  
**Benefit:** 1,761

---

#### PLANNING/DEVELOPMENT OF CROHN'S AND COLITIS SUPPORT GROUP

**Description:** Support group for adults with Crohn's Disease or Ulcerative Colitis

**Gender:** Both Males and Females

**Department:** 7250 (DDC)

**Department Contact:** Carol Woodworth (410-337-1537)

**Objective:** Provide opportunity for adults with Crohn's Disease and Ulcerative Colitis to receive emotional support and desired education regarding their diseases in a safe, and supportive atmosphere.

Increase information with resouces for adults with these diseases.

Provide information with resources for adults with these diseases.

**Partners:** Chrohn's and Colitis Foundation

Community Outreach

**Baseline/Goal:** Adults will become knowledgeable and secure in their ability to manage Crohn's Disease and Ulcerative colitis.

Adults will be able to deal effectively with these diseases in all aspects of their lives.

Adults will receive resources which will be helpful for dealing with these diseases.

**Persons:** 79  
**Expenses:** 441  
**Revenues:** 0  
**Benefit:** 441

---

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

#### PROSTATE CANCER SCREENINGS

**Description:** Screening consists of PSA blood test and DRE. PSA is done prior to screening so that the results are available to physician at the screening site. DRE is performed by the physician. Counseling & education are provided as indicated by the participant's need.

**Gender:** Males

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To provide PSA and DRE to eligible men to detect unknown case of cancer of the prostate.

To provide education and counseling about prevention and need for professional, annual examination and self-examination

**Baseline/Goal:** Possible prevention and early detection of prostate cancer

**Persons:** 60

**Expenses:** 2,302

**Revenues:** 0

**Benefit:** 2,302

---

#### PUBERTY LECTURES

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Persons:** 128

**Expenses:** 180

**Revenues:** 0

**Benefit:** 180

---

#### RAISE

**Description:** Three sessions - tobacco education and behavior modification program for adolescents mandated through the school, legal, or family system

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Christine Duke (410-337-1555)

**Objective:** 1. Participants will demonstrate an increased knowledge of tobacco facts and risks.

2. Participants will contract for behavioral change related to their tobacco use with their parents.

3. Participants will verbalize resources for completing their contract.

**Baseline/Goal:** Decreased tobacco use among participants and their family (if applicable).

Increased family cohesion and functioning.

**Persons:** 24

**Expenses:** 442

**Revenues:** 125

**Benefit:** 317

---

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

#### SAFE SITTER

**Description:** Baby Sitting class for students ages 11-13 years of age.

Safe Sitter at Winston Middle School - International Safe Sitter Basic Course is taught by 2 certified instructors. It is 4 sessions, 2 1/2 hrs. per session.

**Gender:** Both Males and Females

**Department:** 8762 (Family Education)

**Department Contact:** Marian Malinski (410-337-1682)

**Objective:** To teach young babysitters how to avoid emergencies, how to handle emergencies.

To teach safety while alone or babysitting

To teach basic child care skills.

**Baseline/Goal:** The student will be able to provide emergency assistance to a child who is choking. The sitter will be able to do rescue breathing. The student will have confidence in his/her ability to call emergency for help. The student will demonstrate knowledge of child growth and development and be able to entertain children.

**Persons:** 73

**Expenses:** 4,395

**Revenues:** 2,920

**Benefit:** 1,475

---

#### SCOLIOSIS SCREENINGS

**Description:** RN screening of 6,7,8 grade girls and boys according to the guidelines from the National Scoliosis Society and the National Association of School Nurses.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To identify those children at risk for scoliosis at an early age.

To refer children with possible spinal problems.

**Baseline/Goal:** Children will be identified early so that treatment required will be minimal and deformity can be avoided.

**Persons:** 29

**Expenses:** 112

**Revenues:** 0

**Benefit:** 112

---

#### SKIN CANCER SCREENINGS

**Description:** Screening is done by dermatologists. Involves complete visual inspection. Counseling and education is provided by RN and referral information is available to those who need a physician and do not have one. Screening is open to general public.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** mARCIE hOESCH (410-337-1012)

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Objective:** To provide education about skin cancer and safe sun practices.

To identify those at risk for skin cancer.

To identify lesions which maybe cancerous as early as possible.

**Baseline/Goal:** To identify skin cancer/lesions in the early stages.

**Persons:** 86

**Expenses:** 3,890

**Revenues:** 0

**Benefit:** 3,890

---

#### SOCIAL ACCOUNTABILITY REPORT

**Description:** Time involved in preparing the Social Accountability Report

**Gender:** Both Males and Females

**Department:** 8610 (Administration)

**Department Contact:** Beth Kelly (410-337-1507)

**Persons:** Unknown

**Expenses:** 1,440

**Revenues:** 0

**Benefit:** 1,440

---

#### SPIRITUAL CARE GRIEF AND LOSS GROUPS

**Description:** Spiritual listening, grief processing

**Gender:** Both Males and Females

**Department:** 8671 (Spiritual Care Department)

**Department Contact:** Nancy Conner (410-337-1706)

**Objective:** To facilitate expression/working through grief and loss

**Baseline/Goal:** Appreciation/expression of grief/life story comfort/gratitude, decrease stress, increase energy

**Persons:** 31

**Expenses:** 210

**Revenues:** 0

**Benefit:** 210

---

#### SPIRITUAL CARE ORTHOPAEDIC GROUP

**Description:** Presentation and group discussion on "Spiritual Wholeness" integrating the emotional, physical, and spiritual concerns and resources for available for orthopaedic patients.

**Gender:** Both Males and Females

**Department:** 8671 (Spiritual Care Department)

**Department Contact:** Nancy Conner (410-337-1706)

**Objective:** Orthopaedic: Assess, identify, and demonstrate the surgical patients spiritual coping skills while facing life altering events.

**Baseline/Goal:** To bring a sense of spiritual wholeness and well being to patients coping with emotional, physical, and spiritual concerns.

**Persons:** 772

**Expenses:** 1,330

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Revenues:** 0  
**Benefit:** 1,330

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**SPIRITUAL CARE PARKING SUBSIDY - CLERGY**

**Description:** Free parking is extended to needy family members of patients; clergy; religious people visiting patients.  
**Gender:** Both Males and Females  
**Department:** 8671 (Spiritual Care Department)  
**Department Contact:** Nancy Conner (410-337-1706)  
**Objective:** This activity provides free parking to needy family members of patient, clergy, and visiting religious people.  
**Baseline/Goal:** Extend parking courtesy to visiting clergy and needy family members  
**Persons:** 981  
**Expenses:** 24,496  
**Revenues:** 0  
**Benefit:** 24,496

---

**SPIRITUAL CARE PARKING SUBSIDY FOR NEEDY**

**Description:** Free parking is extended to needy family members of patients  
**Gender:** Both Males and Females  
**Department:** 8671 (Spiritual Care Department)  
**Department Contact:** Nancy Conner (410-337-1706)  
**Objective:** This activity provides free parking to needy family members of patient, clergy, and visiting religious people.  
**Baseline/Goal:** Provide parking for family members of patients who are needy.  
**Persons:** 37  
**Expenses:** 3,854  
**Revenues:** 0  
**Benefit:** 3,854

---

**SPIRITUAL CARE PREGNANCY LOSS SUPPORT GROUP**

**Gender:** Both Males and Females  
**Department:** 8671 (Spiritual Care Department)  
**Department Contact:** Nancy Conner (410-337-1706)  
**Persons:** 7  
**Expenses:** 84  
**Revenues:** 0  
**Benefit:** 84

---

**ST CLARE MEDICAL OUTREACH**

**Gender:** Both Males and Females  
**Department:** 7756 (St. Clare Medical Outreach)  
**Department Contact:** ()

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12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Persons:** 2,456  
**Expenses:** 705,871  
**Revenues:** 0  
**Benefit:** 705,871

---

#### STD LECTURES

**Gender:** Both Males and Females  
**Department:** 8762 (Family Education)  
**Department Contact:** Marian Malinski (410-337-1682)  
**Persons:** 128  
**Expenses:** 136  
**Revenues:** 0  
**Benefit:** 136

---

#### SUBSIDIZED TRANSPORTATION SERVICES

**Description:** Provide transportation for indigent patients to and from hospital - cab fare, county ride, ambo, bus tokens  
**Gender:** Both Males and Females  
**Department:** 8619 (INTEGRATED CARE MGMT)  
**Department Contact:** DIANE SKILLE (1748)  
**Partners:** Jimmys Cab  
Baltimore County Ride  
**Persons:** 2,416  
**Expenses:** 298,545  
**Revenues:** 0  
**Benefit:** 298,545

---

#### SUPPORT GROUPS - INDIVIDUALIZED

**Description:** Groups conducted for community members to increase their psychosocial, educational and spiritual understanding of specific health or life conditions, e.g. diabetes, Crohn's and Colitis, Caregivers', Cardiac, Bereavement (Widow/Widower's, etc), tobacco use, arthritis  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Bernadette White (4103371254)  
**Objective:** Provide psychosocial/spiritual support and education related to community members' health and/or life conditions.  
**Partners:** Diabetes Support - Sodexo  
Crohn's & Colitis - Crohn's & Colitis Foundation of America  
**Baseline/Goal:** Members will verbalize increased comfort level or knowledge level in dealing with specific health or life condition.  
**Persons:** 61  
**Expenses:** 328  
**Revenues:** 0  
**Benefit:** 328

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

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**THE CATHOLIC HIGH SCHOOL OF BALTIMORE**

**Description:** LECTURE FOR CAREER DAY- NURSING AS CAREER  
**Gender:** Both Males and Females  
**Department:** 7000 (Labor & Delivery)  
**Department Contact:** Marian Malinski (410-337-1682)  
**Objective:** TO ENCOURAGE HIGH SCHOOL STUDENTS TO CONSIDER NURSING AS A CAREER  
**Baseline/Goal:** THE STUDENTS WILL CONSIDER NURSING AS A CAREER.  
**Persons:** 39  
**Expenses:** 45  
**Revenues:** 0  
**Benefit:** 45

---

**TOBACCO CONTROL MEETINGS**

**Description:** Meetings with community coalitions, local Health Depts., businesses, schools, and other entities regarding tobacco control issues, policies, strategies, and funding.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Christine Duke (410-337-1555)  
**Objective:** Network and collaborate with outside agencies and organizations to support efforts to reduce costs caused by tobacco use.  
**Partners:** Local schools, community coalitions, agencies, and businesses.  
**Baseline/Goal:** Decrease rate of smoking initiation and increase rates of smoking cessation and regulation.  
**Persons:** 339  
**Expenses:** 779  
**Revenues:** 0  
**Benefit:** 779

---

**TOBACCO EDUCATION**

**Description:** Education community members, students, on the effects of tobacco.  
**Gender:** Both Males and Females  
**Department:** 8761 (Community Outreach)  
**Department Contact:** Christine Schutzman (4103371555)  
**Objective:** To increase the public's general knowledge about the health, social and economic problems associated with tobacco use.  
  
To encourage tobacco users and their associates to work toward a tobacco-free lifestyle and community  
**Persons:** 635  
**Expenses:** 490  
**Revenues:** 0  
**Benefit:** 490

12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

#### VILLAGE WELLNESS PROGRAM

**Description:** Improve health status of people in Tanzania, East Africa

**Gender:** Both Males and Females

**Department:** 8800 (TANZANIA)

**Department Contact:** Anthony La Porta (4103371728)

**Objective:** Screenings and development of village health leaders

**Partners:** CHI & Sisters of St. Francis - Funding  
Karatu Lutheran Hospital Personnel  
Lutheran World Relief & Catholic Relief Services - Materials

**Baseline/Goal:** 1. Improve health status  
2. Train Village Wellness Leaders

**Persons:** Unknown

**Expenses:** 37,558

**Revenues:** 0

**Benefit:** 37,558

---

#### VISION SCREENINGS - PEDIATRICS

**Description:** Children PK-12 grade screened for usual acuity. Screenings include RNs, student interns, community health specialists, and volunteers certified by Prevent Blindness of America.

**Gender:** Both Males and Females

**Department:** 8761 (Community Outreach)

**Department Contact:** Karen Zink Brown/Gloria Webste (410-337-1012)

**Objective:** To identify at an early age children at risk for visual impairments.

To provide consistency and accuracy in the screening process for children.

To provide consistency in the referral process for children with visual impairment.

**Baseline/Goal:** This program is aimed at preventing learning and developmental problems related to visual impairment.

**Persons:** 1,152

**Expenses:** 2,313

**Revenues:** 0

**Benefit:** 2,313

---

#### WHA

**Description:** Women's Health Associates provides low risk obstetrical and gynecological care to adolescents, adult and geriatric women.

**Gender:** Both Males and Females

**Department:** 7480 (Women's Health Assoc)

**Department Contact:** KATHY PERRETT (4103374986)

**Persons:** 13,823

**Expenses:** 737,650

**Revenues:** 0

**Benefit:** 737,650

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12/19/2007

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2006 through 6/30/2007

**Totals:**

<b>Number of Activities:</b>	<b>66</b>
<b>Persons:</b>	<b>40,189</b>
<b>Expenses:</b>	<b>2,456,389</b>
<b>Revenues:</b>	<b>6,415</b>
<b>Benefit:</b>	<b>2,449,974</b>

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## Community Benefits Evaluation

### Community Benefits Planning

1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?

The St. Mary's Hospital Strategic Plan has several initiatives that help us focus on community benefit. The first example of an initiative is Financial Stewardship . . . growth to serve the Mission. One goal under this initiative is "SMH will actively support and provide community benefit and services to un-insured and under insured of St. Mary's County." A second initiative is Business Ventures/Continuum Development . . . partnering to improve community access and health status. Similarly, one goal under this initiative is "SMH will actively work to improve health of the St. Mary's County providing health and wellness programs both onsite and out in the community for all within its means."

2. Were hospital staff and leadership involved in developing the plan?

Yes, in accordance with our policy on Strategic Plan development, each fall the leadership of the hospital – including community board members, medical staff members, administrative staff, department leadership (with input from staff via department meetings discussion) – annually review the current year's strategic initiatives and goals, in addition to actions taken and results achieved. Modifications are recommended for the new year. Early in the new year, the Board of Directors reviews the hospital's Mission, discusses the Vision and finalizes the new year's Strategic Plan.

### Community Needs Assessment

3. Does the hospital's plan target specific areas of community need?

The 2007 Strategic Plan includes targeted specific areas of community need as detailed below.

- Uninsured and underinsured through support for Health Share, review of charity care plan to meet community needs, mobile outreach center and free health screenings.
- Investigating how best to provide assistance to areas of the county with limited access to healthcare.
- Active participation in the St. Mary's County Health Advisory Committee and devoting staff and resources to work on the committee's identified health priorities of Cardiovascular Disease and Type II Diabetes.
- Specific progress is being made by the Type II Diabetes Coalition. The objectives of the Coalition are to:
  1. Identify those at risk (pre-diabetics) to prevent or delay progression of disease.
  2. Improve access to available treatments

3. Promote awareness of diabetes, its risk factors, and treatment.
  - Diabetes Coalition activities in FY 2006 included the following:
    1. Design, printing and collection of ADA Diabetes Risk Assessments. Inclusive in this was postage for participation letters which were sent to local service organizations, churches and businesses.
    2. Design and printing of brochures for distribution to local physicians' offices and Coalition partners. The brochures included a) Resources for Diabetes Education; b) Opportunities for Physical Activity; and 3) Managing the Cost of Diabetes Care.
    3. Physician educational programs on the management of diabetes.
      - Improving Emergency Services to the community, including growing the access and utilization of urgi-care centers, working to train people in ALS, PALS, etc.
      - Growing our own workforce, including developing health care careers clubs in the schools, offering internships, scholarships, etc.
      - Supporting recruitment and retention of physicians in needed specialty areas.
4. Did the local health department 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.

The St. Mary's Community Health Advisory Committee, which is staffed by the St. Mary's County Health Department, developed its health priorities from the 2003 St. Mary's Health Profile compiled by the St. Mary's Health Department. The top three priorities for focus by all in the community are Cardiovascular Disease, Type II Diabetes and traffic accidents. These areas were prioritized based upon a review of mortality rates for St. Mary's County versus the State of Maryland where the County has a higher incidence. Cardiovascular Disease has been a priority since the first Health Profile in 1994 and with a concerted effort by health providers and others the mortality rate has steadily declined though it is still somewhat higher than the State's. Another information source includes the SMH Medical Staff Development Plan, which details needed numbers of physicians to assure access to medical care based upon published physician to population ratios.

#### Community Benefits Initiatives

5. Does the hospital identify its Community Based Initiatives?

Some of the hospital's community based initiatives are those identified in the goals and actions of our Strategic Plan and they are: Financial Assistance, Cardiovascular Disease and Type 2 Diabetes, Emergency Services, Workforce Development.

6. Do the hospital's community benefits initiatives reflect evidence-based needs? Give two examples.

### Type 2 Diabetes Coalition

The CDC's Diabetes Prevention Program showed that Americans at high risk for type 2 diabetes could prevent or delay the disease through lifestyle changes in diet and exercise and losing a little weight. The study indicated that lifestyle interventions were effective for participants of all ages and all ethnic groups. For those at risk for developing type 2 diabetes lifestyle changes reduced their risk by 58%.

### Health Share of St. Mary's

SMH was one of three organizations in 1991 that helped create a financial assistance program for the "gray zone" residents of the County – those uninsured or underinsured who need access to health care services. The Department of Social Services tracks this population and we track the enrollment in our Health Share program against the total population. Each year SMH provides emergency and outpatient services to this population working within our Financial Assistance Program.

7. Were the initiatives performance-based and did they involve process and/or outcome measures?

The Type 2 Diabetes Coalition identified three goals. 1. Identify those at (pre-diabetes) to prevent or delay progression of the disease, 2. Promote diabetes awareness in St. Mary's County, and 3. Improve access to diabetes care and treatment. Based on the goals, the coalition has developed a community wide plan defining objectives for each goal. The current work towards the goals is being measured by completion of objectives and by participation numbers. Other than utilizing the mortality rate, outcomes have not been measured to date but measures will be developed in the upcoming year.

The Hospital is the key contributor to the Health Share program in collaboration with local area physicians, pharmacies, and volunteers. Our goal, identified in the fiscal year budget, was to contribute \$574,000 in services to Health Share patients. The actual outcome achieved for the year was \$672,145, a 28% increase over the prior year.

Our charity care plan provided \$515,000 of free and discounted service, providing a significant increase from 2005.

### Community Collaboration

8. Did the hospital involve the community participants in planning and/or implementing its community benefits activities? Was the community involved in identifying the initiatives and setting goals to be achieved?

Because several of our community benefits programs stem from the organized community effort coordinated by the St. Mary's Community Health Advisory Committee, hospital and community efforts are intertwined. This committee's activities include creation of the Type 2 Diabetes Coalition that chaired by SMH Health

Connections Director. SMH provides an approved American Diabetes Association Diabetes Education Program that continues to grow in services and in participants. The Advisory Committee's effort to reduce the incidence of Cardiovascular Disease also has active participation by SMH Physical Therapy staff. SMH has increased its focus on physical activity.

9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and /or implement its community benefits activities?

In addition to those named above, SMH representatives have also participated in other community organizations such as the Colorectal Cancer Coalition and the Tobacco Coalition.

#### 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?

All initiatives, goals and actions detailed in the SMH Strategic Plan have assigned persons/committees who are responsible for assuring success. Progress on all activities and the status of all actions are addressed monthly in management reports and detailed quarterly in the Strategic Initiatives Action Plan to the SMH Board of Directors.

11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?

In addition to the reporting detailed in number 10, community benefits are featured periodically in the quarterly newsletter that goes to the community and also are highlighted in the Annual Report.

## **GAPS IN SPECIALIST COVERAGE**

St. Mary's Hospital is located in a rural area with a population of roughly 95,000. Recruiting specialists is challenging. The greatest need is for orthopedic surgeons, ophthalmologists, gastroenterologists, ENT's/otolaryngologists, urologists, neurologists and psychologists. Due to the small numbers of physicians on staff, they are required to provide an exorbitant amount of emergency call coverage to the Emergency Room. This is likewise true for the four obstetricians currently on staff.

SUBURBAN HOSPITAL

# **Community Benefit Report FY 07**

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# Community Benefit Report FY 07

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SUBURBAN HOSPITAL

# **Community Benefit Report FY 07**

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# **Introduction**

# Suburban Hospital

## **C**ommitment to our **Community**



As a not-for-profit, community-based resource, Suburban Hospital takes its responsibility to care for and improve the health status of the community very seriously. With 64 years of service history, Suburban Hospital stands firm as a healthcare provider guided by the needs of our patients and community. We distinguish ourselves not only through state-of-the-art technology, research, and clinical excellence, but also through strategic initiatives designed to benefit our community at large- creative programs and services that provide care and support far beyond our hospital walls.

Building healthier communities comes from creating stronger, more positive relationships that cross racial, economic, geographic, and ideological lines. Through partnerships with nearly 100 civic groups, congregations, schools, local governments, county coalitions, businesses and private foundations throughout Montgomery County, our outreach programs and charity care initiatives reach hundreds of thousands of individuals each year that otherwise might not have access to quality healthcare.

Specifically, in FY07 Suburban Hospital dedicated **\$1,783,256** in hospital based Community Health Service Programs plus **\$876,577** in Foundation based Community Service Activities. Suburban is affiliated with 33 health coalitions and associations, has partnered with over 30 elementary, middle, and high schools, and has conducted wellness programs in collaboration with over 15 corporate companies encompassing over 20 zip codes throughout Maryland and Washington, DC. In addition, Suburban's Community

Health and Wellness Department conducted over 2,000 community health activities reaching nearly 200,000 citizens. Suburban's Community outreach programs extend well beyond the hospital's inpatient services to all parts of Montgomery County and has continued its commitment to bring health base programs to the underserved in Montgomery County as well as the Southern Maryland region.

## **EXPANDED PREVENTION and DETECTION OUTREACH**



Since the opening of the NIH Heart Center at Suburban Hospital, the Community Health and Wellness Department has continued promoting heart healthy lifestyles and its outreach efforts to the Southern Maryland Counties, which includes Prince George's, Calvert, Charles and St. Mary's. During FY07, staff from the Community Health and

Wellness department has attended 387 health events including health fairs, SAGES seminars, free exercise programs and has provided free health screenings to residents in several community health centers and places of worship.

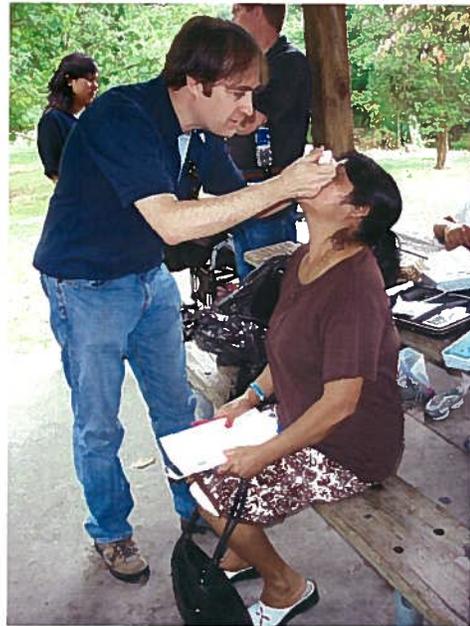
During FY 2007, Suburban's cardiovascular outreach efforts in Southern Maryland flourished. By partnering with area hospitals, faith based organizations, and local community centers, cardiac disease prevention and early detection education programs for minority and indigent community members more than doubled. Consistent with its promises to expand outreach programs to Southern Maryland, Suburban Hospital supported 388 health activities, reaching 23,597 individuals in Prince Georges, Calvert, Charles and St. Mary's Counties.

Suburban recognizes that the most effective way of extending access to care for those in need is collaborating with the familiar organizations in which these individuals belong. From

the beginning, Suburban has partnered with community based organizations to reach out to minority and underprivileged residents. Suburban continues its commitment in fostering community partnerships through the collaboration and support of area civic groups, congregations, local government, and leveraging valuable resources with other not-for-profits.

## **ACCESS TO CARE & SERVICE TO MINORITY HEALTH**

Suburban recognizes that our responsibility to the community must include programmatic strategies to increase greater access to health care services. For example, even though Montgomery County has one of the highest family income levels in the country, surprisingly, the County is also home to a record number of diverse, undocumented and uninsured residents who typically use the emergency room to seek routine medical care. Suburban continues to conduct free screenings and outreach programs without regard to immigration or insurance status.



Indeed, Suburban targets minorities and low-income communities in selecting venues for health education and screening programs. In many cases, Suburban outreach staff assists residents in obtaining insurance through Medicaid or additional free medical care. Suburban's contribution of **\$64,319** to health screening services affords the Department of Community Health and Wellness to continue its commitment to the prevention and early detection of chronic diseases such as diabetes, hypertension, and hyperlipidemia. Identifying at risk individuals and linking them to available health services is a rewarding experience not only for the organization but also for Suburban Hospital staff.

With the continuation of our goal to provide access to care to the community, Suburban's Community Health and Wellness team remain engaged with County health services and safety net clinic operations so that they are able to keep community participants informed and linked with medical homes. Realizing that many newly arrived individuals to the County

may be unfamiliar with vital resources available to them, Suburban Hospital Community Outreach staff have developed an easy to read Resource Guide which lists various County organizations that offer free or discounted community services. By distributing this Resource Guide, new community members are able to easily access available resources regardless of their ability to pay. In addition, the guide affords these same individuals a valuable tool for navigating a system often times perceived as frustrating and inaccessible.

One specific outreach effort is the *Get a Check Up* program which identifies individuals that may be at high risk for colorectal cancer and refers them to available screening programs. In partnership with the Montgomery County Cancer Crusade, Suburban Hospital was able to conduct 43 health education screenings for colorectal cancer reaching 1,893 individuals who may not otherwise know that they are at risk and learn more about enrolling in a free screening program.

***Building stronger and more  
informed communities  
through health partnerships  
and coalition advocacy***

Suburban Hospital and *Clinica Proyecto Salud* located in Wheaton, MD have worked together for over three years in providing educational workshops and screenings for the Latino Diabetes Education Program to encourage individuals to learn about important risk factors associated with Diabetes, along with practical approaches for self management. In addition, Suburban Hospital has extended its efforts in providing access to quality health care to those in need by providing free prostate and colorectal cancer screenings to *Clinica Proyecto Salud* patients.

This past June, Suburban Hospital hosted the Glorifying Our Spiritual & Physical Existence for Life (G.O.S.P.E.L) program's 4<sup>th</sup> Annual Heart Health Symposium. Nearly 200 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.

Suburban envisions Community Benefit not only in the service to those in our backyard, but to community members throughout Montgomery County. For instance, since 1995 Suburban Hospital has provided free cardiovascular diagnostics such as EKGs, MRIs, and CT scans, interventional and diagnostic radiology, laboratory, as well as inpatient services to Mobile Medical Care, Inc., a clinic that provides free to low-cost medical care for the uninsured. In addition to parking two Mobile Medical Vans on the hospital grounds, Suburban Hospital also links volunteer physicians, registered dietitians and nurse practitioners to serve MobileMed patients. Since 1995 MobileMed has expanded from 7 to 22 clinics, which in turn has expanded Suburban Hospital's contribution from an average of \$150,000 in free diagnostic services to nearly **\$500,000** in FY07. More importantly, Suburban Hospital provides similar free medical services to additional community clinics throughout Maryland. Last year, Suburban e reported **\$2,576,000** in charity care and mission driven health services.

## **YOUTH EMPOWERMENT**

*--Taking the time to help our teens grow--*



When young people are organized and engaged with a vision for social change, they can be a very powerful force for a healthy future. With that in mind, Suburban Hospital's youth projects encourage young leaders through a wide array of activities. For instance, the Medical Venturing Program affords high school students who are interested in pursuing medical careers a real-life training opportunity to observe and experience several different facets of the medical profession, including the opportunity to

participate in important grass roots community service projects. Likewise, the *Safe Sitter Program*, instructed at five middle schools, teaches 11-13 year olds the importance of safe babysitting and encourages responsibility for caring for children.

In Spring FY07, Suburban Hospital partnered with the Greater Washington Area Chapter of Hadassah to bring the *Check It Out* program to 11<sup>th</sup> and 12<sup>th</sup> grade girls throughout 21 Montgomery County Public High Schools, thus educating over 4,000 young women about the importance of early detection for breast cancer survival. Each *Check It Out* session was lead by a Suburban Hospital nurse who discussed the importance of early detection, demonstrated how to correctly perform a self breast exam and answered individual anonymous questions from the audience. In addition, each girl received a breast health kit that they were encouraged to share with female family members.

It has been said that parenting is the most difficult job, and for the past four years Suburban Hospital has partnered with the YMCA to bring parents valuable tools for raising children. During FY07, Suburban sponsored two parenting seminars, *The Good Enough Child* with Dr. Brad Sachs and *Family Routines: Easing the Conflict from Breakfast to Bedtime* with Dr. Frank Walton. Both speakers are highly regarded family therapists who discussed the essentials of parenting and shared ways to deal with the pressures of being a parent and raising well adjusted children. All proceeds from these events were used to fund the prevention services of the *YMCA Youth & Family Services*.

When addressing the positive growth of healthy teens, we draw from community resources, incorporating the aid of community-based and civic organizations, corporations, the public sector, churches, parents, and other neighborhood resources. We believe that empowerment education is an effective health education and prevention model that promotes healthy change in both personal and social areas for our community's youth.

## SENIOR STRENGTH!

As our senior community has proven, growing older has no relation to being less active. In fact, in FY07 Suburban Hospital funded over 260 free *Senior Shape* strengthening and flexibility classes and 240 mall walking programs reaching regular program participants over 30,000 times!

**Preparing our Senior  
Community to be FIT  
FOR LIFE!**

In addition to encouraging active lifestyles, Suburban's Community Health and Wellness department conducts monthly blood pressure screenings at 10 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. In FY07 Suburban Hospital held over 80 community health seminars in various senior centers throughout Montgomery County. Through mission driven health services such as Suburban's Elderwell program, which empowers seniors to maintain independence and manage their health, Suburban continues to demonstrate the organization's belief to encourage it's older adult community to live safely and independently by supporting **\$1,228,889** in program operations in FY07.

As we welcome our 65<sup>th</sup> year of caring for our community, Suburban Hospital stands firm as a healthcare provider guided by the needs of our patients and community. A key aspect of Suburban Hospital's vision and commitment to the community is to provide needs-based health education, wellness and promotion services for area residents, with a special focus on underserved seniors, youth, minorities and access to care for the uninsured. As the driving force and pathway to achieving this objective, Suburban Hospital has dedicated **\$ 10,080,545** in outreach programs and services in FY07 to improve the health status of our community.

## **Community Benefit Report FY 07**

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# **Community Benefit Evaluation**



# Suburban Hospital

## Suburban Hospital Community Benefit Evaluation Framework 2007

1. Community giving is a fundamental activity that has historically shaped Suburban Hospital's operation and outreach efforts for the past 64 years. In fact, aligning community health initiatives, charitable programs, and wellness activities that benefit our community through prevention, education and outreach are included in the organization's annual long term strategic plan. Given the opportunity to report community benefit services required by Maryland law to the HSCRC, Suburban Hospital is designing a strategic plan integrating community benefit with the organization's strategic goals. The scorecard incorporates a formal Community Benefits plan and data collection model that can easily be shared with the public and used as a benchmark for department reporting.

For example, last year, Suburban Hospital's Community Benefit Report was presented to the Board of Trustees, senior leadership, nursing directors and the organization's management team. This year, a formal data collection module was implemented for improved tracking and monitoring. In FY07, the Community Health and Wellness department was formally incorporated into the Hospital's strategic planning process and is regularly represented at hospital operations meetings.

2. Suburban Hospital's Board of Trustees is actively engaged in an ongoing dialogue of how the organization broadly serves its community. Equally supportive is the Organization's President and CEO, who leads a motivating role in the System's planning of Community Benefit initiatives. Other hospital operations, finance, and nursing leadership along with all levels of hospital staff are equally involved in developing a community benefit plan and have historically embraced the opportunity and responsibility of reaching out to serve the community. For years, the Community Health and Wellness Department has documented community impact data. Given the instituted state requirement of Community Benefit reporting, the structured format of tracking and reporting data has afforded a natural weaving of community benefit productivity into hospital policy and operation and has been integrated in the hospital's overall scorecard. Over the last two years, Suburban Hospital's Community Benefit data has taken centerfold and formally incorporated into Suburban Hospital's quarterly newsletter, New Directions. Over 250,000 homes receive this publication thus resulting in positive feedback from other health officials, the hospital's own System Board, and individual community members who were previously unaware of the diligent scope of Suburban's outreach and community benefit efforts.

3. Suburban Hospital's Community Benefit plan targets very specific areas of community need. For example, a Community Advisory Board was established in 1998 composed of several public and private health officials along with other outside organization leaders. The Community Advisory and Visioning team identified four specific target areas of need: A focus on health access of minority populations, underserved seniors, at-risk youth, and management of chronic diseases like Diabetes for the under/uninsured.

4. Healthy People 2010 guidelines established by the Maryland DHHS are among vital information sources used to identify community needs. Additional tools used to identify specific health challenges include 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 conducted health surveys from the Scotland teen community to identify which at risk teen behaviors were most prevalent in the target population. The result of these surveys will enable the Department of Community Health and Wellness to design future teen health programs for this unique neighborhood in FY08. In addition, 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.

In addition, Suburban Hospital continues to engage community involvement and feedback through the hospital's efforts to organize a *Community Panel for a Healthy Future* which includes a variety of hospital leadership and is composed of several community representatives from the hospital's neighborhoods and businesses with a common goal to work collaboratively on health advocacy, enhancement of services, and other community initiatives.

5. Suburban Hospital identifies its community based initiatives in great detail. (*See Community Outreach Activities & Dates Section*)

6. Suburban Hospital's community benefit initiatives reflect evidence-based needs which can be described from both a macro and micro perspective. For example, health priorities established at a macro level are guided by the State of Maryland's Department of Health and Human Services who set large scope perspectives on health priorities such as those outlined in the Healthy People 2010. Whereas a micro perspective approach may be more specifically targeted to immediate community needs as established by health partners who design Montgomery County Health Initiatives and those that comprise local health coalitions. A further example would be recognized in Suburban's role and health partnership with the *Montgomery County Cancer Crusade*. In addition to describing such micro level community based initiatives, Suburban Hospital also identifies those community needs established by individual community enclaves that approach the hospital in support of specific health disparities. For example, Suburban has continued its partnership with *Clinical Projector Salud* to offer Diabetes education classes in Spanish to help control and manage the rising number of diabetics identified on a daily basis. Another evidence-based need example is Suburban's active collaboration in serving on the African American Health Program's Cardiovascular Disease Coalition to design targeted educational programs for the African American community. This innovative partnership addresses the growing numbers of individuals with hypertension which is known to lead or contribute to additional chronic diseases and health risks for this particular population.

7. Many of Suburban Hospital's community benefit initiatives are performance-based and include process and outcome measures. For example, in order to improve access to health care for the uninsured, Suburban Hospital provides free diagnostic services to community clinic patients. Since 1995 Suburban Hospital has committed to providing free diagnostic services to all *Mobile Medical Care, Inc.* patients. Suburban experiences targeted outcomes through support to safety net providers that use valuable results from lab work and diagnostic testing provided by Suburban Hospital to treat, educate, and manage specific illness of clinic patients before such illnesses evolve into chronic diseases and then only treatable through long-term care which would result in an even greater cost to our healthcare system. As a result of providing free services upfront, Suburban Hospital in partnership with safety net clinics like *MobileMed*, prevent long-

term effects of illness that may otherwise go untreated or unattended. As a result, measurable outcomes are observed in lower rates of emergency room visits by uninsured individuals with advanced illness that are also likely to drive costs of unforeseen hospital and physician expenses.

8. /9. When addressing Community Collaboration, Suburban Hospital never engages a community health initiative alone. For example, In FY07, Suburban Hospital's Department of Community Health and Wellness conducted over 2,300 health activities. Each initiative is partnered with a school, a recreation or senior center, a County or State health coalition, other charitable organizations, community service groups, a corporate company, and even other hospitals. Suburban Hospital finds strength in numbers and therefore never commits to engaging any community activity without the support of other community participants. Therefore, the implementation of community benefit initiatives is clearly based on community feedback and involvement as they are the hospital's primary source of identifying specific community needs. For example, Suburban Hospital partnered with the Greater Washington Area Chapter of Hadassah to bring the *Check It Out* program to 11 and 12 grade girls in 21 Montgomery County Public Schools to educate over 4,000 young women about the importance of early detection of breast cancer. Another example of Suburban's participation with community organizations to plan and/or implement its community benefit activities is its longstanding health partnership with the Scotland Community. The Scotland Community, which is located near the intersection of Seven Locks Road and Democracy Boulevard, includes approximately 100 low-income African-American families. Established in 1993, the Scotland Community Health Partnership addresses unmet health care needs and focuses on improving the quality of life for these families.

A partnership with the Scotland Community was formed with \$66,000 of seed money from Suburban, and is guided by a steering committee of Scotland residents; religious, governmental, and elected officials; and hospital representatives. In early 1994, this group worked with the Scotland Civic Association to conduct a community needs assessment survey. Four areas were identified as concerns: (i) primary care and wellness; (ii) addiction prevention and intervention; (iii) cardiac care; and (iv) access to a modern exercise facility. In FY07, Suburban's Department of Health and Wellness Staff in partnership with the Scotland Community Center and graduate students from American University conducted a needs assessment from health behaviors surveys of the teen population. From these surveys, future programs are being planned and implemented by focusing on the needs identified by this particular community.

10. Caring for our community through prevention, outreach, and education have long flowed through the veins of Suburban's walls. In fact, long before the State of Maryland established the criteria for Community Benefit reporting, the Hospital's department of Community Health and Wellness historically played an integral role in involving fellow employees in serving the community, volunteering their expertise and time to benefit those in need. From adopting families for the holidays to dedicating hospital work hours to conducting health screenings, mentoring at risk youth at the local elementary schools, and teaching young individuals interested in medical careers through shadowing and interactive training.

11. Hospital leadership and management receive monthly updates of Community Benefit activities and are also given reminders regarding reporting requirements and deadlines. Community Benefit results and data are shared with the Hospital's Board of Trustees and leadership team upon the report's submission. In addition, highlights from the report are published in Suburban's quarterly newsletter that reaches 250,000 homes.

The Director of Community Health and Wellness along with the Corporate Director of Reimbursement work collaboratively to collect and calculate Community Benefit data. Given the most recent initiatives to incorporate a formal data collection process, leaders in Suburban's Management Communication team also

hold an integral role in the implementation, operation, and maintenance of data collection. Furthermore, the Director of Community Health and Wellness reports to Senior Vice President of Patient Care, thereby affording steadfast support from hospital leadership in the operation, implementation, and evaluation of Community Benefit initiatives.

Recently, the Community Benefit report has been included as part of the hospital's official scorecard with targeted goals to be measured semiannually.

## **Union Hospital of Cecil County:**

### Community Benefit Evaluation

#### Community Benefits Planning:

- Union Hospital has explicitly included community benefit activities in its strategic planning. The future of community benefit activities was identified as one of the ten key areas of this planning. Also, the planning process included a meeting of all hospital management staff in order to have their input. Two key areas identified from this management meeting were the need to involve the community in the planning process and to include Cecil County public health information in this planning.

#### Community Needs Assessment:

- The hospital's plan does target specific areas of community need that have been identified by needs assessments conducted by the Cecil County health department and by the United Way of Cecil County. Two examples of identified needs are the need for transportation and access to resources and the need for more health care resources for seniors. The Adult Day Services program @ Union Hospital is an example of a program that is designed to help the community address these needs.

#### Community Benefits Initiatives:

- The Hospital currently utilizes the Community Benefits Inventory for Social Accountability (CBISA) software program to identify and report on its community benefit initiatives. Examples of initiatives that are based on evidence-based needs are those related to Diabetes awareness, safety and emergency preparedness, and access to health care. At this point in time, the performance measures related to these activities are primarily focused on increasing the number of persons with access to these services.

#### Community collaboration:

- The Hospital has collaborated with various community agencies to both identify community needs and to implement community benefit initiatives. Examples of these agencies include the Cecil County Health Department, The United Way of Cecil County, and the Cecil County Senior Services and Community Transit Center.

#### Community Benefits Implementation:

- Two Hospital employees are assigned the role of system administrators for the community benefit reporting process. These administrators are responsible for

reporting both the full management and the executive management of the hospital regarding all aspects of the Hospital's community benefit activities and report.



Listed below are the specialties that we have limited providers to serve the uninsured at Union Hospital:

Dermatology – No providers  
Ear, Nose and Throat – 1 provider  
Endocrinology – 1 provider  
Gastroenterology – 3 providers  
Rheumatology – No providers  
Oral Maxillofacial Surgeons – No providers  
Pediatricians – 4.5 providers  
Vascular Surgery - .25 FTE providers



Union Memorial  
Hospital

Experience Matters  
MedStar Health

## **UNION MEMORIAL HOSPITAL COMMUNITY BENEFIT REPORTING EVALUATION FOR FY 2007**

Union Memorial Hospital, a member of MedStar Health, is one of the top specialty hospitals in Baltimore and a valued member of the communities it serves. For more than 150 years it has provided exceptional health service to the local community and beyond. The affiliation with MedStar Health assures top quality medical services are provided in the community, within an integrated health care system offering advanced care, medical research, education and community outreach.

The hospital is currently licensed to operate 283 beds and is accredited by the Joint Commission. Our annual patient volumes include more than 19,000 inpatient admissions and 178,400 outpatient and emergency department visits. Today, the hospital's main campus at 201 E. University Parkway consists of a nine-story hospital with an emergency department, one medical office building, one outpatient clinic and two other service and administrative buildings.

Approximately 50 percent of Union Memorial's total patients come from its primary service area in northeastern Baltimore City and County. This includes communities of Bolton Hill, Charles Village, Clifton, Govans, Hamilton, Hampden, Loch Raven, Overlea, Parkville, Pimlico and Roland Park. Among the hospital's well-known centers of excellence are: Curtis National Hand Center, Decker Orthopaedic Institute, Harry and Jeanette Weinberg Heart Institute and Union Memorial Sports Medicine.

To enhance the wellness of its community, Union Memorial provides an array of community-based services designed to improve the health of area residents. Working with various organizations, hospital employees and medical staff, Union Memorial participates in health education and screenings as well as provides support activities for individuals in the community living with chronic health conditions.

Union Memorial reinvests revenues in excess of expenses to enhance its capability to deliver high-quality care. These resources provide for a long-term focus on recruitment and retention of outstanding medical professionals, enhancing research and technology, and new facilities and services. In addition, such resources enable Union Memorial to provide numerous other services that benefit the community.

### **Our Mission**

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

## Our Vision

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

## Gaps in Availability of Specialist Providers to Serve the Uninsured

This information has remained consistent with our fiscal year 2006 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

## Community Benefits Plan

Union Memorial's community benefits plan regularly aligns with its strategic initiatives. The plan is developed with the guidance of key stakeholders and assessment of state reports and patient data. Priorities and programs are developed to serve demonstrated needs, with a special focus on populations who are known to have difficulty accessing care and programs that improve overall health.

Community benefit encompasses a wide variety of resources and programs; highlights include:

### Charity care

Union Memorial treats all patients, regardless of their ability to pay. It provides care without charge, or at a discounted rate, to patients who meet certain criteria. The hospital's financial aid policy is consistent with our mission and vision and takes into account each patient's ability to contribute to the cost of his or her care. During fiscal year 2007, Union Memorial provided more than 7.8 million in charity care.

### Services and medical specialties

In fiscal year 2007, the Cancer Program at Union Memorial continued its commitment to the community through numerous outreach services including screenings for breast and cervical, colorectal, lung and prostate cancer. Some screenings are provided free of charge for individuals who meet certain criteria.

Support groups offer patients and the community a way to cope with the issues they face with the comfort of knowing others are there to help. Union Memorial offers various support groups conducted at the hospital and supported by staff members who organize, facilitate and lecture.

Examples of 2007 support groups are:

- Breast cancer
- Cancer
- Prostate cancer
- Look Good, Feel Better

Union Memorial Sports Medicine provided countless hours of free medical care for student athletes and athletic events throughout the community, such as the National Junior Olympic Track and Field Championships, as well as provided a sponsorship for the Greater Baltimore Golf Classic.

### Continuing Education

As a teaching hospital, continuing education for nurses and physicians, as well as educating the next generation of health care providers is a priority for Union Memorial.

### **Nurses/Nursing Students**

By providing educational opportunities for college students in the metro Baltimore area, Union Memorial assists students in selecting career paths and choosing an effective educational route. This helps lower educational costs, reduce recruitment costs and significantly enhance the relationship between the hospital and community. In fiscal year 2007, \$15,000 was awarded in nursing scholarships.

Union Memorial's Nurse Extern Program gives nursing students in the final year of school the unique opportunity to apply the theory learned in the classroom and clinical rotations to the hospital setting. Students work with a designated preceptor(s) in meeting the program goals and objectives, while enhancing the student's personal and professional growth. Twenty nurses completed the program in fiscal year 2007.

### **Resident and fellowship training**

Union Memorial is committed to training the health care leaders of tomorrow. We strive to provide excellent training for residents and medical students, while offering high-quality medical care. A wide variety of specialties, advanced technology and innovative research combine to promote health education and the well-being of patients.

Nearly 70 residents trained at Union Memorial in fiscal year 2007. Fellowships provide advanced training in the specialties of hand surgery, foot and ankle surgery and sports medicine.

### Community Service Activities

Union Memorial encourages volunteerism among its employees, physicians and auxiliaries. Each year, our staff volunteers its time and other resources to make a positive impact and build safe and healthy communities. Examples of community services projects in fiscal year 2007 included:

*A holiday food drive* in which employees donated non-perishable food items that went to needy families throughout Baltimore. The drive was held in conjunction with the Baltimore Police Department's Northern District.

Through the August *School Supply Drive*, employees donated items that were distributed to students at Hampden Elementary School.

### **Sponsorships**

Union Memorial also provides financial support to other non-profit community causes, such as the Baltimore Heart Walk. In fiscal year 2007, Union Memorial was again a proud sponsor of the

annual walk, which raises money to support the American Heart Association's research, education and advocacy efforts. The Union Memorial team was comprised of 126 employees, family and friends. Collectively, the team raised \$22,000.

### **Summary of Net Community Benefits**

	<u># Served</u>	<u>Net Benefit</u>
Community Health Services	84,021	\$ 6,179,798
Health Professionals Education	353	\$12,409,549
Research	N/A	\$ 2,380,927
Financial Contributions	400	\$ 95,489
Charity Care	N/A	\$ 7,893,038

# **Union Memorial Hospital**

## **Gaps In Availability Of Specialist Providers To Serve The Uninsured**

This information has remained consistent with the MedStar Health fiscal year 2006 report. 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 inpatient and outpatient substance abuse treatment
- Limited availability of inpatient and outpatient surgical coverage, including general surgery, ENT, oral surgery, neurosurgery, and GYN
- Medication assistance

**Union Memorial Hospital  
FY 2007 Community Benefit Report  
Physician Subsidies**

Union Memorial Hospital's interpretation of Category C subsidies has not changed from our fiscal year 2006 report.

The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses to hospitals for services defined as subsidized care. They are defined broadly 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".

The hospital provides subsidies to a number of physician practices:

1. \$1,934,690 was paid to the physicians in the Emergency Room;
2. \$128,984 was paid to the physicians in the Department of Psychiatry;
3. \$758,883 was paid to the physicians in the Department of Pediatrics;
4. \$1,645,196 was paid to the physicians in the Department of Anesthesia Services

The subsidies are paid to make up for the shortfall in payments in relation to the cost of providing 24/7 coverage. As one would imagine, the collections for these services is not high enough in the Emergency Room as a result of the large number of uninsured patients. The collections are not high enough in the Departments of Psychiatry, Pediatrics, and Anesthesia Services 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.

**University of Maryland Medical System  
(UMMC and J. Lawrence Kernan Hospital)**

**HSCRC Community Benefit Report  
FY 2007  
Summary of Evaluation Process**

Each of the eight hospitals in the University of Maryland Medical System (UMMS) enjoys a long history of working within the communities it serves. Each hospital's mission includes providing services to the community for the benefit of its residents, often on a reduced or no cost basis.

UMMS hospitals are committed to strengthening their neighboring communities. In doing so, each hospital often provides support, financial and otherwise, to various community-based organizations and partners. For many years, the hospitals in the University of Maryland Medical System have internally coordinated and conducted community health, outreach, education and screening activities with various community partners.

**Community Health, Outreach and Advocacy Strategic Plan**

A Community Health, Outreach and Advocacy Strategic Plan was developed in FY2006 as an effort to better coordinate and direct member hospitals' work moving forward. A System-wide team (the "UMMS Community Health Coalition") of 20 individuals was established to construct this plan and an UMMS community health, outreach and advocacy program.

The scope of work for the UMMS Community Health Coalition centered on creating a "two-way dialogue with the community, faith-based organizations, senior centers, community organizations....and other key, established community partners". To effectuate this work, the Coalition adopted a multi-faceted approach to "listening" to and soliciting community needs and concerns. Members of the Coalition interviewed several elected and appointed officials as well as other community leaders to seek their input, ideas concerns and suggestions on how UMMS could best reach, meet and address the needs of the community.

The Coalition concluded in this Plan that community work should include: (1) effective and efficient delivery of community services, (2) system integration of these services, where appropriate, (3) effective utilization and deployment of resources for community-based activities, (4) effective communication of efforts in order to maximize awareness of community activities, and (5) meet specific targeted community needs within defined geographic area(s).

## **Ongoing Evaluation**

It is important that UMMS member hospitals periodically evaluate the success of any program(s) implemented as a result of the Strategic Plan or initiatives of the Coalition. The means for doing so require that member hospitals and the Coalition:

- Create a baseline of patients educated and screened each year;
- Set goals for increasing these numbers annually;
- Measure/track the number of patients who seek follow up from education or screening results;
- Set goals for increasing these numbers annually;
- Measure community health outcomes in targeted areas, i.e., cardiac-related diseases and diabetes;
- Continue follow up with patients in the target group; and
- Measure health improvements in the target disease areas.

## **Member Hospital Evaluation Processes**

Each of the member hospital of UMMS continually evaluates clinical programs and services based on adherence to its mission and strategic goals and objectives. Community health and educational based initiatives and actions are evaluated based upon:

- clinical quality – how the service improves patient outcomes and quality indicators
- customer satisfaction – how it improves patient and family satisfaction and meets the needs of diverse patient populations
- financial performance – what is the contribution margin and how does it position us to increase revenue
- operational effectiveness – how does it enhance staff productivity, patient flow and cost effectiveness
- workforce development – how does it impact morale, culture, skill development, recruitment and retention of staff

Health outcomes and impact on the community is a consideration in the development of clinical program plans and is measured in terms of clinical effectiveness and quality (length of stay, morbidity, complications, re-admissions, etc.), customer satisfaction (patient satisfaction surveys), and access to services (measures of time to next appointment, focused discussions with community leaders and consumers, etc.)

Each of the member hospitals utilize available community health assessment reports from area health departments in the development of clinical program plans for selected service lines. In addition, the UMMC strategic planning department consistently tracks clinical

and community program demands and supply in conjunction with the Maryland Health Care Commission (MHCC).

When seeking information on specific community health and access issues, each of the hospitals use a variety of methods to obtain community input including community focus groups, participation on area elementary school community committees, and ongoing dialogue with the Farmer Mitchell Board (UMMC) that serves as a resource for the Medical Center's primary health activities. Kernan Hospital administrators have gone to the Franklinton community association for input regarding community issues.

Each of the member hospitals' Community Outreach Manager develops and implements community health screenings, educational lectures, health fairs and various other outreach programs throughout the year. Each of the hospitals' participation at these community and employer-sponsored health fairs provides continuing opportunities to learn what community residents need and desire in terms of access to health screenings, diagnostic and treatment modalities, and clinical research. UMMC maintains an information kiosk at Lexington Market that has free health information and brochures and a calendar of local health events.



RE: Community Benefit Report  
Gap Analysis - University of Maryland Medical Center  
Fiscal Year 2007

The University of Maryland Medical Center (UMMC) and the faculty physicians from the University of Maryland School of Medicine represent all medical and surgical specialties and provide the entire continuum of specialty care to the Medical Center's community.

For the twelve months ended June 30, 2007, UMMC does not have any "gap" in the availability of specialist providers to service the uninsured at the Medical Center.

Sincerely,

*Alicia Cunningham*

Alicia Cunningham  
Senior Director, Reimbursement & Revenue Advisory Services

Cc: Donna Jacobs, UMMS



***University of Maryland Medical Center  
Community Needs Assessment - 2007***

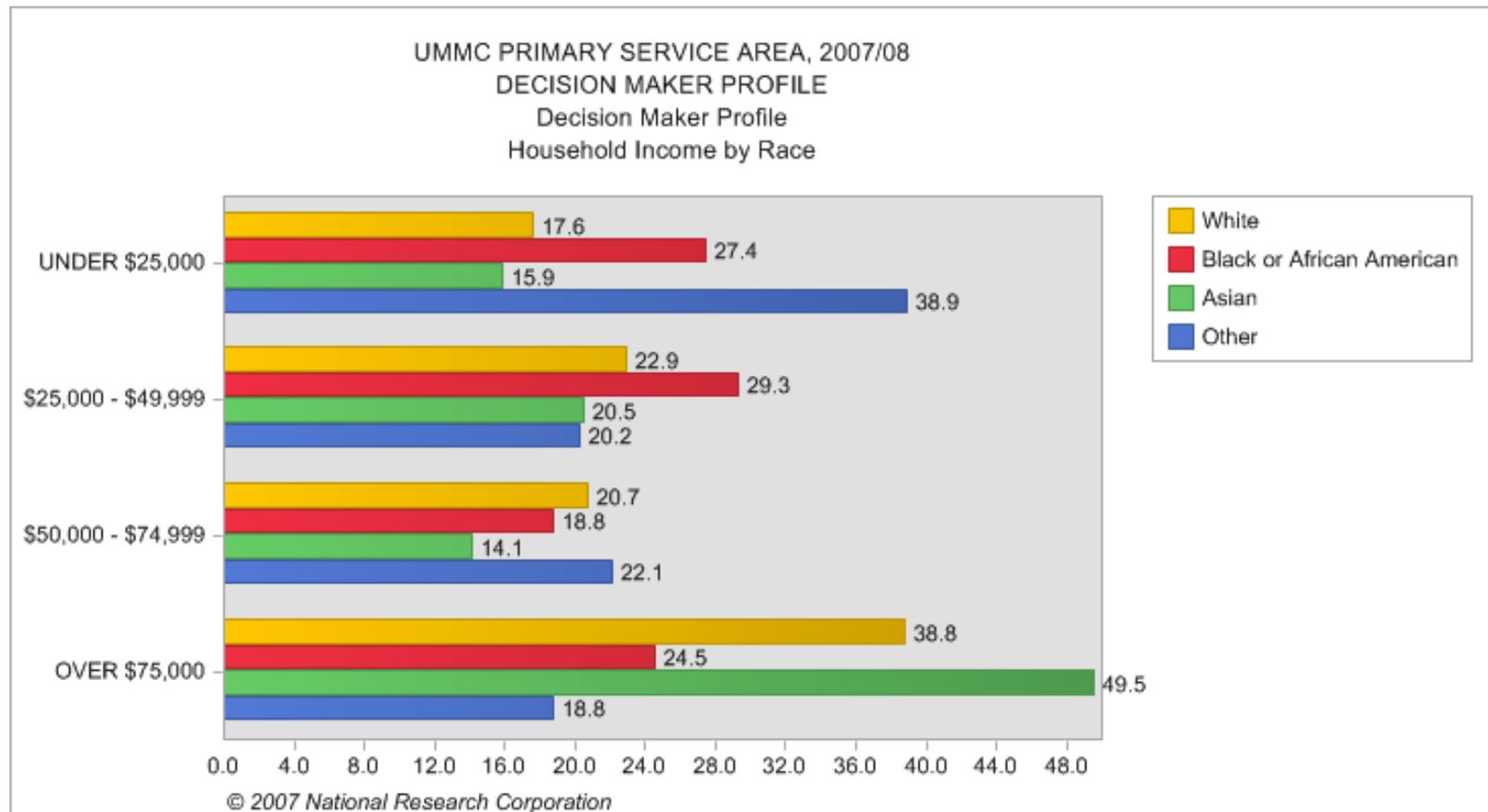
Source of information for this summary is the National Research Corporation (NRC) 2007/08 Community Needs Assessment.

The internet-based questionnaire was developed utilizing NRC's experience in the design and implementation of custom research studies. The 2007 survey took place between April 1, 2007 and June 25, 2007. The respondent was the individual in the household who is the primary healthcare decision-maker.

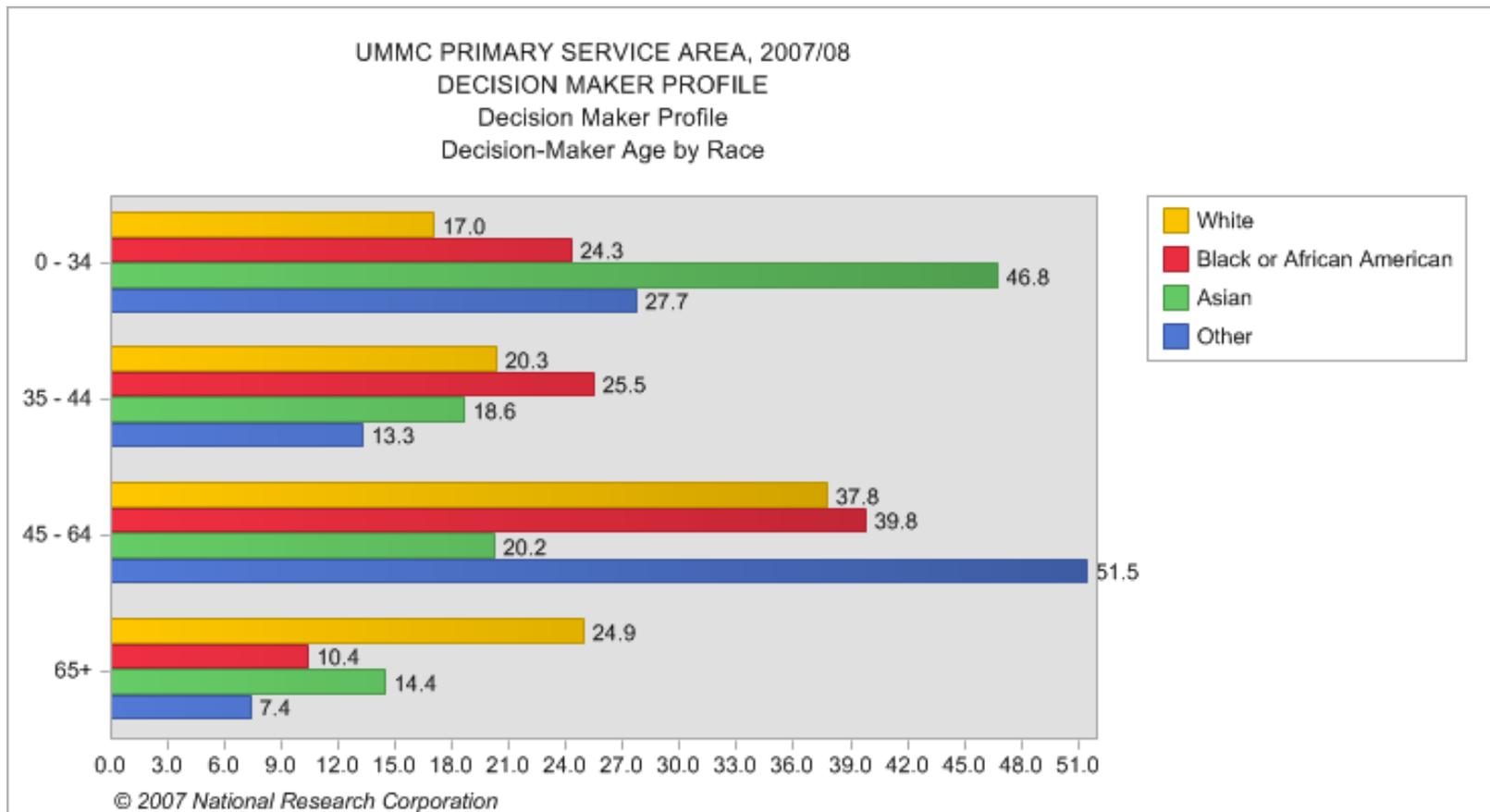
In the University of Maryland Medical Center's primary service area (the zip codes that comprise 80% of the Medical Center's admissions) the sample size was 1,851 households (standard error is +/- 2.3% at the 95% confidence level).

The following pages are a summary of the data collected.

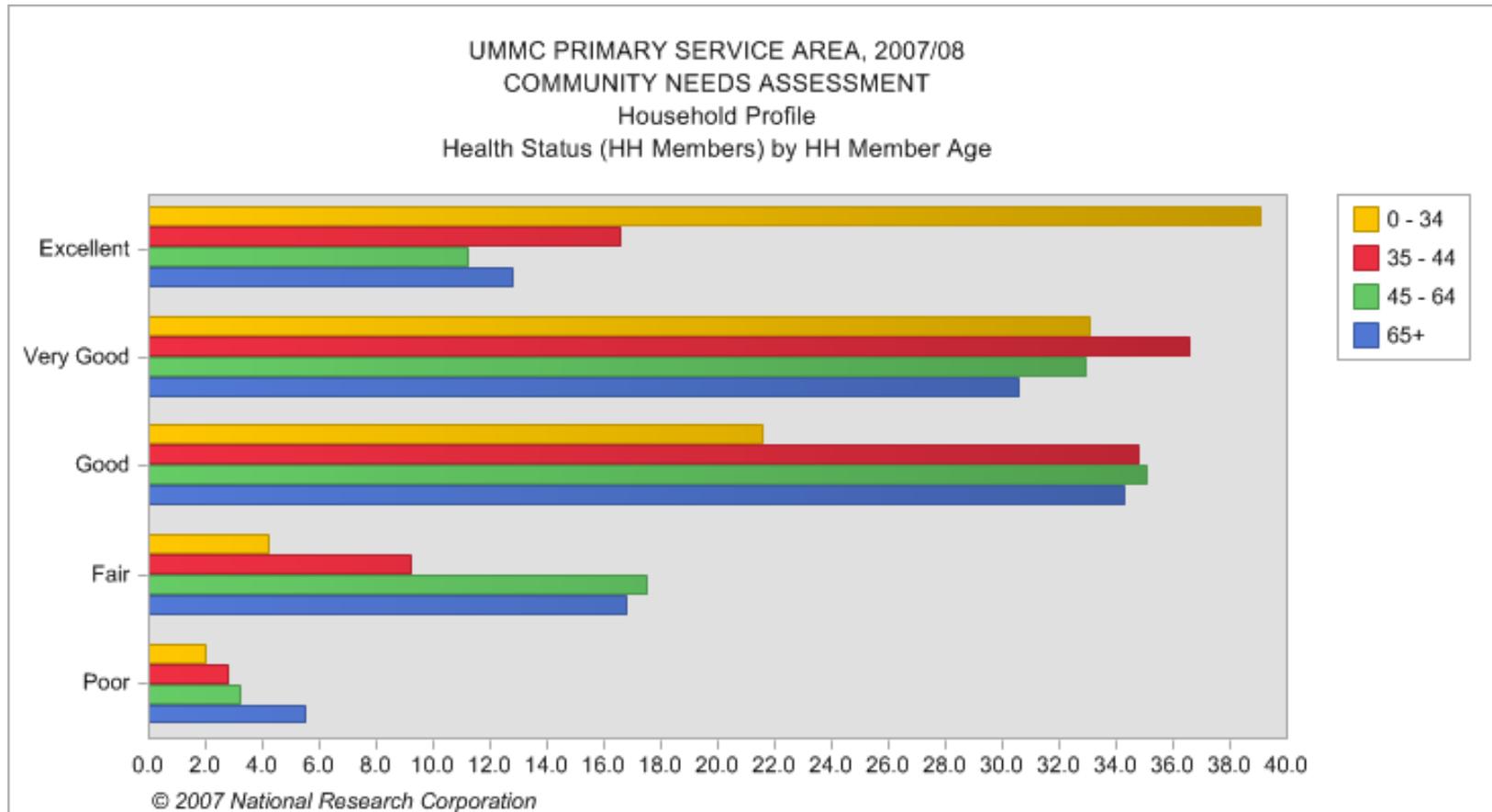
Of the total sample of 1,851 respondents, 1,157 (63% of total) were White, 497 (27%) were Black, 62 were Asian (3%), and the remainder were “Other” or refused to disclose. Average household (HH) income was \$63,204 with 46% of respondents living in a HH with an income under \$50,000.



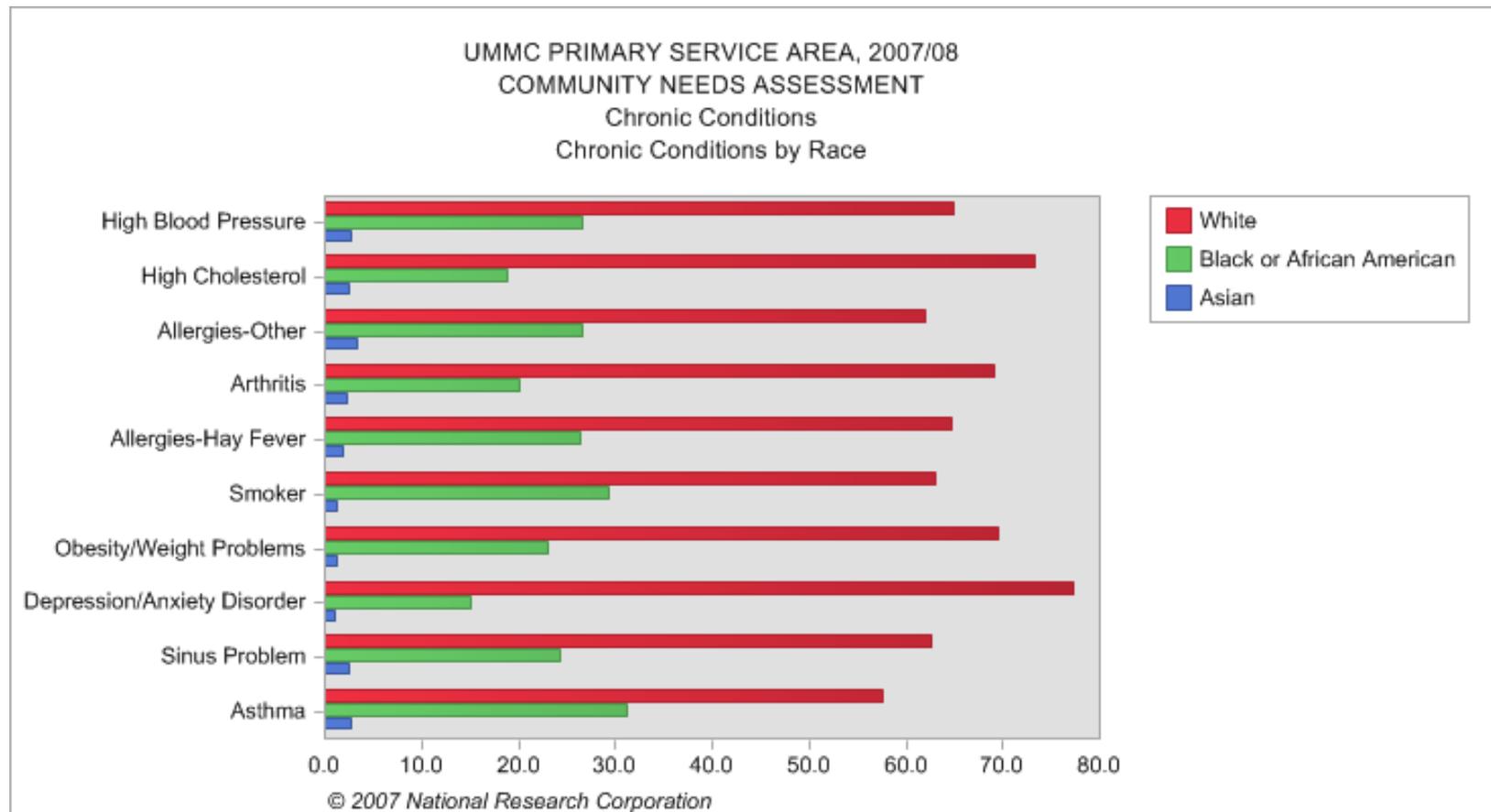
Average age of respondents was 48 with 20% between the ages of 0-34, 21% between the ages of 35-44, 38% between the ages of 45-64 and 21% 65 years of age or older.



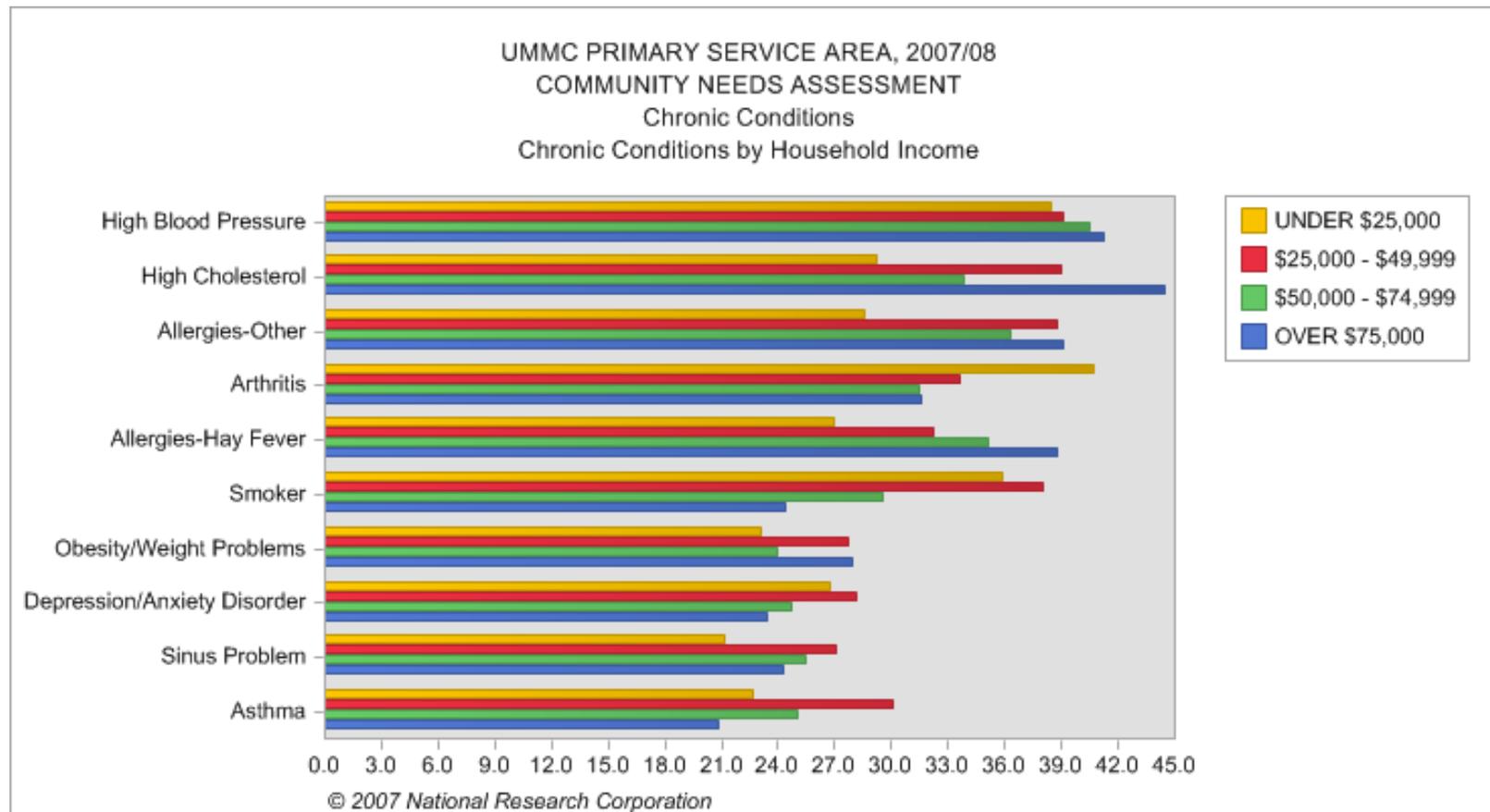
The self reported health status of respondents aged 65 and older is stated as “fair” more frequently than it is “excellent”. Younger respondents report a much higher percent of “excellent” health status than older respondents.



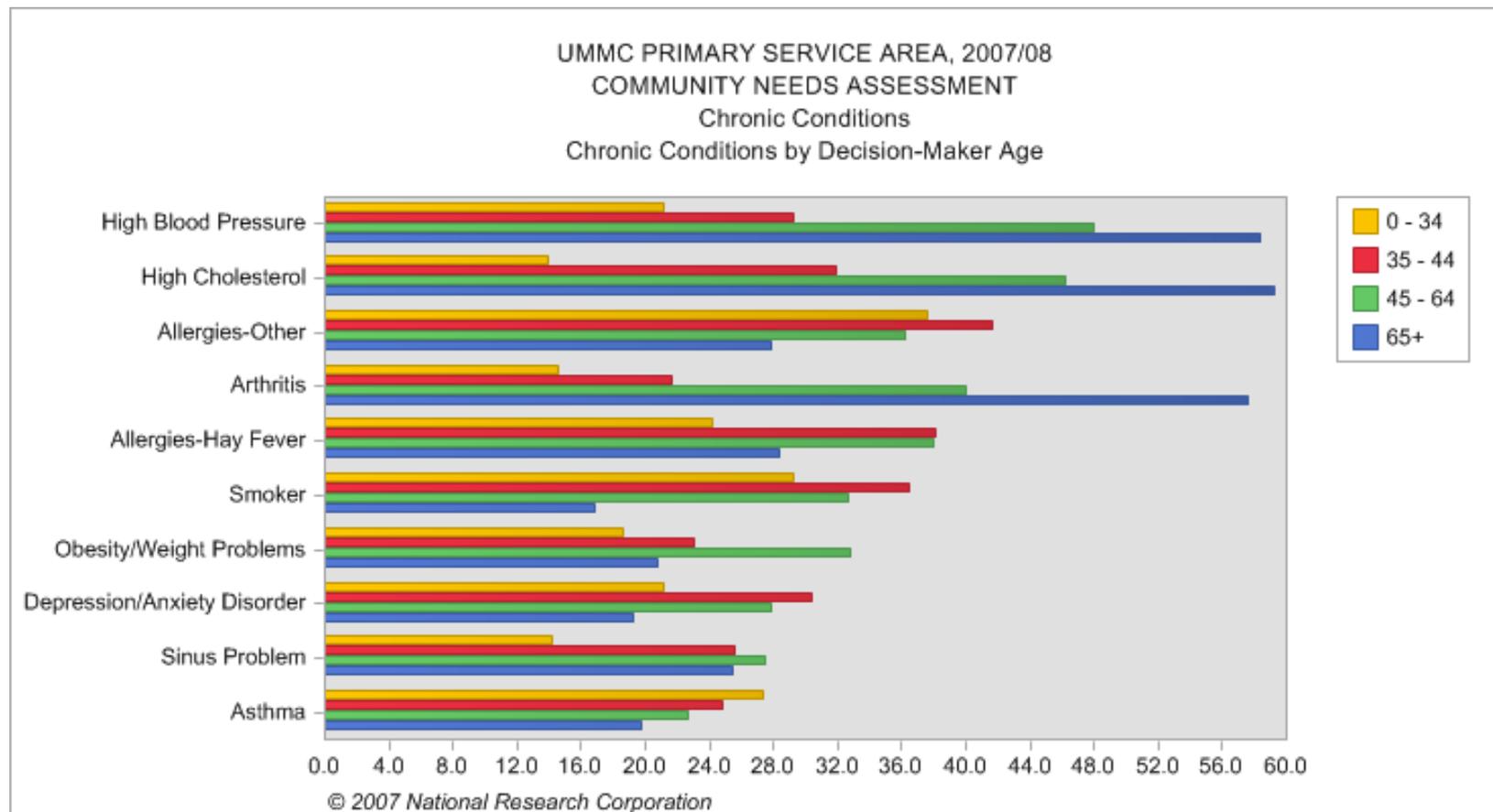
White respondents report chronic conditions of high blood pressure, high cholesterol and depression. Blacks report chronic conditions of smoking, asthma and allergies.



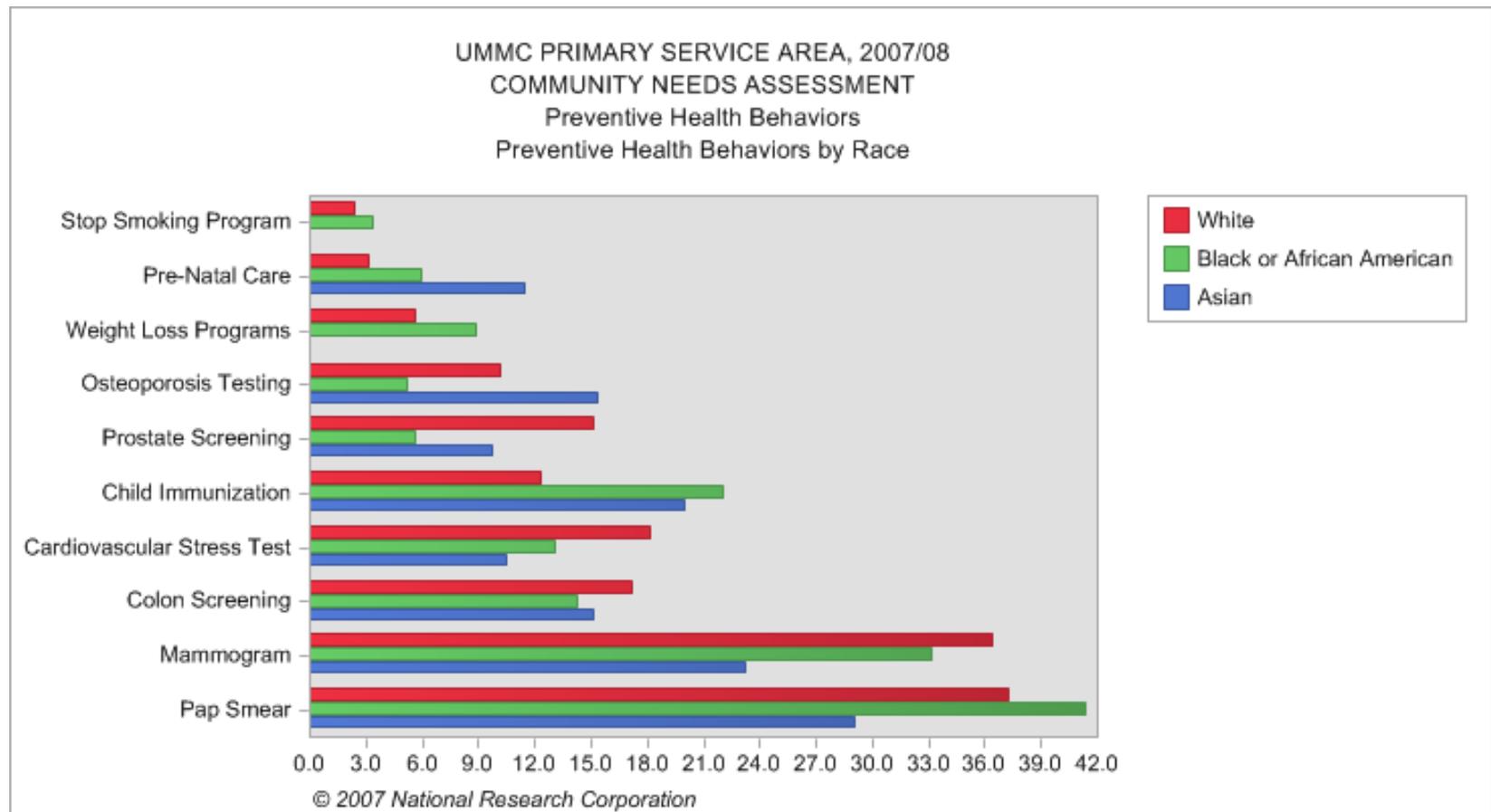
Respondents with an annual household income under \$25,000 report chronic conditions of smoking, arthritis and high blood pressure.



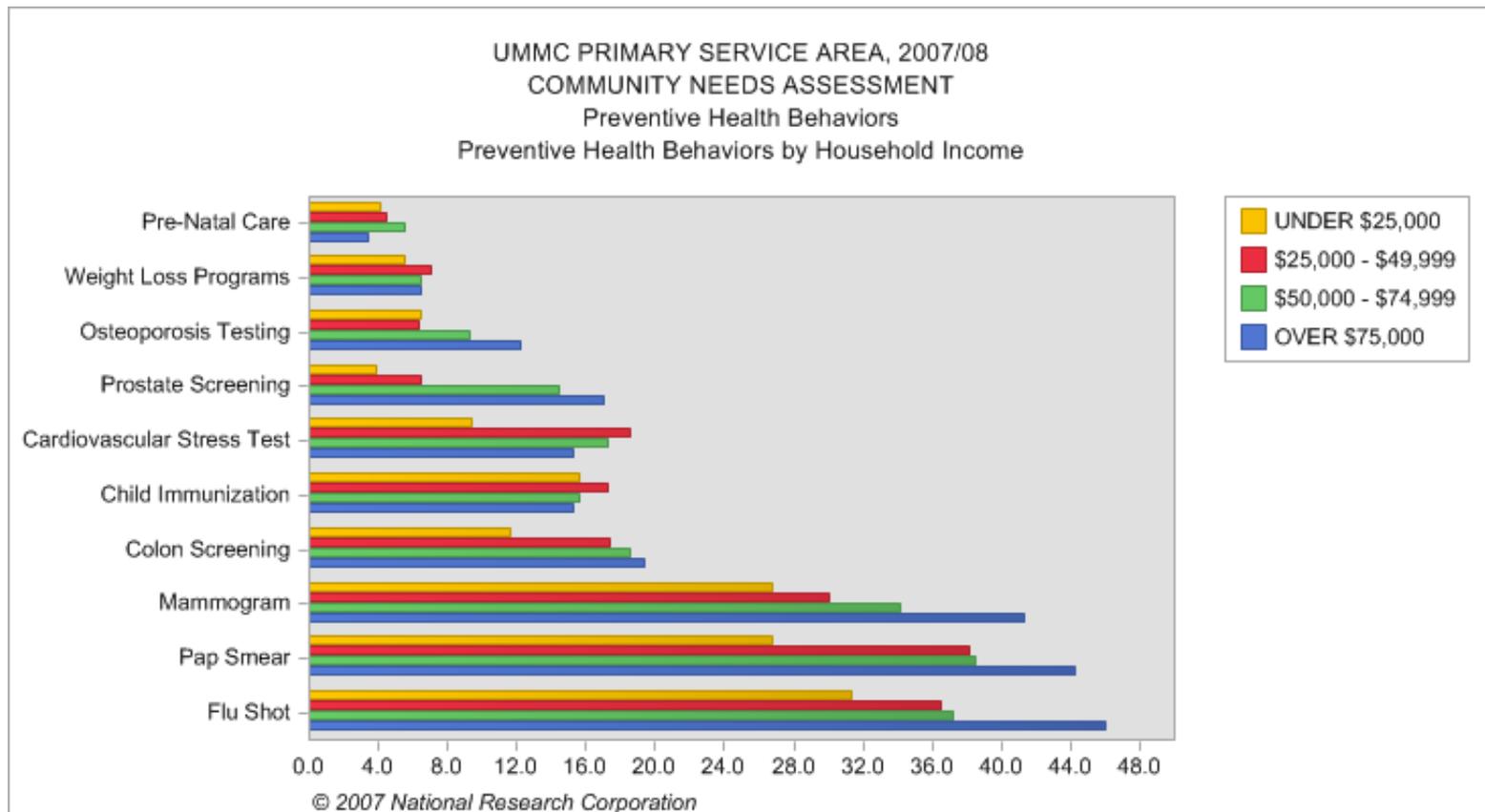
Respondents between the ages of 45 and 64 report chronic conditions of high blood pressure, high cholesterol, arthritis and obesity/weight problems.



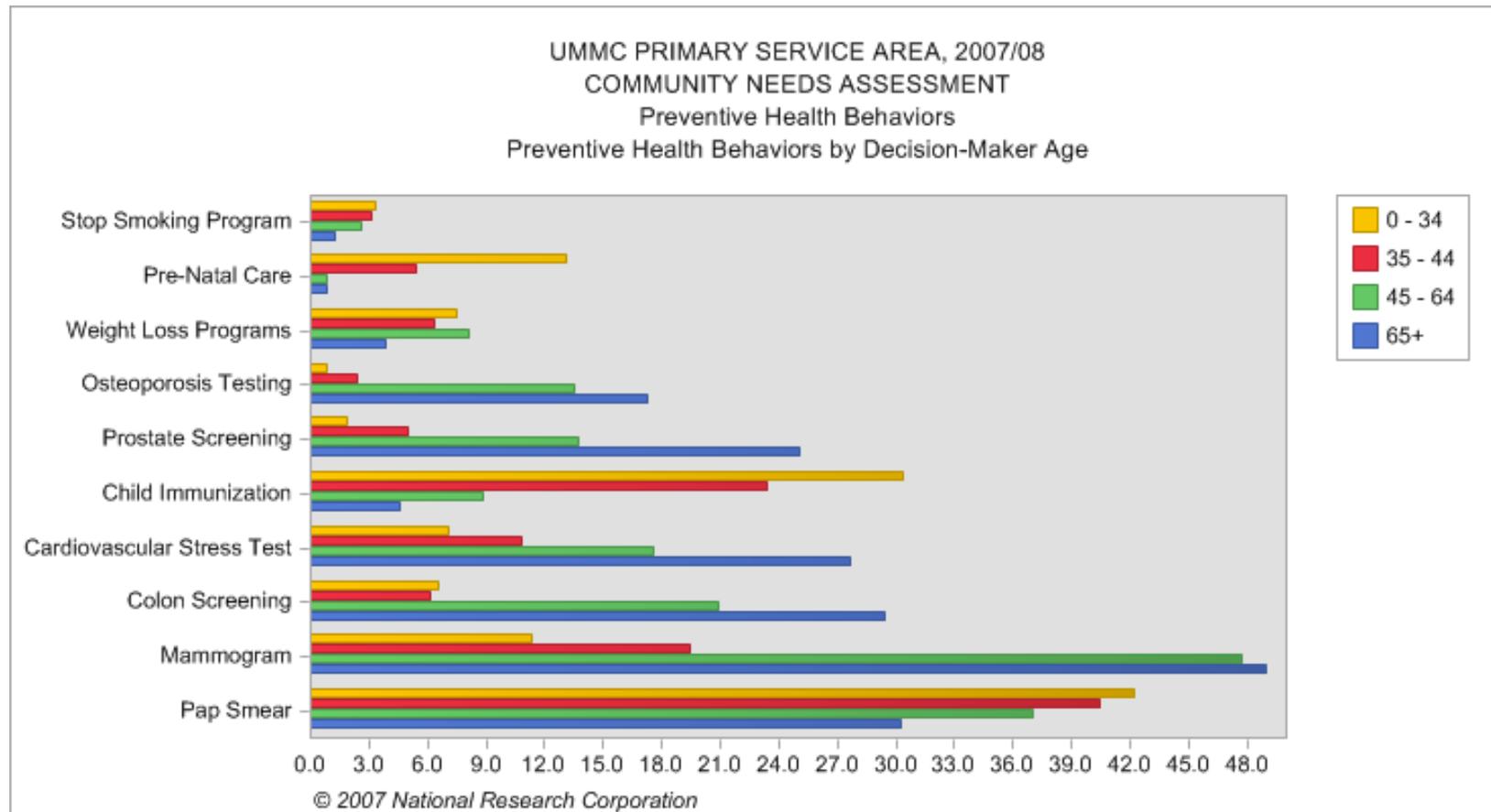
Black respondents were less likely to participate in preventive health behaviors that include stop smoking programs, pre-natal care, osteoporosis testing and prostate screening.



Respondents with HH income under \$25,000 were less likely to participate in preventive health behaviors that include weight loss programs, prostate screening and pre-natal care.



Younger respondents are less likely to participate in preventive health behaviors that stop smoking programs and cardiovascular stress tests.



## **Conclusions based on this data are as follows:**

- Future community health needs assessments should attempt to more closely match the demographics of the community immediately surrounding UMMC.
- Preventive health programs and services should be targeted to populations based on the age of community residents.
- Programs and services that focus on smoking cessation, high blood pressure, high cholesterol and weight loss should be emphasized.

## **Evaluation Efforts and Initiatives**

### **Community Health Assessment Project (CHAP)**

Upper Chesapeake Health sponsored the Community Health Assessment Project (CHAP) in 1996, 2000 and 2005 in conjunction with Healthy Harford, Inc., the Healthy Communities Initiative of Harford County. CHAP is a comprehensive assessment of health in Harford County based on the results of a randomized, stratified survey that was distributed to households in Harford County in 1996 and 2000.

Following CHAP 2000, community report cards were developed with specific goals established for both 2005 and 2010 for the top three identified health priorities: Heart Disease, Cancer and Prevention & Wellness. The report cards were endorsed by Upper Chesapeake Health, the Harford County Health Department and the Harford County Medical Society. The CHAP results are used by Upper Chesapeake Health and other community organizations and groups to help prioritize and guide the development of programs and services.

### **Evaluation of Upper Chesapeake Health Sponsored Events**

In an on-going effort to determine the effectiveness and participant satisfaction level of services and programs that are offered in the community, a formal evaluation survey is distributed at all Upper Chesapeake Health HealthLink Community Outreach events. Responses to the survey are reviewed on a regular basis to determine progress towards defined targets and to continually enhance services and programs based on feedback. The targets that are defined for these surveys are an integral part of the Community Health Improvement's annual performance improvement plan.

### **Evaluation by Primary Care Clinic Patients**

The Upper Chesapeake Health HealthLink Primary Care Clinic provides primary care services to adults 40+ years of age that are uninsured or underinsured and meet specific income criteria. In an on-going effort to determine the patient satisfaction level of care provided through the clinic, a formal evaluation survey is distributed to all patients. The Clinic Coordinator reviews the survey with the patient and encourages their participation. Completed surveys are mailed directly to the Director of Community Outreach.

### **Availability of Specialist Providers**

Referral services that are required by patients beyond the scope of services provided by the Primary Care Clinic are coordinated through a network of approximately 30 Specialty Physician Groups that either donate their services to the Clinic patients or provide services based on a sliding fee scale. The Clinic Nurse Coordinator is responsible for coordinating these referrals.

*"New CBR Requirement"*

*The Maryland General Assembly added a new requirement during the 2005 Legislative Session that hospitals provide a "written description of gaps in the availability of specialist providers to serve the uninsured in the hospital." Please include this brief written description with the hospital's community benefit report submission.*

Upper Chesapeake Health System (UCMC and HMH)

From time to time we have difficulty in having every specialist to see our uninsured patients. It takes tremendous amount of our time cold calling specialty docs to see the patients.

The biggest area of need for patients is GYN. Upper Chesapeake Health System has no GYN doc or Midwife that is willing to see any of our patients. We send those that qualify to the Maryland Breast and Cervical program which is run by the Health Department. Patients that do not qualify for this program have to be referred out of the county.

Dental and Podiatry are also extremely difficult services to come by for our patients.

*Per Vickie Bands – RN for Healthlink which serves the uninsured*

## **Attachment M. Community Benefit Evaluation**

Washington Adventist Hospital conducts a monthly evaluation of its community services. This evaluation examines the type and number of community services; the total number of times a program takes place; the number of people attending; the number of contacts occurring; and the predicted minimum attendance. By comparing predicted attendance to actual attendance, the hospital is able to gauge the community's demand for a program and adjust accordingly in subsequent months.

Programs are tracked according to which service lines they support: cardiovascular, cardiac, oncology, orthopedics, pediatrics, women and children, behavioral health, senior, and other. This tracking system allows the hospital to determine which service lines may need additional community programs. The monthly evaluation also includes anecdotal comments from employees involved in the community services programs. Many of these comments are evaluative in nature and further help to determine whether a program is effectively meeting the health care needs of the community.

At the end of each calendar year, the hospital compiles a summary report of all of its community services for the year. This report includes a written component highlighting resources dedicated to the program; what the program does to fulfill the hospital's mission; the direct products of program activities; and benefits for participants as tracked by participant responses to evaluation/survey forms and other measures. The year-end summary enables the hospital to plan its community services for the following year in response to identified community needs.

## **Gaps in Specialty Services - Community**

Adventist Health Care hospital facilities must compensate physicians to provide services due to gaps in availability of coverage in the following specialties to our underserved population:

### **Washington Adventist Hospital**

Family Practice

Internal Medicine and certain subspecialties

Obstetrics & Gynecology

Orthopedics

Urology

### **Shady Grove Adventist Hospital**

Critical Care

ENT

Neurology

Neurosurgery

Obstetrics & Gynecology

Pediatrics

Urology

We have further concluded that, due to the established community need, recruitment incentives such as relocation assistance and collection guarantees may be warranted to attract quality providers, so long as such incentives are provided in accordance with the applicable state and federal rules and regulations.

# Health & Wellness

Total Encounter roughly 65,843

Health & Wellness provides health education classes, screening events, support groups, and special programs and events that are dedicated to promoting physical, emotional and spiritual health and healing to our community. Numerous outreach efforts are dedicated to our goals for reducing health care costs for individuals and businesses, and offering a broad range of community health education programs, providing prevention programs that target populations such as children, the elderly, women, minorities and men.

In addition to the direct services offered to the community, Health and Wellness collaborates with multiple organizations including Adventist Community Services, American Cancer Society, American Heart Association, American Lung Association, Avon Foundation, Susan G. Komen Foundation, Montgomery County Health and Human Services, Montgomery County Fire and Rescue, Health Kids Campaign, Sister to Sister Foundation and GROWS (Grass Roots Organizations for Well-being of Seniors). These partnerships help improve community health and wellbeing

## Lactation

Breastfeeding is one of the most important things that can be done for a child during the first six-months of life. Not only do we provide breast pumps and supplies at a reduced cost to that of retail stores, we offer a free breast feeding support group called BEST.

At Shady Grove Adventist Hospital, Not only do we manage a “warm-line” telephone consultation program through which new moms receive breastfeeding support guidance, but we also provide breast pumps and breastfeeding supplies at a reduced cost, and we offer a free breastfeeding support group called B.E.S.T. - “Breastfeeding Education, Support and Togetherness” – for moms to attend with their babies. Lactation Consultants facilitate this support group – offering professional guidance and support to new moms breastfeeding their babies. Moms are encouraged to attend B.E.S.T. with their babies as many times as they wish. In response to the number of new moms we find returning to work, we are also now offering a new class - “Pumping and Going Back to Work” for our moms to attend – either before birth or after their babies are born . This class is free, and offers an additional discount on the purchase of breast pumps.

Through Washington Adventist Hospital’s TLC Lactation Station, we continued partnering with the African American Health Program’s Black Baby S.M.I.L.E., by providing 30 long-term pump rentals which is up from 20 in 2006. Another part of

this program is to educate health care providers about the importance of breastfeeding.

## **Maternal /Child Health Education**

In this age of technology, expectant couples have access to many sources of information. Unfortunately, it is not always accurate. The goal of the Maternal /Child Health Education program for Shady Grove Adventist and Washington Adventist Hospitals prenatal education program is to offer evidence-based information in a format that allows couples to consider their options and make educated choices. Class participants also learn communication skills and relaxation techniques that are valuable in managing all of life's future stresses. We believe women who are nurtured and supported in their childbearing choices look forward to birth with greater confidence in their own abilities.

In 2007, the Maternal /Child Health Education program for Shady Grove Adventist and Washington Adventist Hospitals helped prepare parents for their birth experience and challenges of caring for a new baby when they arrive home. We offer a variety of childbirth classes, classes in newborn care, breastfeeding, infant safety and CPR, infant safety and CPR, infant massage, adjustment to parenting, classes exclusively for new dads as well classes for siblings and new grandparents.

All the programs continue to receive great evaluations from our customers. When asked how highly they would recommend this course to others, the average score is almost always over 9.0 on a scale of 1 to 10.

## **Youth Health Program**

The goal of Youth Health program is to provide education to children and their families on issues of their health and safety. In 2007 the Youth Health Coordinator was interviewed by the Gazette, for our very popular Babysitting program. Also Montgomery County Public Schools has doubled the amount of babysitting classes offered at the schools.

This year Youth Health participated in four major community events, Asthma screening for the month of the young child at the Lake Forest Mall and Wheaton Plaza, Mommy and Me program at Congressional Mall offering screening and educational talks to parents and children, a Backpack Safety event at White Flint Mall with over 1700 attendees. This year we also provided two pediatric flu clinics at Lake Forest Mall.

## **Community Health Education**

Community Health Education uses a variety of strategies to improve the health status of the community as a whole by providing classes and programs that are both educational, as well as fun. We offered an array of classes from nutrition and self-improvement, as well as fitness classes, which include land and water. We also offered CPR and First Aid classes. In addition to providing community health classes, we actively participate in health fairs where we offer health screenings and flu shot clinics. As part of our mission to provide health awareness to the community, we established a number of partnerships in the area. We have added six additional sites where we provided flu shot clinics to the community. As a result of this collaboration, we were able to have a greater visibility in our community. WAH service area has maintained a relationship with Riderwood where we have provided lectures on various health topics. Furthermore, we continue to strengthening our relationship with Cancer Project and offered free nutritional classes to our community at free of charge.

## **Cardiac Outreach**

The statistics are staggering and heart disease remains a huge health hazard amongst Americans, especially women and minorities. In an effort to reduce cardiac and vascular risks and to promote early detection, cardiac outreach has touched many lives through our Heart Healthy Screening Programs. We strive to decrease and help eliminate the health disparities that exists among cultures in our communities, especially within the African American and Latino population.

The Cardiac & Vascular Outreach program for Adventist HealthCare is committed to supporting our mission by providing programming and screenings that will both educate, enable and empower the people of our community to better understand and manage their risk factors to make lifestyle changes with the goal of lowering their risks to heart disease.

## **Oncology Outreach**

Cancer has become the number one cause of death in the United States. It is the second leading cause of death behind heart disease and one in four deaths in Maryland are due to cancer.

The Breast Cancer Screening Program at Shady Grove and Washington Adventist Hospital helps low-income, uninsured women 40 years of age and older in Montgomery and Prince George's Counties, Maryland fight and defeat breast cancer. In partnership with the Montgomery County Women's Cancer Control Program and the State of Maryland Breast and Cervical Diagnosis and Treatment Program, the Breast Cancer Screening Program offers a continuum of

care to patients including screenings and individual patient education, instruction on breast self-examinations and access to treatment. In 2007 the Shady Grove Breast Cancer Screening Program saw over 670 patients with two women diagnosed with breast cancer. All patients diagnosed with breast cancer are case managed from diagnosis through treatment and beyond. Diagnosed patients are also recommended to the support group at Shady Grove Adventist Hospital as well as the Look Good Feel Better program. An example is Nida Simmon is a 41 year old female who entered the SGAH BCSP program with a positive CBE from a private physician. The patient did not show for her first appointment. Upon contact with the patient she appeared anxious and frightened. The patient's medical provider was very concerned about the patient following through. With support telephone contact from the BCSP staff, the patient did come for her BCSP visit and a mass was palpated. The patient's mammogram revealed a Suspicious Abnormality. The patient was then assisted with the D&T application, which required several contacts until final completion. Within 2 months a surgical consult appointment was scheduled and the patient had a breast biopsy performed. The biopsy revealed benign changes. The patient then was scheduled for a follow up 3 month mammogram.

My name is Mariluz Salvatierra and I am both proud and blessed to say that I am a breast cancer survivor. In April of 2006, a lump was found on my right breast through a mammogram performed at Washington Adventist Hospital. If it were not for the hospital's Breast Cancer Screening Program, I may have never been at that mammogram. The way I felt when I was diagnosed with cancer was indescribable and its effect was crippling. Less than a month later I had a lumpectomy performed. I started chemotherapy treatment soon thereafter. My body reacted to the chemotherapy in ways that both scared and amazed me. First, I noticed that my hair began to fall out. Next, my fingernails turned very dark, almost black. Last, my skin's complexion and texture changed. I had eight total sessions of therapy; four of the sessions were chemotherapy. The other four were not chemotherapy, but they felt just the same. Times were hard then. But I thank God that I beat breast cancer. I feel so much better now. And my skin and nails returned to normal. My hair is even growing back, and it's healthy. I have even had reconstructive breast surgery. I am, in every sense of the word, a new woman. I take much better care of myself these days. I go to the doctor regularly and I make sure that I never miss an appointment. God has truly blessed me. He has given me back my health, but best of all, I can now watch my son grow and enjoy watching him become a man.

The Colorectal Cancer Screening Program, supported by the Cigarette Restitution Fund, provides education, outreach, and free screenings to eligible men and women residing in Montgomery County. The goal of the Colorectal Cancer Screening Program is to target men and women who are considered to be "at-risk" for colorectal cancer. This includes persons who are aged 50 and over, medically uninsured or underinsured, and who are low income. African Americans and Hispanic/Latinos have been identified as our main target

population as data reveals high colorectal cancer diagnosis rates in people of these minority groups. Program Coordinators for the screening program are continually out in the community promoting the program and providing outreach to faith-based settings (churches and synagogues), soup kitchens, area shelters, community centers, and work sites. It is our goal to increase awareness within the community of the cancer risk and the benefits of early detection and screening. In 2007 1,831 men and women were educated and 10 men and women were screened through our free colorectal cancer screening program. There were no cancers diagnosed through the program.

Shady Grove Adventist and Washington Adventist Hospitals began working bi-weekly on education and outreach efforts at two Mobile Medical clinics in Rockville and Gaithersburg, the majority of the patients are minorities, which consist of Latinos and Africans/African Americans. The first Tuesday of each month I attend a Mobile Med clinic at the Ascension House in Gaithersburg and the third Tuesday of every month I attend the Mobile Med clinic at the Rockville Senior Center. At each clinic site I set up a table with educational brochures on breast, colorectal, and prostate cancer as well as pamphlets on our free colorectal cancer program as well as the free breast cancer screening program through the Women's Cancer Control Program. While patients are waiting for their appointment I provide information about these programs and if interested I help the patients fill out consent forms for the free colorectal cancer program. I also will call the Women's Cancer Control Program to have applications sent to women who are interested in the free mammograms. Since July 81 men and women have been educated about these cancers and have helped sign up 11 patients for the free colonoscopy screening.

Each year Shady Grove Adventist and Washington Adventist Hospitals holds a free cancer screening day for the public. This year we added Thyroid Cancer Screening to the 5 other different types of cancer that we screen for; bladder, colorectal, skin, oral, and prostate. In 2007 we screened 297 people Washington Adventist Hospital also had a display and information about breast cancer and tobacco cessation. There we distributed educational material to 46 women about breast cancer and told them about the screening program that our hospital offers. We also informed at least 35 participants about smoking cessation. There was speaker from the Cancer Project at the event educating about nutrition and cancer, and offering the participants an opportunity to sign up for free nutrition classes.

## **Health Ministry**

The goal of health ministry is to work with and support faith communities and other related organizations to develop their health ministry and parish nurse programs and assist them in the integration of physical, mental and spiritual well being and healing.

In 2007, Health Ministry reached out to 60 congregations in the community by providing health-related programs, services, education and support. The Faith Community Nurses and health ministers were supported by educational and network meetings covering such topics as mental health, team building, ministering to cancer patients, community resources and services that the health system provides.

Direct programs and services to the congregations supported their health activities by providing resources for health fairs, flu vaccinations, and specific classes such as babysitting classes. Over 1350 flu and pneumonia vaccinations were given and over 600 people also attended health fairs.

In partnership with Columbia Union College, 11 new faith community nurses were prepared to work in their congregations. Working with educational institutions and other community organizations enhances the ability to provide quality programs to the community.

2007 has been a year of transition as the Health Ministry Department looks toward the future, evaluates past accomplishments and prepares to meet the newest trends in Faith Community Nursing. An Advisory Board was formed made up of community partners to help plan the future for the Health Ministry/Faith Community Nurse program.



WASHINGTON COUNTY  
HOSPITAL

NEW CBR REQUIREMENT -FY2007

*“The Maryland General Assembly added a new requirement during the 2005 legislative session that hospitals provide a brief written description of gaps in the availability of specialist providers to serve the uninsured in the hospital.”*

The uninsured patients in the community served by Washington County Hospital have difficulty obtaining care for conditions treated by the providers in the following specialties:

General Surgery  
Neuro Surgery  
Plastic Surgery  
Pain Management  
Dermatology

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.

**Evaluation Framework for Community Benefits  
Washington County Hospital  
December 2007**

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**Community Benefits Planning**

Meeting the healthcare needs of the Washington County region of Western Maryland is central to the overall strategic plan for Washington County Hospital. Senior leaders, hospital staff, and board members develop the plan together, based on their knowledge of the community's healthcare needs.

In fiscal year 2007, several strategic initiatives focused on improving patient access to care.

- The need to improve access to the emergency department has been an ongoing project. Originally built to see 45,000 patients annually, in fiscal year 2006, the emergency department, express care, and the urgent care centers saw 88,284 patients. In addition to changes last year – the implementation of an electronic bed board system – the emergency department and Express Care were renovated to increase bed capacity. The emergency department now has 28 monitored beds as well as 10 overflow beds; Express Care expanded from four beds to seven.
- In January, 2007, the hospital was designated a primary stroke center by the Maryland Institute for Emergency Medical Services and Systems in recognition of the fully-integrated care it provides our stroke patients. From the moment the hospital's emergency department is notified that a stroke patient is on the way through discharge planning and rehabilitation, every healthcare provider is alert to ensuring that the patient receives the best possible care. Having an accredited primary stroke center is a significant benefit to our community.
- The Wound Center at Washington County Hospital opened in October 2006. It specializes in the treatment of chronic, non-healing wounds. Two hyperbaric chambers promote healing through oxygen saturation. Since its opening, the Wound Center had more than 3,600 visits and provided 1,200 hyperbaric oxygen therapy treatments. Now, patients who once had to travel out of the area for wound care can receive it in their home county.

**Community Needs Assessment**

Washington County Hospital conducted an assessment of health needs as perceived by community members in 2005. It was funded by the First Data Western Union Foundation. As a result of that survey, it was clear that the hospital needed to reach out to the minority community to provide education about healthy lifestyle choices.

In response, the hospital's education center developed a program called Sisters Helping Sisters targeted to women between the ages of 12 and 24 in the African-American community. The program was grant funded by the Department of Health and Human Services Office of Women's Health. In partnership with local agencies like the YMCA and local churches, the hospital offered screenings, exercise programs, and educational opportunities that encouraged participants to lead a healthier lifestyle. The program was so well received that a second phase, also grant-funded, began this fall. It is geared toward women ages 19 to 24 with additional emphasis on pre-pregnancy nutrition.

### **Community Benefits Initiatives**

Community benefits initiatives have evolved as hospital staff have identified healthcare needs within our community. Of the many we provide, here are just two that are outstanding examples of our commitment to residents' well-being.

- The Parish Nursing program supports 47 faith communities and 114 parish nurses and health ministers. It is an opportunity for healthcare professionals to share their knowledge directly with the members of their faith communities. They provide individual and family support during a health crises, they offer health screenings, and they provide educational opportunities. Parish nurses and health ministers work to include the relationship between an individual's mind, body, and spirit into all encounters with congregation members.
- Patients who are ready for discharge often can't find a way home. That's when staff from the hospital's patient transport department step in to help them with a ride home in our courtesy van. It operates Monday through Saturday and will transport patients within a 30-mile radius of the hospital. The van has a wheel-chair lift as well as a baby seat. During the last fiscal year, the van took 1,499 patients home, to a nursing home or to free breast cancer screenings.

### **Community Collaboration**

The hospital works with many local and national organizations in planning and executing healthcare programs in our community. There were several identified through local partnerships that have made a difference in the well-being of area residents.

- The Make A Difference Breast Cancer Screening Program is a collaboration between the Maryland Affiliate of the Susan G. Komen For the Cure, the John R. Marsh Cancer Clinic (a hospital department), Breast Cancer Awareness-Cumberland Valley, and the Washington County Health Department's Breast and Cervical Cancer Program. It offers free breast cancer screenings to women. In fiscal year 2007, 266 women were seen in the clinics; many more received breast health education through health fairs in the community.

- In October 2006, the hospital joined with the Washington County Health Department, the Sheriff's Office, the county's Emergency Services department and others to host a roundtable on pandemic flu. It was an opportunity for community members to learn how they could prepare for pandemic flu. About 100 participants learned how they could lessen the impact of pandemic flu on their families and what local healthcare organizations were doing to help.
  
- In June, 2007, the hospital hosted a community health fair at the Robinwood Medical Center. Healthcare providers, including physicians, were available to offer blood pressure screenings, evaluations for speech therapy, stroke assessments, brake reaction tests, and much more. It drew hundreds of participants, who especially appreciated the chance to speak directly with a physician about their healthcare concerns.

## Western Maryland Health System

### Community Benefits Evaluation Framework

#### Community Benefits Planning

1. *Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?*

Western Maryland Health System includes community benefits as part of its strategic plan under the strategic goal for mission integration that reads “demonstrate the organization’s mission and values in practice, emphasizing the direct benefit to the community and the underserved”. Through the strategic planning process, adequate resources are identified and community benefits initiatives are aligned with system-wide objectives. The relevant key strategies for FY07 include:

- Continue an organized community health improvement program with emphasis on common lifestyle choices affecting regional health problems
- Develop an understanding, both internally and externally, of WMHS’s community benefit
- Participate actively in community organizations, planning and events to fulfill our mission and obligation to good corporate citizenship
- Foster employee involvement and awareness in mission fulfillment.

Community benefits initiatives focus is on community health improvement, community investment in health and safety, and serving low-income uninsured and underserved populations.

2. *Were hospital staff and leadership involved in developing the plan?*

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, Wellness and Community Health, 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.

#### Community Needs Assessment

3. *Does the hospital’s plan target specific areas of community need?*

WMHS’s plan targets the needs of the low-income uninsured and underserved populations, prevalence of chronic disease and associated risk factors, and community asset development. Priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable.

4. *Did the local health department 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.*

The Allegany County Health Department's Priorities for Improving Community Health Status included in the Maryland Health Improvement Plan (2001) was used by the health system. Additional information was used to clarify community needs including: 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 covering topics ranging from cardiovascular disease and uninsured levels to discharge data.

This year the WMHS obtained current needs assessment information from the local health department through the core service agency to determine the best approach for a collaborative grant application to the Maryland Community Health Resources Commission. In response to the data, the Workgroup on Access to Care created a program which was funded to integrated community based mental health and substance abuse services with somatic services for the uninsured and underinsured.

#### Community Benefits Initiatives

5. *Does the hospital identify its Community Benefits Initiatives?*

WMHS incorporates the community benefits initiatives in the strategic plan. A separate list is also created each year to ensure the appropriate monitoring occurs. (See attached list.)

6. *Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.*

WMHS's community benefits initiatives reflect evidence-based needs for health improvement, community investment, and access for the low income uninsured. WMHS is in a medically underserved and economically depressed region of western Maryland. With nearly 15% of Allegany County residents living below the federal poverty level and over 30% living below 200% of federal poverty, the county's poverty rate is almost twice the state average (2000 US Census). Mortality data shows the leading causes of death in the Allegany County area to be cardiovascular disease, respiratory disease, cancer, cerebrovascular disease, and these rates are higher than elsewhere in the state (Maryland Vital Statistics 2006). Based on the premise that personal health behaviors are a primary determinant of disease, death, and health care costs, the WMHS Board initiated the creation of a community health improvement plan, and this year helped bring together community partners to launch an initiative to reduce obesity risks. The community health improvement activities are one example of community benefits initiatives reflecting evidence-based needs of the community.

Western Maryland Health System (WMHS) historically offered charity care to the uninsured and underinsured. However, quite often uninsured adults would go without health care until

it became urgent and much more expensive to treat or they would utilize the emergency room inappropriately for primary care. With 21.7% of the county's adult population being uninsured, and the age-adjusted death rate for Allegany County higher than the state average, the need was great. The Community Health Access Program (CHAP), a joint venture of Western Maryland Health System and Allegany Health Right, provides access to primary care "medical homes" for clients so that they can receive consistent care when they are ill and when they are well. This year the care coordinators at WMHS worked diligently with community partners at the health department and social services office to transition eligible clients to the Maryland Primary Adult Care Program, while maintaining the uncovered services through the community network. This is another example of a community benefit initiative reflecting evidence-based need.

7. *Were the initiatives performance-based and did they involve process and/or outcome measures?*

The community benefits initiatives of the WMHS are divided into three main categories; health improvement, access to care, and community investment. Most of the health improvement and access to care activities are performance-based and have both process and outcome measures. Community partners are engaged, programs target identified needs, and outcomes are measured. Several of the community investment initiatives are done in collaboration with community partners based on a need they have identified and monitor. All the activities have an identified indicator to measure achievement and WMHS utilizes the data for program improvement.

#### 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 goals to be achieved?*

WMHS involves community participants in planning and implementing community benefits activities, including identifying initiatives and setting goals to be achieved. The WMHS Community Advisory Board is comprised of representatives from business, social service agencies, religious organizations, and public health. They are involved in identifying initiatives and setting goals. The CHIP Partners involve representatives from the health department, YMCA, community action agency, area colleges and universities, and cooperative extension. This group focuses on the planning and implementation of community health improvement activities and is lead by staff at the WMHS Wellness Center. As the lead agency for the Allegany Community Access Program, WMHS collaborates with over seven health and human services agencies to continually improve access to care for the uninsured.

9. *Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?*

The WMHS participates in numerous partnerships with individual non-profits in the community striving to improve health and safety in the community. Some examples include the WMHS Pharmacy Department assisting Associated Charities with the development and implementation of its Short-Term Prescription Program, or Cancer Services partnering with

the American Cancer Society to provide support services for individuals with cancer. The WMHS is also represented on various boards and committees in the community that impact community benefit planning. Quite often, WMHS is asked to respond to an identified need through these community organizations. WMHS also participates in several statewide and national networks focused on community health improvement and access issues which impact the community benefit planning and implementation.

#### 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?*

Currently, a variety of staff is monitoring how activities fulfill the identified goals and submit the status in reports to their direct supervisor. A separate report is not compiled for community benefits but rather incorporated into the regular reporting process. The CBISA software from Lyons is now being utilized.

*11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?*

Through reports to the Board by the administrative team, hospital leadership is kept informed as to the progress and results of various community benefits initiatives. In addition to progress being reported through the year, the outcomes of several initiatives are highlighted in year end presentations to the WMHS Board of Directors and WMHS Community Advisory Board.

Western Maryland Health System

Community Benefits Initiatives

<b>Health Improvement</b>	<b>Access –Uninsured, Poor &amp; Underserved</b>	<b>Community Investment Improve Health &amp; Safety</b>
<p><u>Community Health Education (A1)</u></p> <ul style="list-style-type: none"> <li>• Health Fairs (screenings done as part of health fairs)</li> <li>• Educational Presentations</li> <li>• Child Birth, Prenatal, Sibling &amp; Breastfeeding Classes</li> <li>• Support Groups (Hand in Hand)</li> <li>• Self Help, Wellness And Health Promotion Programs Including: tobacco cessation, nutrition, &amp; stress management</li> <li>• Look Good Feel Better</li> <li>• Public Service Announcement &amp; Radio</li> <li>• Parish Nursing (coordination, training and newsletter)</li> </ul> <p><u>Community Based Clinical Services (A2)</u></p> <ul style="list-style-type: none"> <li>• Screenings for cholesterol, vision, blood pressure, osteoporosis screening, skin cancer, prostate, BMI, waist to hip ratio</li> <li>• Health Risk Appraisals</li> </ul> <p><u>Health Care Support Services (A3)</u></p> <ul style="list-style-type: none"> <li>• CHIP Care Coordination</li> </ul> <p><u>Mission Driven Health Svs (C)</u></p> <ul style="list-style-type: none"> <li>• Lifeline</li> <li>• Blood Drives</li> </ul> <p><u>Community Building Activities (F)</u></p> <ul style="list-style-type: none"> <li>• Community Health Improvement Advocacy (F7)</li> </ul>	<p><u>Community Based Clinical Services (A2)</u></p> <ul style="list-style-type: none"> <li>• Mammograms</li> <li>• Pap Clinic</li> </ul> <p><u>Health Care Support Services (A3)</u></p> <ul style="list-style-type: none"> <li>• CHAP Care Coordination</li> <li>• CAP: Information &amp; Referral to Community Services</li> </ul> <p><u>Mission Driven Health Svs (C)</u></p> <ul style="list-style-type: none"> <li>• WMHS Owned Healthcare Clinics Or Urgent Care Centers</li> <li>• Hospice</li> <li>• Outpatient Mental Health</li> <li>• Adult Medical Day Care</li> </ul> <p><u>Charity Care (H)</u></p>	<p><u>Financial Contributions</u></p> <ul style="list-style-type: none"> <li>• Cash (E1)-matching funds, event sponsorship: EMS Scholarship</li> <li>• Grants (E2) Trauma Coor.</li> <li>• In-kind Contributions (E3) - hours donated by staff to community, boards &amp; committees while on work time, pharmacists' help with Associated Ch., and finance help AHR, Meals On Wheels, Coordination of Holiday Families &amp; Ladies of Charity.</li> </ul> <p><u>Community Building Activities (E)</u></p> <ul style="list-style-type: none"> <li>• Economic Development (F2)</li> <li>• Workforce Enhancement-recruitment of physicians and other health care professionals for federal MUA (F8)</li> </ul>

*Western Maryland Health System*

Community Benefit Plan

**Anticipated Outcomes**

Health Improvement:

- Increased number of residents participating in recommended preventive health screenings and education addressing identified needs
- Community-wide engagement in health improvement initiative that reflects the Maryland Nutrition & Physical Activity plan to reduce obesity risks

Access- Uninsured, Poor and Underserved:

- Increased number of low-income uninsured will receive needed health care
- Reduced utilization of the emergency room by individuals provided access to care

Community Investment – Improve Health & Safety:

- Enhanced problem solving capacity of community with successful investments and meaningful partnerships
- Shared advocacy and leveraging of additional funds to improve health and safety of the community



*National Consultants to Healthcare Providers*

## PHYSICIAN SUPPLY/DEMAND ANALYSIS

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### WESTERN MARYLAND HEALTH SYSTEM CUMBERLAND, MARYLAND

The Coker Group, through principled professional consulting, assists healthcare providers in their pursuit of a sound business model.

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**FINAL**

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<i>Cardiology</i>	<i>Infectious Disease</i>	<i>Physical Medicine/</i>
<i>Cardiovascular/thoracic Surgery</i>	<i>Internal Medicine</i>	<i>Rehabilitation</i>
<i>Colon &amp; Rectal Surgery</i>	<i>Nephrology</i>	<i>Plastic Surgery</i>
<i>Dermatology</i>	<i>Neurology</i>	<i>Psychiatry</i>
<i>Endocrinology</i>	<i>Neurosurgery</i>	<i>Pulmonology</i>
<i>Family Practice</i>	<i>Obstetrics/Gynecology</i>	<i>Rheumatology</i>
<i>Gastroenterology</i>	<i>Ophthalmology</i>	<i>Urology</i>
<i>General Surgery</i>	<i>Orthopaedic Surgery</i>	<i>Vascular Surgery</i>
<i>Geriatrics</i>	<i>Otolaryngology</i>	

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**EXECUTIVE SUMMARY**

Western Maryland Health System, (the "System" or "WMHS") located in Cumberland, Maryland, commissioned Coker Consulting, LLC., d.b.a. The Coker Group ("Coker") of Roswell, Georgia to assist the System in the development of a physician supply/demand analysis that provides strategic direction for both current and projected physician manpower needs for the System and the appropriate communities it serves. This report addresses the entire service area for both hospitals, Cumberland Memorial Hospital and Medical Center and Sacred Heart.

It is important to remember that the current healthcare environment is one characterized by rapid change. Nationally, reimbursement continues to move from traditional fee-for-service to a more managed care. Physician manpower analysis continues to be useful to hospitals only so long as the manpower numbers, demographic projections, and other data remain current. In addition, no medical staff plan exists within a vacuum. It is essential to continually link any medical staff development initiatives to overall strategies contained in the System's strategic plan.

Therefore, it is critical the System review and update this document on an annual basis. Only then can the time and effort expended to create this plan best assist the System and the population it serves. This report has been designed with this in mind.

A summary of the findings include the following:

- The System's primary and secondary service area has been defined as fifty-one zip codes by WMHS.
- The population of the zip codes included in the service area is expected to decrease from 128,640 in 2003 to 127,276 in 2008, a decrease of 1,351. This study is based upon these current and projected population figures for the service area.
- The System competes with other hospitals and health systems in the surrounding communities. It is unrealistic to assume that the System should shoulder the burden or benefit from recruiting all of the needed physicians outlined in this study.
- For purposes of this study, primary care physicians will be defined as general/family practitioners, internists, obstetricians/gynecologists, and pediatricians. We recommend that the System recruit an additional ten (10) family practitioners, thirteen (13) internists, seven (7) ob/gyn's, and five (5) pediatricians.
- A number of medicine subspecialties need greater coverage within the service area over the five-year projection period. These include allergy (1), cardiology (4), dermatology (1), gastroenterology (3), geriatrics (2), hematology/oncology (2), nephrology (1), neurology (2), and rehab (1).
- Behavioral health services are also underserved in the market. The System should evaluate what could be done to meet this need in the market. We believe at least three (3) additional psychiatrists are needed.

- Physician deficits were also identified based on the quantitative analysis or due to other factors in the following surgical specialties over the five-year period.
  - Cardiovascular/thoracic (1)
  - General surgery (2)
  - Neurosurgery (2)
  - Ophthalmology (2)
  - Orthopedic surgery (4)
  - Otolaryngology (2)
  - Plastic Surgery (1)
  - Urology (2)
  - Vascular surgery (2)
  
- We believe the hospital based specialties statistics reflect the following needs over the five-year period.
  - Anesthesiology (3)
  - Pathology (1)
  - Radiology (3)

An individual specialty analysis summary has been provided on page 56 of this report.

**LIMITATIONS AND CAUTIONS REGARDING QUANTITATIVE SUPPLY/DEMAND ANALYSIS**

It is important to point out that any quantitative determination of medical staff manpower requirements is not entirely foolproof, or "rocket science" specific. Each model or analytical technique has certain limitations and weaknesses, and all projections are only as good as the data provided. Since all supply/demand analyses are based on historical data, every analysis is somewhat out-of-date the moment it is calculated. Even if the data were completely correct, a 100 percent accurate long-term projection is not possible.

Also, most established national manpower standards are based on admissions data. Certain specialties traditionally are low-admitters, or do not admit at all (e.g., dermatology, emergency medicine, occupational medicine). In certain other specialties, a high volume of services and procedures take place in outpatient settings (e.g., ENT, ophthalmology, plastic surgery). For physicians in these specialties, admissions volumes will be less reflective of total activity and revenue as well.

Medical staff decision-makers must always temper the quantitative results from supply/demand studies with qualitative judgments regarding the hospitals' strategic direction. A quantitative analysis may dictate that the hospital needs a radiation oncologist, but this need must always be weighed against the strategic direction of the hospital and the subspecialty support needs of the medical staff.

**NEVERTHELESS, A QUANTITATIVE ANALYSIS OF MEDICAL STAFF REQUIREMENTS IS AN IMPORTANT PORTION OF ANY MEDICAL STAFF PLAN. IF IT IS USED AS A "ROADMAP" OR AS A SET OF QUANTITATIVE GUIDELINES TO POINT THOSE MAKING MANPOWER PLANNING DECISIONS IN THE RIGHT DIRECTION, THEN IT IS BEING PROPERLY UTILIZED AND WILL BE VERY USEFUL.**

## SPECIALTY ANALYSIS SUMMARY

Specialty	Est. Service Area Additional Need in 2008	Additional Needs Due to Market Conditions	Anticipated New Physicians Needed by 2008
Allergy & Immunology	0.5	0	1
Anesthesiology	1	3.2	3
Cardiology	0	3.9	4
Cardiovascular/thoracic Surgery	0	0.5	1
Colon/Rectal Surgery	0.5	0	0
Dermatology	0.2	1	1
Emergency Medicine	0	0	0
Endocrinology	0	0	0
Family Practice	10.9	7.9	10
Gastroenterology	3.3	0.8	3
General Surgery	1	2.3	2
Geriatrics	4.2	0	2
Hematology/Oncology	1	0.8	2
Infectious Disease	0.2	0	0
Internal Medicine	18.5	4.1	13
Nephrology	0.2	0.5	1
Neurology	1	0.8	2
Neurosurgery	0	2	2
Obstetrics/Gynecology	4	5.6	7
Ophthalmology	2.9	0	2
Orthopaedic Surgery	3.8	2	4
Otolaryngology	1	1	2
Pathology	1.4	0	1
Pediatrics	5.4	3	5
Physical Med./Rehabilitation	1.6	0	1
Plastic Surgery	1.6	0	1
Psychiatry	0.8	4	3
Pulmonology	0	1	0
Radiology	1	2	3
Rheumatology	0.1	0	0
Urology	0.5	1.8	2
Vascular Surgery	0.6	1	2
<b>Totals</b>	<b>67.2</b>	<b>49.2</b>	<b>80</b>