COMMUNITY BENEFIT NARRATIVE REPORT

FISCAL YEAR 2012

Holy Cross Hospital
1500 Forest Glen Rd
Silver Spring, MD 20910

Submitted December 15, 2012

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I General Hospital Demographics and Characteristics

FY12 Bed Designation:	409		
FY12 Inpatient Admissions:	34,477		
FY11 Primary Service Area ZIP Codes: (see figure 1)	20904 20902 20906 20910 20901 20903 20783	20853 20877 20705 20874 20878 20707 20895	20708 20774 20912 20886 20852 20850 20706
All other Maryland Hospitals Sharing FY11 Primary Service Area:	Adventist Rehabilitation Hospital of Maryland - 20783, 20850, 20852, 20853, 20874, 20877, 20878, 20886, 20895, 20901, 20902, 20903, 20904, 20906, 20910 Doctor's Community Hospital - 20706, 20774 Johns Hopkins - 20707, 20904 Laurel Regional Hospital - 20705, 20706, 20707, 20708, 20783, 20904 Montgomery General Hospital - 20853, 20904, 20906 Prince George's Hospital Center - 20706, 20774 Shady Grove Adventist Hospital - 20850, 20852, 20874, 20877, 20878, 20886 Suburban Hospital - 20850, 20852, 20878, 20895, 20902, 20906 Washington Adventist Hospital - 20705, 20706, 20783, 20901, 20902, 20903, 20904, 20906, 20910, 20912		
Percentage of Uninsured Patients, by county:	Montgomery County: 11.5% Prince George's County: 14.8%		
Percentage of Patients who are Medicaid Recipients, by county	Montgomery County: 7.1% Prince George's County: 7.0%		

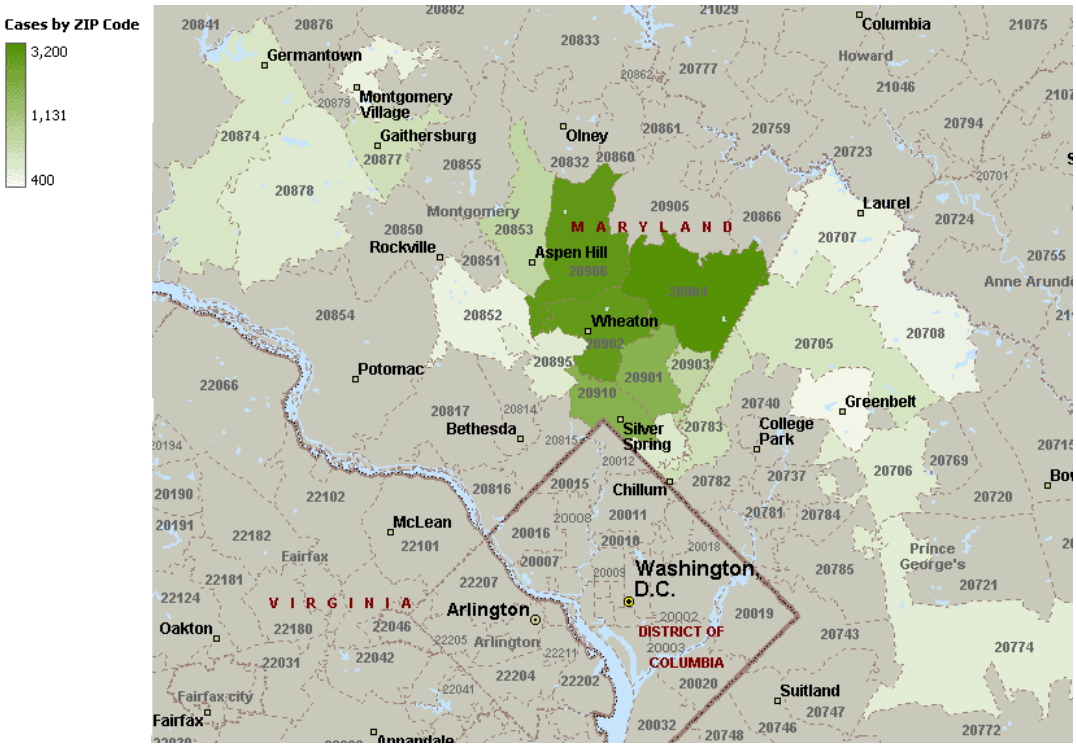


Figure 1. FY11 Primary Service Area (ZIP codes with 60% of discharges).

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

a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents. An estimated 1.6 million people make up our four market area or our *Community Benefit Service Area* (CBSA). We draw 82 percent of our discharges from a defined market area with four sub-areas within Montgomery and Prince George's Counties (see figure 2). Eighteen percent of our discharges come from outside this four-market area. When considering inpatients only, we draw 62 percent from Montgomery County and 26 percent from Prince George's County.

Figure 2. HCH Four market area represents our Community Benefit Service

Our CBSA has an average household income of $103,023 (compared to a US average of $67,315) and is one of the most culturally and ethnically diverse areas in the nation. During the last two decades the minority population has grown considerably and the minorities have become the majority. [1] Today, within our CBSA, 34 percent of residents are non-Hispanic Whites compared to 63 percent of the total United States population (see Table II).

[1] Carol Morello and Dan Keating, "Minorities are majority population in Montgomery County," *The Washington Post,* February 10, 2011 (from http://www.washingtonpost.com/wp-dyn/content/article/2011/02/09/AR2011020904310.html).

The last two decades also brought a shift in the areas foreign-born population, many of whom speak English less than "very well." The foreign-born population of Montgomery County increased from 12 percent in 1980 to more than 30 percent in 2009.[2] Forty-two percent of those who are foreign-born speak English less than "very well" (U.S. Census Bureau, 2010 American Community Survey). In Prince George's County, the gain in the foreign-born population as a percent of total population gain from 2000-2007 was the highest in the state at 199.9 percent compared to a state average of 70.7 percent. Approximately 20% of the county's residents are foreign-born, of which 36 percent speak English less than "very well" (U.S. Census Bureau, 2010 American Community Survey). The highest rates of linguistic isolation are among Latino Americans and Asian Americans.

At median income of $94,420 and $69,947 in Montgomery County and Prince George's County, respectively, our CBSA is relatively affluent compared to the U.S. median income of $50,221. However, disparities exist. For example, minority populations in Montgomery County average lower median income than the income level determined for self-sufficiency (see Table II). The presence of disparities and inequities is an underlying theme of our community health needs assessment. Despite income levels in Prince George's County about equal to the county's self-sufficiency income level, life expectancy is lower and mortality rates are higher in Prince George's County.

The highest population density is concentrated near our hospital in Silver Spring, especially on the southern border between Montgomery and Prince George's Counties and in Gaithersburg. Areas to the immediate south and east of Holy Cross Hospital have the lowest median income in the area, and Silver Spring and Gaithersburg are next. Areas in Silver Spring and Gaithersburg have the highest percentages of residents who speak English less than very well.

For many health conditions and negative health behaviors, minorities, especially non-Hispanic blacks, bear a disproportionate burden of disease, injury, death, and disability when compared to their white counterparts (CDC, 2005) and are more likely to be without health insurance than non-Hispanic whites. Minorities also make up a disproportionate number of persons unable to afford health care when needed (Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities, 2006).

Along with its growth, the area is also rapidly aging. We face similar dramatic demographic change with the coming unprecedented aging of our county. As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 65+ population in Montgomery and Prince George's Counties will increase by 95 percent (119,770 in 2010 to 233,030 in 2030) and 121 percent (81,510 in 2010 to 179,970 in 2030), respectively (Maryland Department of Planning Population Projections, 2012).

[2] Neal Peirce, "Outreach to immigrants: A suburb's exciting new way," *The Washington Post,* May 17, 2009 (http://www.postwritersgroup.com/archives/peir090517.htm).

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

Table II

Community Benefit Service Area (CBSA) Target Population (target population, by sex, race, ethnicity and average age):

	CBSA Area
2012 Total Population	1,585,117
Total Male Population	768,507
Total Female Population	816,610
Females, Child Bearing Age (15-44)	331,301

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	**2012 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	531,642	33.5%	62.8%
Black Non-Hispanic	550,596	34.7%	12.3%
Hispanic	296,816	18.7%	17.0%
Asian & Pacific Is. Non-Hispanic	159,504	10.1%	5.0%
All Others	46,559	2.9%	2.9%
Total	**1,585,117**	**100.0%**	**100.0%**

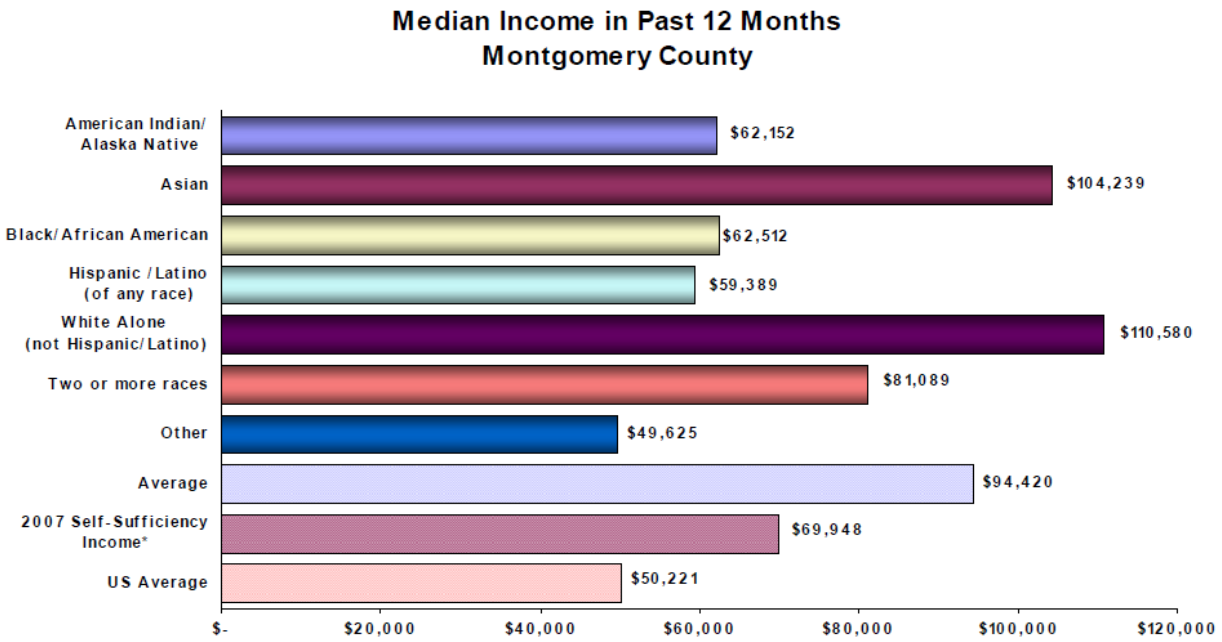
POPULATION DISTRIBUTION

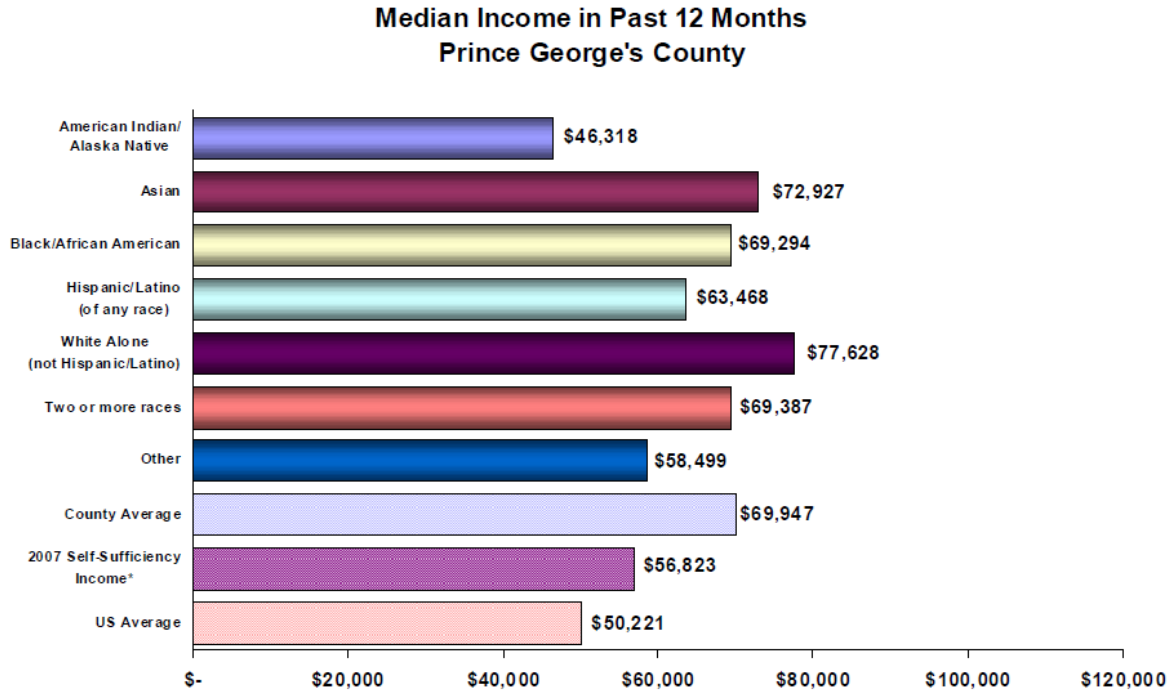
	Age Distribution		
Age Group	**2011 Pop**	**% of Total**	**USA 2011 % of Total**
0-14	325,007	20.5%	337,355
15-17	70,856	4.5%	66,967
18-24	144,596	9.1%	148,446
25-34	212,717	13.4%	204,824
35-54	478,718	30.2%	460,510
55-64	179,649	11.3%	210,250
65+	173,574	11.0%	207,989
Total	**1,585,117**	**100.0%**	**1,636,341**

Median Household Income within the CBSA :

AVERAGE HOUSEHOLD INCOME

CBSA Area	USA
$103,023	$67,315





Household Income by race for Montgomery and Prince George's County.
*Income for two adults, one preschool and one school age child
Source: U.S. Census Bureau, 2009 ACS

Percentage of households with incomes below the federal poverty guidelines within the CBSA: >25K = 10.4%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2011 Household Income	HH Count	% of Total	USA % of Total
<$15K	32,219	5.6%	13.0%
$15-25K	27,725	4.8%	10.8%
$25-50K	105,380	18.4%	26.7%
$50-75K	109,012	19.1%	19.5%
$75-100K	87,113	15.2%	11.9%
Over $100K	210,516	36.8%	18.2%
Total	**571,965**	**100.0%**	**100.0%**

Please estimate the percentage of uninsured people by county within the CBSA:

Uninsured by County

Race/Ethnicity	Montgomery County	Prince George's County	Maryland	USA
Average, All Races	**11.5%**	**14.8%**	**11.1%**	**15.1%**
American Indian/Alaska Native	11.4%	25.9%	20.0%	29.2%
Asian	12.6%	17.5%	14.3%	14.8%
Black/African American	15.2%	11.3%	12.7%	18.1%
Hispanic/Latino (of any race)	32.8%	41.2%	33.6%	31.0%
White Alone (not Hispanic/Latino)	3.9%	7.2%	7.3%	10.7%
Two or more races	7.1%	12.9%	9.6%	14.5%
Other	40.0%	48.4%	39.7%	34.1%

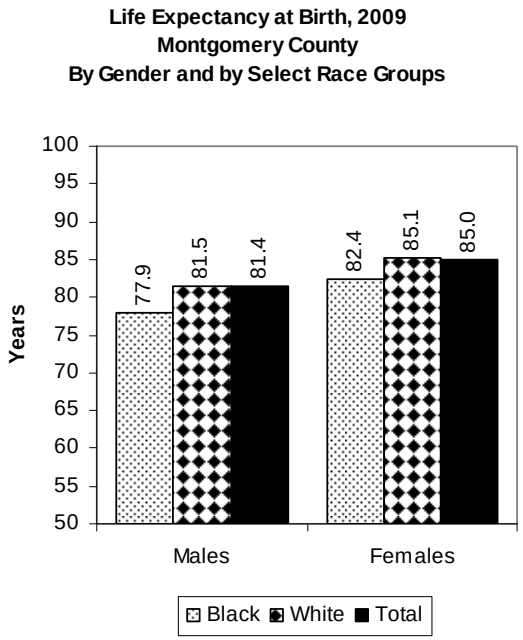
Source: U.S. Census Bureau, 2009 American Community Survey

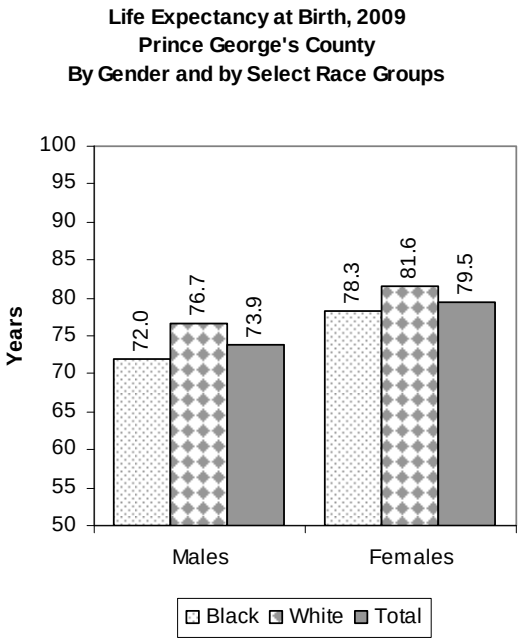
Percentage of Medicaid recipients by county within the CBSA:

Montgomery County: 9.8% (95,130 recipients)
Prince George's County: 12.1% (104,446 recipients)

Source:
Medicaid data from Health Services Cost Review Commission, 2011; Population Data from U.S. Census Bureau, 2009 American Community Survey

Life expectancy by county within the CBSA: Montgomery County = 83.8 years; Prince George's County = 77.5 years
Source: State Health Improvement Process (SHIP), Maryland Department of Health and Mental Hygiene, VSA 2009





Source: Institute for Health Metrics and Evaluation (IHME). United States Adult Life Expectancy by State and County 1987-2009. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2012

Mortality Rates/100,000 by county within the CBSA (including by race and ethnicity where data are available):

Montgomery County

All Cause Death Rate: 530.4

Males: All races, ethnicities, and ages combined

Cause	Rank	Rate
Diseases of the Heart	1	154.9
Malignant Neoplasms	2	152.0
Major Non-Cardiac Vascular Diseases	3	44.7
Accidents	4	24.4
Influenza and Pneumonia	5	20.6

Females: All races, ethnicities, and ages combined

Cause	Rank	Rate
Malignant Neoplasms	1	119.6
Diseases of the Heart	2	107.5
Major Non-Cardiac Vascular Diseases	3	38.0
Chronic Lower Respiratory Disease	4	16.3
Alzheimer's Disease	5	16.3

Prince George's County

All Cause Death Rate: 760.3

Males: All races, ethnicities, and ages combined

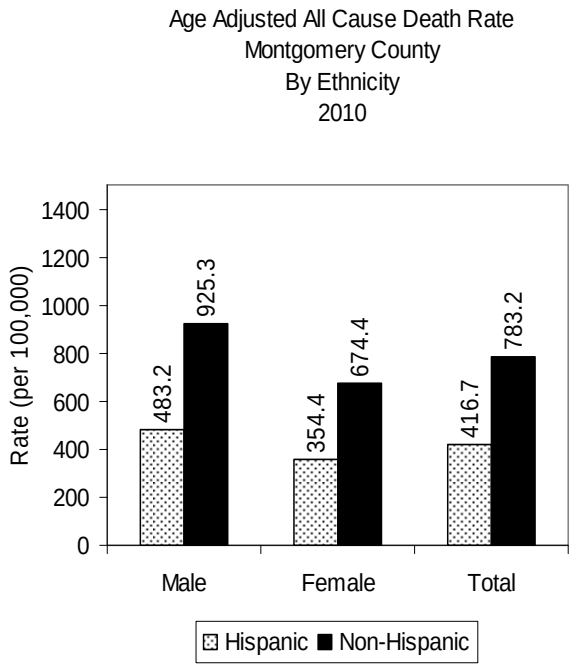
Cause	Rank	Rate
Diseases of the Heart	1	249.3
Malignant Neoplasms	2	218.2
Major Non-Cardiac Vascular Diseases	3	52.9
Accidents	4	33.9
Chronic Lower Respiratory Disease	5	33.9

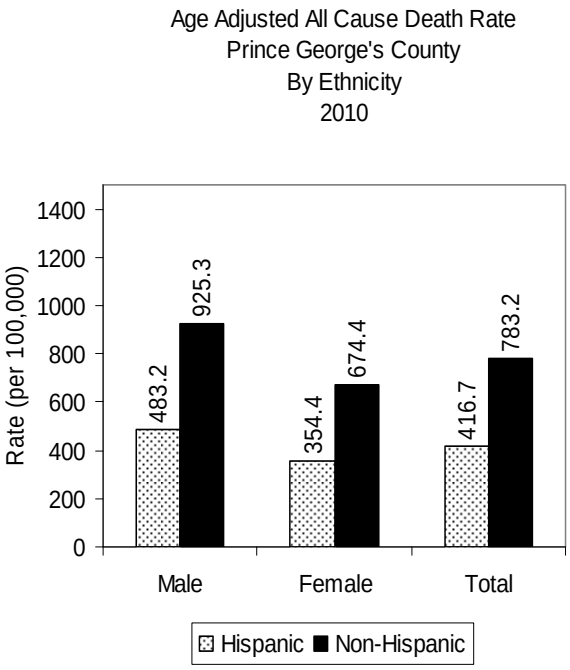
Females: All races, ethnicities, and ages combined

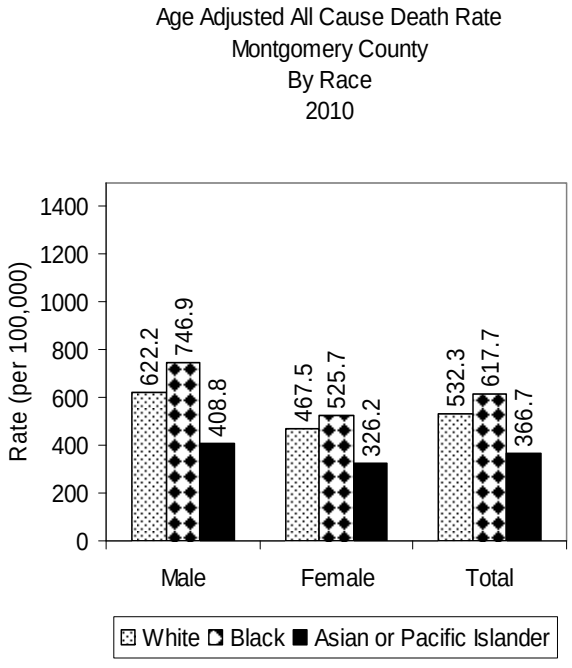
Cause	Rank	Rate
Diseases of the Heart	1	176.5
Malignant Neoplasms	2	150.1
Major Non-Cardiac Vascular Diseases	3	52.3
Diabetes Mellitus	4	29.1
Chronic Lower Respiratory Disease	5	21.9

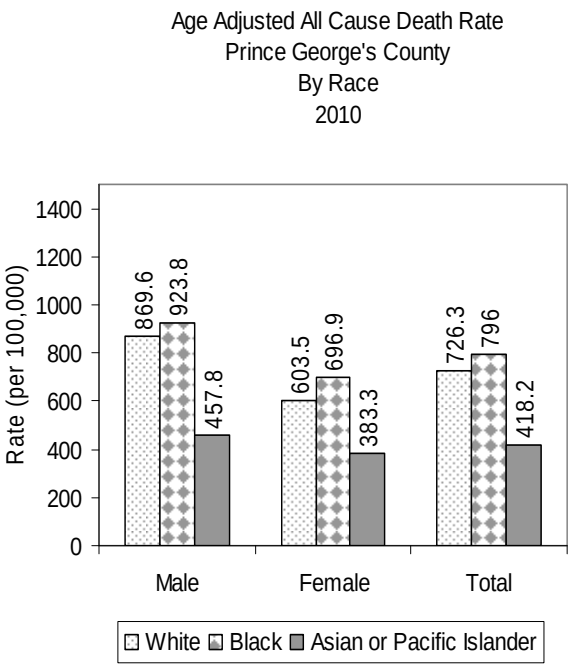
Source: Maryland Family Health Administration, Maryland Assessment Tool for Community Health, 2010

Mortality Rates/100,000 by county within the CBSA:









Source: Maryland Family Health Administration, Maryland Assessment Tool for Community Health, 2010

Access to healthy food, quality of housing, and transportation by county within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources).	(See Table II Supplements A)

Available detail on race, ethnicity and language within CBISA

Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	971,777	863,420	5,773,552
Age*, %			
Under 5 Years	6.6%	6.8%	6.3%
Under 18 Years	24.0%	23.9%	23.4%
65 Years and Older	12.3%	2.9%	12.3%
Race/Ethnicity, %*			
White	57.5%	19.2%	58.2%
Black	17.2%	64.5%	29.4%
Native American	40.0%	0.5%	0.4%
Asian	13.9%	4.1%	5.5%
Hispanic or Latino origin	17.0%	14.90%	8.20%
Median Household Income**	$92,451	$70,384	$70,017
Households in Poverty**, %	6.3%	7.2%	8.6%
Pop. 25+ Without H.S. Diploma**, %	9.6%	14.6%	12.1%
Pop. 25+ With Bachelor's Degree or Above**, %	56.2%	28.8%	35.6%
Language other than English spoken at home, pct age 5+***	37.5%	19.6%	15.9%

Sources: *U.S. Census (2010), **American Community Survey (2008-2010), ***American Community Survey (2006-2010)

Source: State Health Improvement Process (SHIP), Maryland Department of Health and Mental Hygiene, 2012

Other:	(See Table II Supplements B and C)

Table II Supplement A
State Health Improvement Process (SHIP) Measures

	Obj #	SHIP Measure (County Baseline Source)	Montgomery County Baseline	Prince George's County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Healthy Babies	1	Life expectancy at birth (VSA 2009)	83.8	77.5	78.6	77.9		82.5	6.6	7.6
	2	Infant Mortality Rate per 1,000 births(VSA 2007-2009)	5.7	10.4	7.2	6.7	White/NH-4.9 Black-11.3 Asian- 4.4 Hispanic-2.6	6.6	20.8	14.9
	3	Percentage of births that are LBW (VSA 2007-2009)	8.00%	10.60%	9.20%			8.50%		
	4	Rate of SUIDs (includes deaths attributed to Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB) and deaths of unknown cause) per 1,000 births (VSA 2005-2009)	0.5	0.9	1	0.9		0.89	54.6	49.6
	6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	82.80%	67.00%	80.20%			84.20%		
Healthy Social Environments	7	Rate of indicated non-fatal child maltreatment cases reported to social services per 1,000 children under age 18 (Dept of Human Resources FY2010)	3.2	3.6	5	9.4		4.8	35.6	65.7
	8	Rate of suicides per 100,000 population (VSA 2007-2009)	7.1	6.3	9.6	11.3		9.1	25.9	37
	9	Rate of deaths associated with fatal crashes wheredriver had alcohol involvement per 100 million Vehicle Miles of Travel (SHA 2009)	***, 11 (Count only)	0.3	0.27	0.4		0.27	N/A	N/A
	10	Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)	74.00%	79.00%	81.00%	N/A		85.00%	-8.6	N/A
	11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	85.00%	73.30%	80.70%			84.70%		
	12	Rate ED visits related to domestic violence/abuse per 100,000 population (HSCRC 2010)	30.7 ##	62.7 ##	69.6	N/A		66	55.9	N/A
Safe Physical Environments	13	Rate of new (incident) cases of elevated blood lead level in children under 6 per 100,000 (MDE 2009)	28.7	74.6	79.1	N/A		39.6	68.8	N/A
	14	Rate of deaths associated with falls per 100,000 population (VSA 2007-2009)	7.7	4.6	7.3	7		6.9	-5.1	-9.6
	15	Rate of pedestrian injuries (SHA 2007-2009)	44.2	47.8	39	22.6		29.7	-13.3	-95.6
	16	Rate of Salmonella infections per 100,000 (IDEHA 2010)	13.7	11.7	18.8	15.2		12.7	27.1	9.87
	17	Rate of ED visits for asthma per 100,000 population (HSCRC 2010)	406.0 ##	717.0 ##	850			671		
	18	Percentage of census tracts with food deserts (USDA 2000)	1.10%	13.6%	5.80%	10.00%		5.50%	81	89
	19	Number of days per year the AQI exceeded 100; not all counties are measured for AQI (EPA 2008)	5	N/A	8.4	11		8	40.5	54.5
Infectious Disease	20	Rate of new (incident) cases of HIV in persons age 13 and older per 100,000 (IDEHA 2009)	18.8	56.4	32	N/A		30.4	41.2	N/A
	21	Rate of Chlamydia infection for all ages per 100,000 (IDEHA 2009)	198.2	631	416.7	N/A	White- 101.6 Black-410.2 Asian- 50.9 Hispanic- 246.2 (all ages)	N/A	52.4	N/A
	24	Percentage of adults who have had a flu shot in last year (BRFSS 2008-2010)	49.20%	33.90%	43.00%	25.00%	White/NH-55.2% Black- 37.3% Hispanic- 40.2%	61.50%	14.4	96.8
Chronic Disease	25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	130.2	224.2	194			173.4		
	26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	130.1	173.8	177.7			169.2		
	27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	168.8 ##	308.4 ##	347.2			330		
	28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	123.3 ##	257.7 ##	237.9			225		
	29	Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)	5.9	6.1	13.4	12.6		12.4	56	53.2
	30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	47.70%	28.60%	34.00%	30.80%		35.70%		
	31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	8.40%	17.90%	11.90%			11.30%		
	32	Percentage of adults who currently smoke (BRFSS 2008-2010)	7.80%	20.60%	15.20%			13.50%		
	33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	19.20%	26.00%	24.80%			22.30%		
	34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	741.2 ##	713.1 ##	1,206.30			1,146.00		
	35	Rate of hospital admissions related to dementia/ Alzheimer's per 100,000 population (HSCRC 2010)	9.4	11.5 ##	17.3	N/A		16.4	45.9	N/A
Healthcare Access	36	Percentage of civilian, non-institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)	87.60%	82.20%	86.50%			90.90%		
	38	Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)	66.80%	57.80%	59.00%			62.00%		
	39	Percentage of people who reported there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	11.00%	15.80%	12.00%			11.40%		

Figures in Red/Green represent when the county baseline is worse/better than the sate and national baselines.
Three-year rolling averages are presented for many of the measures as a means to display more stable data (less year-to-year variation) while showing change over time. Data details for figures found in "National Baseline" and "Maryland Baseline" columns can be found on the Maryland SHIP webpage under MEASURES at http://dhmh.maryland.gov/ship/measures.html.

Only visits made by Maryland residents to Maryland hospitals were used for the analysis; visits made by Maryland residents to out-of-state hospitals were not included. Actual rates are likely to be higher.

* Race/ethnicity definitions based on the sources of data used. Hispanic origin can be from any race; White/NH denotes those who are both White and of Non-Hispanic origin.

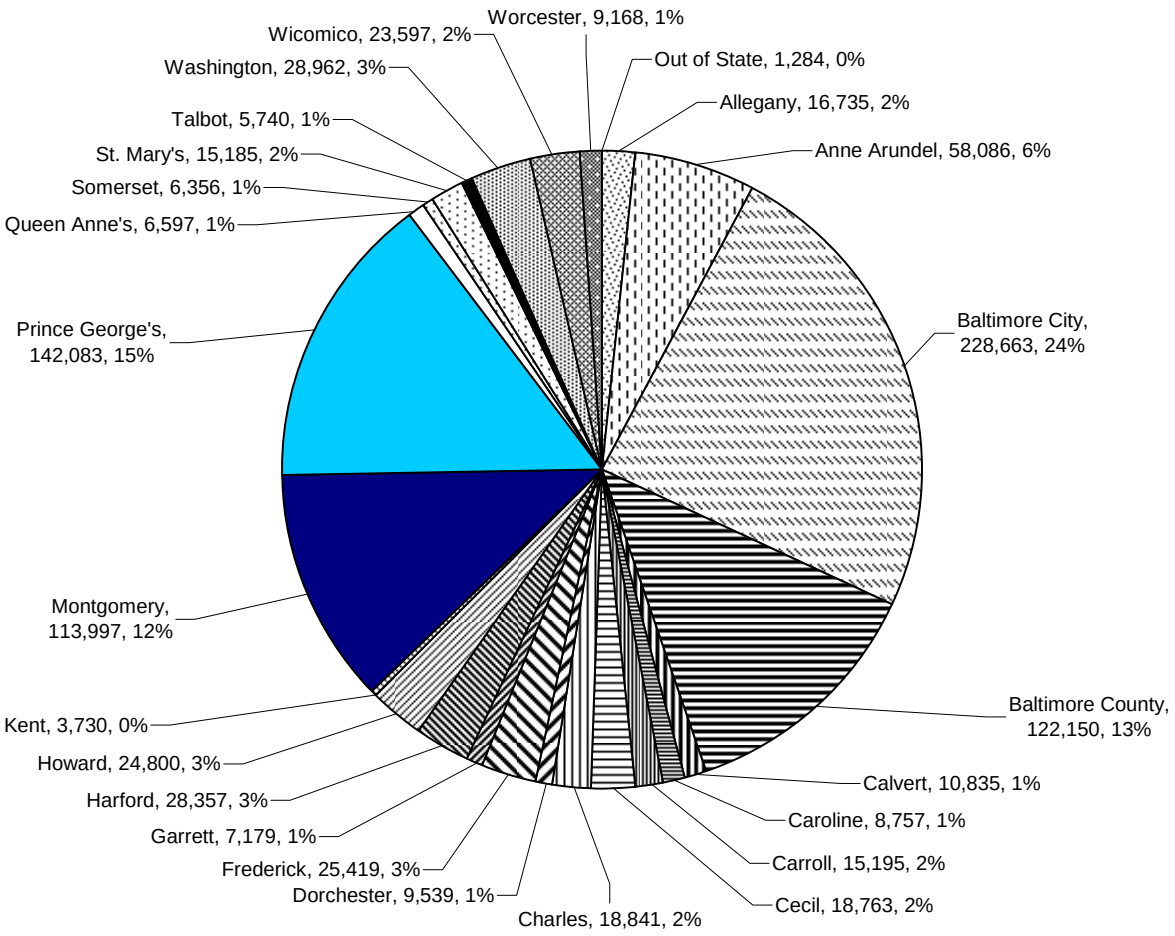
***Rates based on counts less than 20 are not shown due to instability.

^ Maryland baseline value for Objective #36 - Proportion of persons with health insurance -- has been adjusted to allow for comparison with county level data.

Percent difference formula: $\frac{\text{x county} - \text{x state}}{\text{x state}} \times 100$

Table II Supplement B

FY11 Average Number of All Medicaid Eligible Persons Per Month by County
Per Month Average for the State = 949,589



Source: Maryland Medicaid eHealth Statistics, Maryland Department of Health and Mental Hygiene, 2011

Table II Supplement C
CDC COUNTY HEALTH RANKING DATA GRID

Measures	Montgomery County	Prince Georoge's County	Maryland	US Benchmark/ Target	Source
HEALTH OUTCOMES					
MORTALITY					
Years of potential life lost/100,000 pop.	4,094	8,374	7,537	5,564	National Center for Health Statistics (NCHS)
MORBIDITY					
% Adults reporting fair or poor health	9%	12%	13%	10%	Behavior Risk Factor Serveillance System (BRFSS)
Avg. physically unhealthy days/month	2.7	3	3.2	2.6	BRFSS
Avg. mentally unhealthy days/month	2.6	3	3.3	2.3	BRFSS
% Live births with low birth weight <2500g	8.0%	10.5%	9.1%	6.0%	NCHS
HEALTH FACTORS					
HEALTH BEHAVIORS					
Tobacco: % Adults reporting currently smoking	10%	16%	18%	15%	BRFSS
Diet & Exercise: % Adults reporting obesity (BMI > 30)	19%	32%	27%	25%	National Center for Disease Prevention & Health Promotion (CDC)
Alcohol Use: %Adults reporting binge drinking	13%	10%	15%	8%	BRFSS
Motor-vehicle related mortality/100,000 pop.	7	17	13	12	NCHS
Hi-Risk Sexual Behavior: Births/1,000 teen females, ages 15-19	20	38	34	22	NCHS
New Chlamydia cases/100,000 pop.	207	638	439	83	NCHS
Access to Care: % Adults 18-64 without insurance	17%	22	17	13	Small Area Health Insurance Estimates
Quality of Care: discharges for ambulatory care sensitive conditons/1,000 Medicare en	44	62	70	52	Medicare/Dartmouth Institute
% Diabetic Medicare enrollees receiving HbA1c test	83%	76%	81%	89%	Medicare/Dartmouth Institute
% Chronically ill Medicare enrollees admitted to hospice in last 6 mos. of life	27%	23%	28%	35%	Medicare/Dartmouth Institute
SOCIOECONOMIC FACTORS					
Education: % high school students graduating in 4 yrs	85%	70%	80%	92%	National Center for Education Statistics
% Population age 25+ with 4-year college degree or higher	56%	30%	35%	34%	Census/American Community Survey (ACS)
Employment: % Population age 16+ unemployed & looking for work	5.3%	6.9%	7.0%	5.3%	Bureau of Labor Statistics
Income: % Children (<age 18) living in poverty	7%	8%	10%	11%	Small Area Income & Poverty Estimates
Gini coefficient of household income inequality (multiplied by 100)	44	38	44	38	Census/ACS
Family & Social Support: % Adults reporting not getting social/emotional support	19%	24%	21%	14%	BRFSS
% Households that are single-parent households	22%	40%	32%	20%	Census/ACS
PHYSICAL ENVIRONMENT					
Air Quality: # Days air quality was unhealthy due to fine particulate matter	0	4	4	0	Environmental Protection Agency (EPA)/CDC
# Days that air quality was unhealthy due to ozone	10	29	16	0	EPA/CDC
BUILT ENVIRONMENT					
% Zip Code in county with healthy food outlet	74%	91%	62%	92%	Zip Code Business Patterns
Liquor stores/10,000 pop.	12	18	20	n/a	County Business Patterns
Recreation Facilities/100,000 pop.	15	8	12	17	County Business Patterns

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.
For the purposes of this report and as described in Health General 19-303(a)(4), a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

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

Examples of sources of data available to develop a community needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(12) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

1. ***Identification of community health needs:***
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

Community Health Needs Assessment Background

Holy Cross Hospital identifies unmet community health care needs in our community in a variety of ways. We use a range of available needs assessments and reports to identify unmet health care needs. Each year since 2005, we have invited input and obtained advice from a group of external participants to review our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the next year. We also solicited guidance on long-term strategies during 2010 when we developed our fiscal 2011-2014 strategic plan.

External group participants include the public health officer and the department director of Montgomery County Department of Health and Human Services, a variety of individuals from local and state governmental agencies, and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas including public health, minority populations and disparities in health care, social determinants of health, health and social services. The group's input helps to ensure that we have identified and responded to the most pressing community health care needs.

On an ongoing basis, we participate in a variety of coalitions, commissions, committees, boards, partnerships and panels. Our ethnic health promoters and community outreach workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The Affordable Care Act), which puts in place comprehensive health insurance reforms that will enhance the quality of health care for all Americans. In an effort to enhance the quality of health care, the Affordable Care Act will also require non-profit hospitals to complete a community health needs assessment every three years. Building on our efforts since 2005 to obtain external input, Holy Cross Hospital collaborated with Montgomery County Department of Health and Human Services (MCDHHS) and other community partners (including all other hospitals located in Montgomery County) to develop and participate in a formal county-wide process to identify and address key priority areas that would improve the health and well-being of Montgomery County.

Healthy Montgomery: The Montgomery County Healthy Montgomery Community Health Improvement Process was initiated to address the need of all organizations to have valid, reliable, and user-friendly data related to health and the social determinants of health and to coordinate efforts of public and private organizations, like Holy Cross Hospital, to identify and address health and health-related issues in Montgomery County.

In 2010, Holy Cross Hospital and the other three hospital systems in Montgomery County each gave $25,000, for a total of $100,000, in grants to the Urban Institute to provide support for the development of *Healthy Montgomery*. This included:

- Coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Maryland Department of Health and Mental Hygiene)
- Compiling needs assessments and improvement plans from organizations in the county (many of these documents are now available through the Healthy Montgomery Website),
- Supporting the effort to select the 100 indicators to include in the Healthy Montgomery Website, and
- Preparing indicators and maps that show the social determinants of health for the county as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the Needs Assessment document.

In 2011 and 2012, Holy Cross Hospital and the four other individual hospitals each gave $25,000, for a total of $125,000, in grants to the Institute for Public Health Innovation. These funds continue to support the *Healthy Montgomery* Steering Committee meetings, preparation and presentation of all of the community conversations, preparation of the Needs Assessment Report (quantitative data and information from the community conversations), support for the Steering Committee in determining selection criteria that will be used to choose the priorities for community health improvement, and support for the priority selection process.

At this time, Prince George's County does not have a similar county-wide data program so Holy Cross Hospital used the data sources found in *Healthy Montgomery* to extract data that was specific to Prince George's County so that health information could be analyzed for both counties. The Center for Disease and Control County Health Rankings Data was also analyzed. As the needs assessment process evolves in Prince George's County, we will incorporate this information in our ongoing analysis and response.

Healthy Montgomery

Healthy Montgomery builds on past and current efforts, including environmental scans, comprehensive needs assessments, community health-related work, and relevant information from the healthcare provider organizations in the county. In addition to numerous quantitative data sources, Community Conversations were held with groups of residents to solicit their ideas about health and well being in their communities and in the county as a whole. These conversations provided views of diverse subpopulations on the issues they find critical.

The health improvement process has four objectives: (1) To identify and prioritize health needs in the county as a whole and in the diverse communities within the county; (2) To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide variety of county and sub-county information resources and utilize methods appropriate to their collection, analysis and application; (3) To foster projects to achieve health equity by addressing health and well-being

needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and (4) To coordinate and leverage resources to support the *Healthy Montgomery* infrastructure and improvement projects.

Healthy Montgomery is under the leadership of the Healthy Montgomery Steering Committee, which includes planners, policy makers, health and social service providers (including Holy Cross Hospital) and community members. It is an ongoing process that includes periodic needs assessment, development and implementation of improvement plans and monitoring of the resulting achievements. The process is dynamic, thus giving the county and its community partners the ability to monitor and act on the changing conditions affecting the health and well-being of county residents. The material presented in this document is based on Montgomery County's Community Health Needs Assessment conducted during 2009-2011.

Community Needs Index

For each ZIP code in the United States, the Community Needs Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparities related to income, education, culture/language, insurance and housing. We use the Community Needs Index to identify communities of high need and direct a range of community health and faith-based community outreach efforts to these areas (www.chwhealth.org/cni).

Other Available Data

As available, we also use a range of other specific needs assessments and reports to identify unmet needs, especially for ethnic and racial groups, those with limited English proficiency, seniors, and women and children. Our work is built on past available needs assessments, and we use these documents as reference tools, including the following key resources:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014;
- Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012;
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008.

We review our own internal patient data and review purchased and publicly available data and analyses on the market, demographics and health service utilization.

Data Gaps Identified

Where available, the most current and up-to-date data was used to determine the health needs of the community. Although the data set available is rich with information, not surprisingly, data gaps exist.

- Data such as health insurance coverage and cancer screening, and certain incidence and mortality rates are not available by geographic areas within Montgomery or Prince George's Counties.

- Data is not available on all topics to evaluate health needs within each race/ethnicity by age-gender specific subgroups.
- Diabetes prevalence is not available for children, a group that has had an increasing risk for type 2 diabetes in recent years due to increasing overweight/obesity rates.
- Health risk behaviors that increase the risk for developing chronic diseases, like diabetes, are difficult to measure accurately in subpopulations, especially the Hispanic/Latino populations, due to BRFSS methodology issues.
- County-wide data that characterize health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children.
- Analysis of linked birth-death records would provide detailed information about characteristics and risk factors that contribute to fetal and infant losses in Montgomery and Prince George's Counties among those populations that could be at elevated risk for poor birth outcomes.
- An ongoing source of Pregnancy Risk Assessment Monitoring System (PRAMS) data at the county level at least every three years would improve policy and planning efforts in maternal, fetal and infant health.
- Data is not as available in Prince George's County when compared to Montgomery County.

2. ***In seeking information about community health needs, what organizations or individuals outside the hospital were consulted? Include representatives of diverse sub-populations within the CBSA, including racial and ethnic minorities (such as community health leaders, local health departments, and the Minority Outreach & Technical Assistance program in the jurisdiction).***

   In 2012, the following external participants were consulted and provided input and advice on our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority needs and the direction to take for the next year:

   - Uma S. Ahluwalia, Director, Montgomery County Department of Health and Human Services
   - Uma S. Ahluwalia, Director, Montgomery County Department of Health and Human Services
   - Ronald Bialek, President and CEO, Public Health Foundation; Member, Montgomery County Commission on Health
   - Becky Boeckman, Director, Pastoral Care, First United Methodist Church
   - Steven Galen, President and CEO, Primary Care Coalition
   - Rose Marie Martinez, Sc.D., Director, Institute of Medicine; Member, Montgomery County Commission on Health
   - Cesar Palacios, Executive Director, Proyecto Salud
   - Angela M. Pickwick, Dean of Health Sciences, Montgomery College, Takoma Park Campus

- Douglas Propheter, CEO, Workforce Solutions Group of Montgomery County and Montgomery Works
- Wayne L. Swann, Swann Enterprises; Member, Montgomery County Commission on Health
- Richard Takamoto, Executive Director, Research Administration, Kaiser Permanente; Member, Montgomery County Commission on Health
- Ulder J. Tillman, M.D., Montgomery County Health Officer and Chief of Public Health Services

Input on community health needs and what resources are available for community members was also discussed during our monthly meetings with the Minority and Outreach & Technical Assistance Local Health Disparities Committee (LHDC). The LHDC was established in FY2012, through grant funding from the DHMH Office of Minority Health and Health Disparities to increase community and organizational capacity building to reduce health disparities.

In addition to the LHDC, we actively participate in the Montgomery County Commission on Health, Montgomery County Council on Aging, the Grass Roots Organization for the Well-being of Seniors, Montgomery Cares and many other non-profit organizations to gather information and develop action plans to address community health needs.

3. When was the most recent needs identification process or community health needs assessment completed? (this refers to your current identification process and may not yet be the CHNA required process)

Provide date here. 10/27/11 (mm/dd/yy)

The *Healthy Montgomery* Community Health Improvement Process was launched in 2009, priorities were identified in late 2011 and an action plan will be developed in 2012. Holy Cross Hospital used preliminary information from *Healthy Montgomery,* as it became available, during February – October 2011. The Holy Cross Hospital Board of Trustees accepted the Community Health Needs Assessment on October 27, 2011. The CHNA was amended on August 28, 2012 to incorporate the county priorities. The Holy Cross Hospital Board of Trustees approved the amended CHNA on October 18, 2012 as part of the Community Benefit Plan.

4. Although not required by federal law until 2013, has your hospital conducted a Community Health Needs Assessment that conforms to the definition on the previous page within the past three fiscal years? **Please be aware, the CHNA will be due with the FY 2013 CB Report.

_X_ Yes, during Fiscal 2012
___ No

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

III. COMMUNITY BENEFIT ADMINISTRATION

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

a. ***Is Community Benefits planning part of your hospital's strategic plan?***

_X_ Yes
___No

b. ***What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):***

i. Senior Leadership

1. _X_ CEO
2. _X_ CFO
3. _X_ Other (Senior Vice President, Corporate Development; Vice President, Mission Services, Vice President, Community Health; Vice President, Strategic Planning; Vice President, Revenue Cycle Management; Executive Director, Community Care Delivery)

ii. Clinical Leadership

1. _X_ Physician (Medical Director, Community Care Delivery)
2. _X_ Nurse (Senior Vice President Operations; Chief Nurse Officer; Senior Director, Women's and Children's Services; Directors, HCH Health Centers at Silver Spring and Gaithersburg)
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _X_ Individual (Manager, Community Benefit - 1.0 FTE)
2. ___Committee
3. _X_ Other (Senior Market Analyst, Planning)

The CEO Review Committee on Community Benefit meets quarterly made up of all individuals listed above and here. Community Benefit Operations is administered by the Manager, Community Benefit with oversight by the Vice President, Community Health and the Senior Vice President, Corporate Development who serves as Chief Community Benefit Officer.

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

Spreadsheet __X__yes _____no
Narrative __X__yes _____no
In addition, it undergoes an external audit as part of the audited financials

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

Spreadsheet __X_yes ____no
Narrative __X_yes ____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. ***Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).***

<u>For example</u>: for each major initiative where data is available, provide the following:

   a. ***Identified need: This includes the community needs identified in your most recent community health needs assessment as described in Health General 19-303(a)(4). Include any measurable disparities and poor health status of racial and ethnic minority groups.***

   b. ***Name of Initiative: insert name of initiative.***

   c. ***Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)***

   d. ***Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?***

   e. ***Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.***

   f. ***Date of Evaluation: When were the outcomes of the initiative evaluated?***

   g. ***Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).***

   h. ***Continuation of Initiative: Will the initiative be continued based on the outcome?***

   i. ***Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.***

Initiative 1: Komen Community Assisted Mammogram Program (K-CAMP)

Identified Need: Incidence and death rates for all cancers have been declining due to advances in research, detection and treatment, yet, cancer remains a leading cause of death in the United States (U.S. Department of Health and Human Services, 2010). It is also the second leading cause of death for both Montgomery County and Prince George's County residents (Vital Statistics, 2009) and is the top leading cause of death among Montgomery County Asians and Pacific Islanders. The burden of battling cancers within our community varies; with disparities clearly present (DHHS, 2011).

For example, in Montgomery County almost 19% more white women are diagnosed with breast cancer each year when compared to African American/Black women, however, 50% more African American/Black women in the county die from breast cancer when compared to white women. The incidence and death rates between counties also shows disproportionate results. Montgomery County has a 10.5 % higher incidence rate of breast cancer when compared to Prince George's County; however, the death rate for Prince George's County is 40% higher when compared to Montgomery County.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Komen-Community Assisted Mammogram Program (K-CAMP)	- To reduce disparities in breast health care among low-income, medically underserved, uninsured racial and ethnic women and men. - To provide high quality, culturally competent outreach and education to 30,000 individuals over three years. - To provide early detection of breast cancer by screening 2,250 individuals over three years. - To provide high quality, culturally competent and comprehensive breast health care navigation and case management services to an estimated 450 uninsured or underinsured racial and ethnic women over three years.	Multi-Year CY2010-2012	- Community Clinics Inc. - Community Ministries of Rockville's Mansfield Kaseman Clinic - Diagnostic Medical Imaging, PA - Holy Cross Health Centers, Silver Spring and Gaithersburg - People's Community Wellness Center - Proyecto Salud, Wheaton - Montgomery County African American Health Program, and Asian American Health Initiative - CASA of Maryland Inc. - Community Ministries of Rockville	FY2012	*Process* Average time from diagnosis to treatment is three weeks Case management and navigation services for abnormal findings provided to 317 (74%) of total participants with abnormal findings 45,000 educated Achieved 100% success rate in linking low-income eligible participants with symptoms to the State of Maryland Breast and Cervical Cancer Diagnosis and Treatment Program for medical expense coverage. *Impact* K-CAMP: 1,141 mammograms (713 screening, 428 diagnostic), 260 breast ultrasounds, 116 surgical referrals and 12 diagnosed cancers	Dependent on grant funding	$260,626

Initiative 2: Senior Fit

Identified Need: As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 65+ population in Montgomery and Prince George's Counties will increase by 95 percent (119,770 in 2010 to 233,030 in 2030) and 121 percent (81,510 in 2010 to 179,970 in 2030), respectively (Maryland Department of Planning Population Projections, 2012). Older adults are at high risk for developing chronic illnesses and related disabilities and experience disproportionate rates of heart disease, cancer, diabetes, congestive heart failure, arthritis and dementia (including Alzheimer's). For example, one out of every two Montgomery County senior residents, 65 years and older, has hypertension. African American /Black adult residents are approximately one and a half times more likely (39.9%) than White residents (24.6%), twice as likely as Asian/Pacific Islander residents (17.1%) and three times more likely than Hispanic/Latino residents (14.4%) to experience high blood pressure.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Senior Fit	To provide age appropriate exercise classes to minimize symptoms of chronic disease and improve strength, flexibility and endurance and encourage self-management. The *Senior Fit* program targets the 55+ population of Montgomery and Prince George's Counties and strives to: - Improve the health of older adults in our community by offering a free, accessible - exercise class designed to increase strength and flexibility - Reduce the pain level of people with chronic illness - Teach self-management skills related to physical activity - Improve socialization of participants and - Build a referral network among physicians, nurses, community center staff and allied health professionals	Multi-Year, in operation since 1995	- Holy Cross Hospital, - Kaiser Permanente of the Mid-Atlantic States, - Montgomery County Dept. of Recreation, Maryland National Capital Park and Planning Commission and - Local churches - Asbury Methodist Village	Process – 2012 Impact – 2011	*Process* - 3,576 enrolled participants - 68 weekly classes held at 22 sites with average daily attendance of 870 - 96,250 encounters for FY12 - Average participant age: 73.9 for females and 75.3 for males. - 61% of participants reside in a ZIP code with a CNI score of 3.0 or higher, weighted CNI score for all participants is 2.94. - 78.5 % Female, 21.5% Male - 14%Asian, 29% Black/African American, 4% Hispanic, 53% White Non-Hispanic *Impact* Matched data from the April 2011 and October 2011 showed that a high percentage of participants performed "above average" on three of four tests (85% lower body strength, 87% agility and dynamic balance, and 95% upper body strength). These results are within a 1% variance from the previous test given to the same participants in April 2011. It also showed that 14% of participants scored an "At Risk" value for upper body	Yes	$265,410

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Senior Fit (cont.)					(shoulder) flexibility in October (13% in April) and 8% scored below average (3% in April). These findings are critical guideposts for adjusting program content, and point out a need to add exercise modules that are associated with strengthening this functional ability.		

Initiative 3: Kids Fit

Identified Need: During the past twenty years, obesity rates have increased in the United States; doubling for adults and tripling for children. More than 50% of Montgomery County residents and more than 65% of Prince George's County residents are overweight or obese. Obesity affects all populations, regardless of age, sex, race, ethnicity and socioeconomic status (U.S. Department of Health and Human Services, 2010), however, disparities do exist and rates are affected by race/ethnicity, sex and age.
Men (61%) are more likely to be at least overweight. Seven out of every ten Hispanic/Latino adults and African American/Black adults are either overweight or obese. Obesity levels (BMI at or above 30.0) are lowest among the Asian/Pacific Islander adults (2.6%) and highest among African American/Black (28%) and Hispanic/Latino adults (30%). Men and adults aged 45-64 are also less likely to engage in 30 minutes of moderate activity for 30 minutes or more per day. Hispanic/Latino adults (39.7%) and White adults (35.2%) are more likely than Asian/Pacific Islander (25.3%) and African American/Black (29.1%) adults to engage in at least light-to-moderate physical activity.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Kids Fit	Increase awareness of healthy behaviors to prevent or decrease obesity in children aged 6-12.	Multi-year, in operation since 2008	- Montgomery County Housing Opportunities Commission, - New Hampshire Estates Elementary School, - Silver Spring Boys and Girls Club, - HCH Foundation	Fall 2011 and Spring 2012	<u>Process</u> - 141 enrolled participants - 8-10 weekly classes held at 5 sites - 5,288 encounters for FY12 - Average participant age: 9 - 40% Female, 60% Male - The majority of participants are African American/Black and Hispanic/Latino <u>Impact</u> Target for FY12 was to improve Presidential Fitness test scores, which measure upper body strength, core strength, speed and agility and lower body flexibility, by 5%. Overall scores for girls improved by 8% and overall scores for boys improved by 7%.	Yes	$59,527

Initiative 4: Chronic Disease Self-Management Program

Identified Need: Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, they are also among the most preventable (U.S. Department of Health and Human Services, 2010). In Montgomery County and Prince George's County heart disease is the leading cause of death and stroke is the third leading cause of death. Heart disease is the leading cause of death for African American/Black, Hispanic/Latino and White residents and is the second leading cause of death among Asian and Pacific Islander residents. African American/Black residents die from stroke at a rate that is 15% (34.4 deaths per 100,000 population) higher than White residents (29.8 per 100,000 population) and more than double the rate experienced by Hispanic/Latino residents (14.5 per 100,000 population). Men are disproportionately affected by heart disease mortality with a death rate that is more than 50% higher than it is for women. (167.5 deaths per 100,000 population vs. 106.2 per 100,000 population, respectively). African Americans/Blacks are also disproportionately affected by heart disease mortality. The mortality rate for African Americans/Blacks (159.5 per 100,000 population) is three times the rate Hispanic/Latino residents (53.9 per 100,000 population) and more than double the Asians and Pacific Islanders rate (71.7 per 100,000 population).

Diabetes Mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death (CDC, 2008) It is the ninth leading cause of death in Montgomery County and the fourth leading cause of death in Prince George's County (Maryland Vital Statistics, 2009). Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. It is also the leading cause of kidney failure, lower limb amputations and adult-onset blindness (U.S. Department of Health and Human Services, 2010). Further analysis of Montgomery County data reveals that it is the fourth leading cause of death among African Americans/Blacks, fifth leading cause of death among Hispanics/Latinos, and sixth leading cause of death among Asians and Pacific Islanders (DHHS, 2011). African American/Blacks also die from diabetes more often when compared to the overall county. The mortality rate (28.8/100,000) for African American/Black residents is more than twice the overall county rate (12.7/100,000). Among African American/Black women, diabetes is the third leading cause of death. The overall mortality rate for Prince George's County is 31.4/100,000.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Evidenced-Based, Stanford University Chronic Disease Self-Management Program (CDSMP)	To enable Montgomery and Prince George's Counties' participants, who have one or more chronic diseases, to build self-confidence and to assume a major role in managing their chronic health conditions. As measured by: - Increases in healthy behaviors - Positive changes in health status (less pain, fatigue, and worry; less health distress) - Increased self-efficacy - Better communications with	Multi-year, in operation since 2007	- Holy Cross Hospital, - Montgomery County Dept. of Health and Human Services, - Maryland Dept. on Aging, - Holy Cross Hospital Foundation	Process – FY12 Impact – 1999 and 2001	*Process* 15 workshops held in FY12; 237 participants with 922 encounters; 61% of participants attended at least 4 out of 6 sessions. Average participant age: 73 years Race/Ethnicity: African American – 27%, American Indian/Alaskan Native – .003%, Asian American – 4%, White Non-Hispanic– 54%, Hispanic – 1.4%, Unknown– 8%, Average number of Chronic Diseases per workshop: 32 (averages 2 per person) Number lay instructors trained in FY12: 15 Number lay instructors completed refresher	Yes	$58,849

CDSMP (cont.)	health providers - Fewer visits to physicians and emergency rooms				training, if any: 14 Number of master trainers for program: 4 *Impact* Over a period of 2 years, Agency for Healthcare Research and Quality (AHRQ)-funded investigators compared health behaviors, health status, and health services use in patients age 40 to 90 years (average age, 65) who had completed the CDSMP (Lorig et al., 1999). When compared to baseline measures taken for the 6 months prior to the CDSMP, researchers found that CDSMP participants had: - Increased exercise. - Better coping strategies and symptom management. - Better communication with their physicians. - Improvement in their self-rated health, disability, social and role activities, and health distress. - More energy and less fatigue. - Decreased disability. - Fewer physician visits and hospitalizations. Lorig et al. (2001a) found that after 1 year, CDSMP participants had: - Significant improvements in energy, health status, social and role activities, and self-efficacy. - Less fatigue or health distress. - Fewer visits to the emergency room. No decline in activity or role functions, even though there was a slight increase in disability after 1 year. In the same study by Lorig et al. (2001a), after 2 years CDSMP participants had: - No further increase in disability. - Reduced health distress.		

					- Fewer visits to physicians and emergency rooms. - Increased self-efficacy. The increase in patients' perceptions of their self-efficacy was associated with reduced health care use (Lorig et al., 2001a). Self-efficacy, the degree of belief people have that they can perform the behavior required to produce a desired outcome, is crucial to the success of the CDSMP (Lorig et al., 1999). The more self-efficacy people have, the more control they believe they have over their behavior (Lorig et al., 1999; Lorig, Mazonson, & Holman, 1992). Therefore, increasing self-efficacy contributes to better decision making processes, stronger motivation, and perseverance (Lorig et al., 1992).		

Initiative 5: Transitional Care Program

Identified Need: Despite the median income of both Montgomery County and Prince George's County being well above the national average, many residents are without health insurance. Barriers like lack of health insurance and the high cost of medical care decrease access to quality health care and can lead to unmet health needs. This includes delays in receiving appropriate care, inability to get preventive services, and potentially preventable hospitalizations thus increasing mortality and morbidity (HHS, 2010). Approximately 10% of Montgomery County residents and 15% of Prince George's County residents were without health insurance; however, racial disparities exist in both counties. Hispanics are more than 5 times as likely to be without health insurance in Montgomery County and more than 2.5 times as likely in Prince George's County when compared to their white counterparts. Almost 65% of the Montgomery County uninsured population and almost 60% of the Prince George's County uninsured population come from households with combined incomes of less than $75,000 annually. Montgomery County has the largest number of non-citizen residents (64,000) with no health insurance among all the jurisdictions in Maryland (38 percent of the State's 170,000 non-citizen residents with no health insurance (Healthy Montgomery, 2011). In addition to high rates of uninsured, one in every five adults (18-44 years), one in every four Hispanic/Latino adults, one in every six African American/Black adults, and one in every six adult males living in Montgomery County reported they were unable to see a doctor in the past year because they could not afford it (Healthy Montgomery, 2011). Almost all Healthy Montgomery Community Conversation groups ranked affordable/accessible health care as a priority. Concerns about poverty, employment, income and transportation created anxiety about health care access.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Transitional Care Program	To link uninsured patients discharged from the hospital to a primary care provider at one of our three health centers by providing coordination of care by ensuring health center follow-up, patient education, medication management, transportation assistance and links to self-care management programs.	Multi-Year, in operation since 2010	Montgomery Cares Suburban Hospital	FY2012	<u>Process</u> - 1,742 people me program criteria • 318 (18%) were established HCH clinic patients • 632 (36%) were new HCH clinic patients • 669 (38%) received follow-up care outside of HCH clinic or with no confirmed follow-up care • 124 (7%) lost to follow-up - 1,072 received successful telephone contacts - 1,258 had confirmed appointments within first week of discharge or per discharge instructions - 1,126 (89.5%) appointments kept overall <u>Impact</u> Rate of readmissions in ≤ 30 days: 7.4%	Yes	$132,252

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

Healthy Montgomery, the health improvement process for Montgomery County organized a steering committee of representatives from county government agencies, county commissions, non-profit organizations, local health providers, and hospitals. The steering committee used data collected from 100 indicators to determine the most pressing needs of the county. These data are organized into 13 categories: access to health services; cancer; diabetes; exercise, nutrition and weight (obesity); heart disease and stroke; maternal, fetal and infant health; family planning; immunizations and infections disease; mental health and mental disorders; respiratory diseases; substance abuse and illicit drug use; wellness and lifestyle; and prevention and safety.

During FY12, the Healthy Montgomery steering committee conducted a priority setting process and identified six priority community needs based on three lenses, unhealthy behaviors, lack of access and health inequities; six categories emerged as top priorities. The top priorities selected are behavioral health, cancers, cardiovascular health, diabetes, maternal and infant health, and obesity. We took this information and juxtaposed our strengths with the identified needs and incorporated five of the six top priorities into our community benefit plan and chose to add access to health services as a top priority for hospital programming. The top priorities of the hospital are access to health services, cancer, diabetes, obesity, cardiovascular health, and maternal and infant health.

We recognize that we cannot pursue all of the identified health needs and that choices need to be made. We made choices using a rigorous process to ensure that documented unmet community health needs intersect with our mission commitments and key clinical strengths (see figure 3). At this time, behavioral health has not been incorporated into our community benefit plan because it is not a key clinical strength of the hospital and we do not have the infrastructure needed to sustain programs that would make an impact in this area. However, although we currently cannot sustain programs aimed to improve the mental health of the county, Holy Cross will continue to participate in the ongoing needs assessment process to determine how we can play a role in improving outcomes in this area. Our capacity to address this need will expand when Holy Cross opens the Holy Cross Germantown Hospital in 2014. The hospital will include a psychiatric unit.

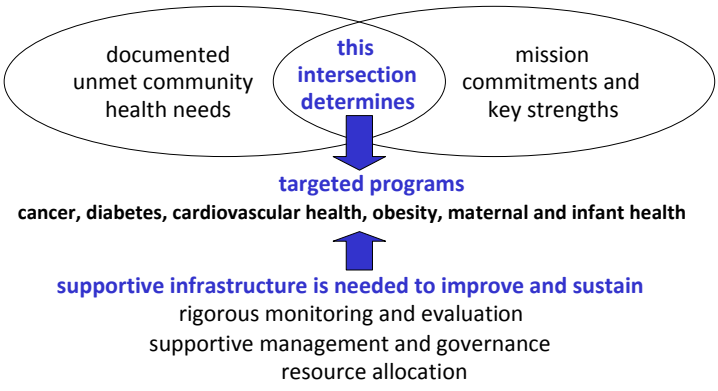


Figure 3. HCH's approach to meeting community health needs aligned with the strengths of the hospital.

V. PHYSICIANS

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

Providing care for uninsured patients is challenging for many of the independent medical staff members, especially by "on call" specialty physicians in the emergency center who feel the liability and financial burden of caring for these patients is too great.

Inpatient specialty care is provided by specialty physicians, hospitalists, and other professional staff that provide care in the following specialties: Neurology, cardiology, pulmonary, orthopedics, dermatology, infectious disease, oncology, hematology, medical imaging, laboratory, infusion center, anesthesiology, presurgical testing, surgery, obstetrics, gynecology, physical therapy, home care, hospice, patient education, pharmacy, sleep lab, electrocardiogram, and pain management. Gaps will occur when the ratio of uninsured patients to insured patients threatens sustainability.

Uninsured outpatients have access to hospital services but are in need of outside resources for most of their specialty care. All three of the Holy Cross Hospital Health Centers, the only clinics in the county operated by a hospital, are fortunate to have experienced, full-time physicians that are able to treat and manage many of the patients requiring specialty care. The Holy Cross Hospital Health Centers are able to provide specialty care in neurology, orthopedics, hematology, ophthalmology, and otorhinolaryngology on-site, on a limited basis. These specialists can accommodate the immediate needs of the health centers. Nurses also report having a difficult time referring patients for urology.

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

In order to meet the needs of the uninsured/underinsured population, Holy Cross Hospital has approximately 100 physician contracts for the provision of on-call clinical services as needed. These services are provided on a 24-hour/7-day a week basis, operate on a negative margin and are frequently used by the uninsured/underinsured population. If subsidies were discontinued, the following services would not be available and patients would need to be transported to other facilities or have unmet needs:

Category One: Hospital-based physician subsidies with which the hospital has an exclusive contract and/or subsidy in order to retain services that represent a community benefit

- We provide a $363,139 subsidy to anesthesiology to bring in a third (or more) anesthesiologist in off hours. This is required in part because of our very large maternity partnership program that serves uninsured, pregnant women and our very busy emergency department that drives off-hours demand for specialty care, disproportionately by uninsured patients.

Category Two: Non-Resident house staff and hospitalists

- The hospital contracts/employs non-resident house staff and hospitalists and medical directors to provide inpatient services, including night coverage to admit and cover the uninsured/underinsured population. In FY12, Holy Cross Hospital provided a net benefit of $1,177,930.
- The hospital contracts/employs pediatric hospitalists to meet the inpatient need of uninsured/underinsured infants and children. In FY12, Holy Cross Hospital provided a net benefit of $1,341,467.

Category Three: Coverage of Emergency Department call

- The hospital contracts with individual physicians and physician groups to ensure the needs of the uninsured/underinsured population are met by providing subsidies for the coverage of emergency department calls. In FY12, Holy Cross Hospital provided a net benefit of $3,553,328 to ensure medical directors and emergency coverage in the following areas:
    - General Surgery, Orthopedic Surgery, Neurology/Stroke Care, Neurosurgery, ENT, Oral Surgery, Interventional Cardiology, Plastic Surgery, Urology, Ophthalmology, Vascular Surgery, Thoracic Surgery, Psychiatry and Anesthesiology

Category Four: Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

- No additional subsidies provided beyond those described above, however, all hospital based contracted physicians and on-call physicians follow the hospital's charity care policy.

Category Five: Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- No subsidies provided

VI. APPENDICES

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

For <u>example</u>, state whether the hospital:

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

b. Include a copy of your hospital's FAP (label appendix II).

c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

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

Financial Assistance Policy Description

All Holy Cross Hospital registration, financial counseling and customer service staff members are trained to be familiar with the availability of financial assistance and the criteria for such assistance.

In addition:

- The financial assistance application and information about the program are prominently displayed in all registration areas, the main lobby, the emergency center and each cashier's office. The information available is offered in both English and Spanish, the predominant languages in our patient population at Holy Cross Hospital.
- Material describing the financial assistance program and an application are to be given or sent to all patients who request this information.
- Staff is responsible for being particularly alert to those who are registered as self-pay patients and provide them with information on how to contact a financial counselor or provide them financial assistance information. All financial assistance applicants are screened for eligibility for federal, state or other local programs before financial assistance is offered.
- All financial counselors are bilingual (English/Spanish).
- The financial assistance application is accessible through the hospital's external website
- Notice of financial assistance availability is indicated on all hospital billing statements
- Holy Cross Hospital uses Ethnic Health Promoters that inform community members about our financial assistance policy on a one-on-one basis or in group settings where people gather in the community (e.g., hair salons, churches, community centers).
- A written notice is published annually in local newspapers in English and Spanish to advise the public of our financial assistance policy.

The Holy Cross Hospital financial assistance policy provides systematic and equitable clinical services to those who have medical need and lack adequate resources to pay for services. In FY12, Holy Cross Hospital provided $23.7 million in financial assistance. Individuals who are uninsured are able to obtain primary health care services at three Holy Cross Hospital health centers located in Silver Spring, Gaithersburg and Aspen Hill, Maryland. The health centers provide a convenient option for uninsured residents in need of high quality, discounted medical care. In FY12, health center visits increased 8.5 percent from 21,348 in FY11 to 23,155 and exceeding our target of 22,125 by 4.7 percent. Financial assistance also increased 23.4 percent from $19.2 million to $23.7 million and exceeded our budget of $20.9 million. We opened our third health center in the Aspen Hill in April of 2012 to accommodate the increase in patient visits at both Gaithersburg and Silver Spring Health Centers.

b. Include a copy of your hospital's FAP (label appendix II).

HOLY CROSS HOSPITAL

Patient Financial Assistance

Purpose

It is part of the Holy Cross Hospital mission to make medically necessary care available to those in our community who are in need regardless of their ability to pay. The Hospital maintains a formal financial assistance program to equitably and efficiently provide access for those who cannot pay. Since all care has associated cost, any "free" or "discounted" service provided through this program results in that cost being passed on to other patients and their payers. Holy Cross Hospital therefore has a dual responsibility to cover those in need while ensuring that the cost of care is not unfairly transferred to individuals, third party payers and the community in general.

It is the purpose of this policy to:

- Ensure a consistent, efficient and equitable process to provide free or reduced-cost medically necessary services to patients who reside in the state of Maryland or who present with an urgent, emergent or life-threatening condition and do not have the ability to pay.
- Ensure regulatory agencies and the community at large that the hospital documents the financial assistance provided to these patients so that their eligibility for the assistance is appropriately demonstrated.
- Protect a stated level of each patient's assets when determining their eligibility for financial assistance under this policy.
- Provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance under this policy.

Applies to HCH

- Financial counseling and revenue cycle staff
- Hospital contracted physicians

Policy Overview

The Holy Cross Hospital financial assistance policy applies in those cases where patients do not have sufficient income or assets to pay for their care and fulfill their obligation as patients to cooperate with and avail themselves of all programs for medical coverage (including Medicare, Medicaid, commercial insurances, workers compensation, and other state and local programs). The Hospital's financial assistance policy is comprised of the following programs - each of which may have its own application and documentation requirements.

- **Scheduled Financial Assistance Program:** Holy Cross makes available financial assistance to eligible patients who have a current or anticipated need for inpatient or outpatient medical care. This assistance requires completion of a full application and provision of supporting documentation. Once approved, such financial assistance remains in effect for a period of six months after the determination unless the patient's financial circumstances change or they become eligible for coverage through insurance or available public programs during this time.

- **Presumptive Financial Assistance Program:** Holy Cross makes available presumptive financial assistance to eligible patients as follows:

    - Patients, unless otherwise eligible for Medicaid or CHIP, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
        - Households with children in the free or reduced lunch program;
        - Supplemental Nutritional Assistance Program (SNAP);
        - Low-income-household energy assistance program;
        - Primary Adult Care Program (PAC) until such time as inpatient benefits are added to the PAC benefit package;
        - Women, Infants and Children (WIC)

    - Services provided within Holy Cross Health Centers and the Obstetrics and Gynecology Clinic as well as for select outpatient services provided at the Hospital. In some cases both the eligibility and documentation requirements will reflect the processes and policies of county or other public programs for financial assistance. This assistance is based on the same financial assistance eligibility schedule,

Policy Overview (continued)

but normally requires a less extensive documentation process. Should a patient who is granted presumptive status for routine outpatient care have a need for more substantial services or inpatient services, more extensive documentation will be required, and a redetermination of eligibility will be made.

- **Medical Financial Hardship Program:** Holy Cross also makes available financial assistance to eligible or "medically indigent" patients who demonstrate a financial hardship as a result of medical debt. This program requires a more extensive documentation process. Reduced-cost financial assistance will remain in effect during the 12-month period after the date the reduced-cost medically necessary care was initially received and will apply to the patient or any immediate family member of the patient living in the same household when seeking subsequent care at Holy Cross Hospital.

If a patient meets the eligibility requirements of more than one of the programs listed above, the Hospital shall apply the reduction in charges that is most favorable to the patient. If reduced-cost care is approved for a patient, the maximum patient payment for care will not exceed the charge minus the hospital mark-up.

The documentation requirements and processes used for each financial assistance program are listed in the financial assistance and billing and collection procedures maintained by the Revenue Cycle Management division.

Within two business days of the receipt of a completed application for financial assistance, medical assistance or both, a determination of probable eligibility will be made.

Covered Services

The financial assistance policy applies only to hospital charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Hospital; i.e., inpatient, outpatient, emergency center, clinic, and Health Center. It does not apply to services that are operated by a "joint venture" or "affiliate" of the hospital. Hospital contracted physicians (Emergency Center, Anesthesia, Pathology, Radiology, Hospitalists, Intensivists and Neonatalogists are contracted) also honor scheduled financial assistance determinations made by the hospital. Financial assistance is only applicable when a patient takes advantage of the most appropriate cost effective setting to obtain their care.

Provision of services specifically for the uninsured: In the event that Holy Cross provides a more cost effective setting for needed services

(such as the Obstetrics and Gynecology Clinic or the Health Centers for uninsured patients), in cooperation with community groups or contracted physicians, specific financial assistance and payment terms apply that may differ from the general Holy Cross Hospital financial assistance program. In these heavily discounted programs, patients are expected to make the minimum co-payments that are required regardless of the level of charity care for which the patient would otherwise be eligible. Those minimum obligations are not then eligible to be further reduced via the scheduled financial assistance policy.

Services Not Covered

Services not covered by this financial assistance policy are:

1) Private physician services or charges from facilities in which Holy Cross Hospital has less than full ownership.
2) Cosmetic, convenience, and/or other Hospital services, which are not medically necessary. Medical necessity will be determined by the SVP of Medical Affairs after consultation with the patient's physician and must be determined prior to the provision of any non-emergent service.
3) Services for patients who do not cooperate fully to obtain coverage for their services from County, State, Federal, or other assistance programs for which Holy Cross believes they are eligible.

Patient Eligibility Requirements

Holy Cross provides assistance to Maryland residents and patients who present with an urgent, emergent or life-threatening condition whose income is less than 300% of the federal poverty level and whose monetary assets (assets that are convertible to cash excluding up to $150,000 in equity in their primary residence, personal tools used in their trade or business, and deferred retirement plan assets) do not exceed $10,000 as an individual or $25,000 within a family. Holy Cross will also provide assistance to patients with family income up to 500% of the federal poverty level that demonstrate a financial hardship as a result of incurring hospital medical debt that exceeds 25% of family income over a 12-month period.

Any individual may make a request to reconsider the level of reduced-cost care approved or denial of free or reduced-cost care by the Hospital for the individual. In such cases, requests are to be made to the financial counseling manager who will consider the total financial circumstances of the individual including outstanding balances owed to the Hospital, debt and medical requirements as well as the individual's income and assets. The financial counseling manager will assemble the patient's request and documentation and present it to the financial assistance exception committee (comprised of the Vice President, Mission Services, the Chief Financial Officer, and the Senior Vice President, Corporate

Development) for consideration.

In any case where the patient's statements to obtain financial assistance are determined to be materially false, all financial assistance that was based on the false statements or documents will be rescinded, and any balances due will be processed through the normal collection processes.

The scheduled financial assistance program provides free medically necessary care to those most in need – patients who have income equal to or less than 200% of the federal poverty level. It also provides for a 60% reduction in charges for those whose income is between 201% and 250% of the poverty level, and 30% assistance from 251% to 300% of the federal poverty level. For those patients who demonstrate a medical financial hardship, a minimum of 30% assistance may be provided from 301% to 500% of the federal poverty level. The Hospital's schedule of financial assistance will change according to the annual update of federal poverty levels published in the HHS Federal Register.

Continuing financial obligation of the patient: Patients who receive partial financial assistance have been determined to be capable of making some payment for their care. Unless a specific patient financial assistance exception request is made and approved, or hospital management formally adopts a procedure that exempts collection processes for particular services, patients are expected to pay the amount of the reduced balance. In cases other than the above, any patient who fails to pay their reduced share of the account in question will have that account processed through our normal collection procedures, including the use of outside agencies and credit reporting. However, the hospital will not pursue a judgment against anyone who has legitimately qualified for any scheduled level of Holy Cross Hospital financial assistance. Payment plans are also made available to uninsured patients with family income between 200% and 500% of the federal poverty level that request assistance.

Notice of Financial Assistance

The financial assistance program is publicized to patients of Holy Cross Hospital to whom it may apply. The information will be made available via the following methodologies:

1) Notice of the availability of financial assistance will be prominently displayed in all hospital registration areas, the emergency center, health centers, and each cashier's office in the predominant languages represented by our patient population. The financial assistance application and the Hospital patient information sheet are also accessible on the hospital's external website.
2) Notice of financial assistance availability is indicated on all hospital billing statements along with a reference to the external website and

phone number where inquires can be made.
3) All self-pay patients are advised of the existence of the financial assistance program during the pre-registration and registration process.
4) Information regarding eligibility and applications for financial assistance will be mailed to any patient who requests it at any time – including after referral to collection agencies.
5) A notice will be published each year in a newspaper of wide circulation in the primary service area of the hospital.

References

- Trinity Health. "Billing, Collection and Support for Patients with Payment Obligations", Trinity Health system policy 6-11-1, revised January 24, 2007.
- Federal Poverty Guidelines, HHS Federal Register

Questions and more information

Contact the financial counseling department at extension 7195 or the financial counseling manager at extension 7155 with questions and for more information.

Policy Modifications

The Holy Cross Hospital Board of Trustees must approve modifications to this policy. In addition, this policy will be presented to the Board for review and approval every two years.

Revision History

- Originating Department: Administration
- Original Date: April 9, 2009
- Latest Revision Date: September 29, 2011
- Effective: November 1, 2011

Approval

Name	Title	Date
Julie D. Keese	VP, Revenue Cycle Management	
Sr. Rachel Callahan, CSC	VP, Mission Services	
Roseanne Pajka	SVP, Corporate Development	
Anne Gillis	Acting CFO & VP of Finance	
Kevin J. Sexton	President and CEO	
Board of Trustees		10/27/11

HOLY CROSS HOSPITAL

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PATIENT INFORMATION SHEET

Holy Cross Hospital is committed to being the most trusted provider of healthcare in our community. That involves a commitment to provide accessible services to individuals who are uninsured or underinsured and do not have the resources to pay for necessary care. In addition, Holy Cross Hospital provides urgent or emergent care to all patients regardless of ability to pay.

Our Financial Assistance Program

Holy Cross Hospital provides substantial financial assistance to low-income patients who do not qualify for public programs such as Medicaid, MCHIP, MHIP, etc. or have insurance that does not cover medically necessary care. For qualifying patients, our program covers all medically necessary services charged and billed by the hospital and our hospital-based physicians such as emergency physicians, radiologists, pathologists, hospitalists, anesthesiologists and neonatologists.

Eligibility for our financial assistance program is determined on an individual basis, evaluating both income and assets. Qualifying patients must make less than 300% of the federal poverty level. Income limits vary by family size. In addition, qualifying patients must demonstrate less than $10,000 of net assets for an individual or less than $25,000 in net assets for a family. Once granted, the eligibility applies to all medically necessary services not covered by other programs unless the patient becomes eligible for coverage under public programs during this time.

Holy Cross Hospital offers financial assistance for individuals whom qualify under specific means-tested County, Local and State programs. These programs include Household with Children in the National School Lunch, Food Stamps or Supplemental Nutritional Assistance, Maryland Energy Assistance, Primary Adult Care, and Women, Infant and Children Programs. Additionally, Medical Financial Hardship assistance is also available if you have Holy Cross debt greater than 25% of your family income (not including co-insurance, co-payments, hospital based physician bills, and/or deductibles).

In order to evaluate eligibility, documentation must be provided to verify income and assets. For a listing of required documents and further details on how to apply for financial assistance, please request an application from any of our registration representatives or contact our financial counseling office at **301-754-7195**. The application can also be accessed through our website at www.holycrosshealth.org on our “For Patients & Visitors” page.

Patient’s Rights and Obligations

Maryland law requires that each hospital notify patients’ of their right to receive assistance in paying their hospital bill. Maryland law also requires that each hospital notify patients’ of their obligation to pay the hospital bill and provide complete and accurate information to the hospital in the timeframes specified.

Patients' have the **Right** to:

- Apply for financial assistance and if criteria are met, receive assistance from the hospital in paying their bill.
- Contact the hospital to request an explanation of their hospital bill and an itemization of services received.
- Contact the hospital for assistance if they feel they have been wrongly referred to a collection agency.

Patients' are **Obligated** to:

- Pay the hospital bill in a timely manner if they have the ability to pay.
- Contact the hospital immediately if the patient cannot afford to pay the bill in full and seek assistance in resolving their outstanding balance.
- Provide accurate and complete information to the hospital regarding insurance coverage prior to or at the time of service and upon request.
- Contact the hospital promptly to provide updated/corrected information if their financial position changes.

Hospital Contact Information

If you have questions about your bill, would like to request an itemized statement or to pay or establish payment arrangements for your bill, please contact a customer service representative at 301-754-7680, Monday through Friday, between 9:00 a.m. to 4:00 p.m. For your convenience, you may make an online payment using a major credit card by visiting our website at www.holycrosshealth.org.

Refer to "Our Financial Assistance Program" section for financial assistance contact information.

Applying for the Maryland Medical Assistance Program

For assistance in determining whether you qualify for Medicaid or other available programs, please contact one of the numbers below or visit the Maryland Department of Health and Mental Hygiene at www.dhmh.state.md.us/gethealthcare for more information.

Eligibility is based on medical conditions, economic situation, citizenship, age, and family size.

Silver Spring	Rockville	Germantown	Prince Georges Co.
Local Office 8818 Georgia Ave., 1st Fl. Silver Spring, MD 20910 Phone: 240-777-3100 **Service Eligibility Unit** 8630 Fenton Street, 10th Fl. Silver Spring, MD 20910 Phone: 240-777-3066	**Local Office** 1301 Piccard Dr., 2nd Fl. Rockville, MD 20852 Phone: 240-777-4600 **Service Eligibility Unit** 1335 Piccard Dr., 1st Fl. Rockville, MD 20852 Phone: 240-777-3120	**Local Office** 12900 Middlebrook Rd., 2nd Fl. Germantown, MD 20874 Phone: 240-777-3420 **Service Eligibility Unit** 12900 Middlebrook Rd., 2nd Germantown, MD 20874 Phone: 240-777-3591	**Local Office** 6505 Belcrest Rd. Hyattsville, MD 20782 Phone: 301-209-5000

Physician Services

Holy Cross Hospital does not employ the physicians who practice at the hospital, so each physician group that provided services to you will bill you separately for their services.

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

Holy Cross Hospital Mission, Vision and Value Statement

Our Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.

Our Core Values

- Respect
- Social justice
- Compassion
- Care of the poor and underserved
- Excellence

Our Role

Holy Cross Hospital in Silver Spring, Maryland, exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area.

Our health care team will achieve this trust through:

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

Listening. Responding. Improving Health.

Holy Cross Hospital's Commitment to Meeting the Needs of the Community

celebrating 50 years HOLY CROSS HOSPITAL

December 2012

In 2013, we celebrate **Holy Cross Hospital's 50th anniversary** and reflect upon the millions of patients and families who have trusted their health, lives and future to Holy Cross Hospital. With this trust comes a tremendous responsibility for Holy Cross Hospital to respond to the needs of our community.

Holy Cross Hospital's commitment to meeting community needs has always been, and will always be, a fundamental part of our mission and day-to-day operations. In fact, the Sisters of the Holy Cross, who founded Holy Cross Hospital in 1963, were themselves founded more than 150 years ago with a focus on responding to need – wherever that need may be. Holy Cross Hospital has demonstrated its commitment with consistent dedication and ever-increasing investments since we first opened our doors.

As a not-for-profit hospital and one of the largest hospitals in Maryland, we embrace our responsibility to reinvest our earnings into sustainable community benefit programs to improve the health of all those we serve and to ensure access to health care for all, regardless of a patient's ability to pay. In fiscal 2012, Holy Cross Hospital provided more than $47 million in community benefit including more than $23 million in free or reduced-cost services, through 327,000 encounters with community members.

Two years ago, the Maryland Health Services Cost Review Commission named Holy Cross Hospital one of only five exemplary community benefit programs in the state. This year, we were one of only four hospitals to be awarded a perfect score for our community benefit program.

The diverse community that we serve today brings great vitality to our community's culture, but also presents complex and varied health care needs to which we must respond. We regularly study our community and request feedback from community groups to identify the greatest unmet health care needs. Then we target our efforts toward those unmet needs that intersect with our organization's key strengths and mission commitments. We develop and implement innovative and sustainable community benefit programs that might not otherwise be available.

Through a collaborative community health needs assessment process, *Healthy Montgomery: The Montgomery County Community Health Improvement Process,* we identified unmet needs in the following six areas: cancer, diabetes, cardiovascular health, obesity, and maternity and infant health. We respond to needs in these areas by addressing lack of access, health inequalities and unhealthy behaviors.

This report highlights the needs assessment, as well as five innovative Holy Cross Hospital programs that demonstrate how we listen to our community's needs, respond with meaningful programs, and evaluate our efforts to ensure that we are improving our community's health.

As we look forward to the opening of Holy Cross Germantown Hospital in 2014, the addition of a new patient care building to Holy Cross Hospital in 2015, and the next 50 years, we will continue to uphold the commitment made in 1963 to improve the health of all those we serve.

Judith Ann Rogers

Judith Rogers
President
Holy Cross Hospital

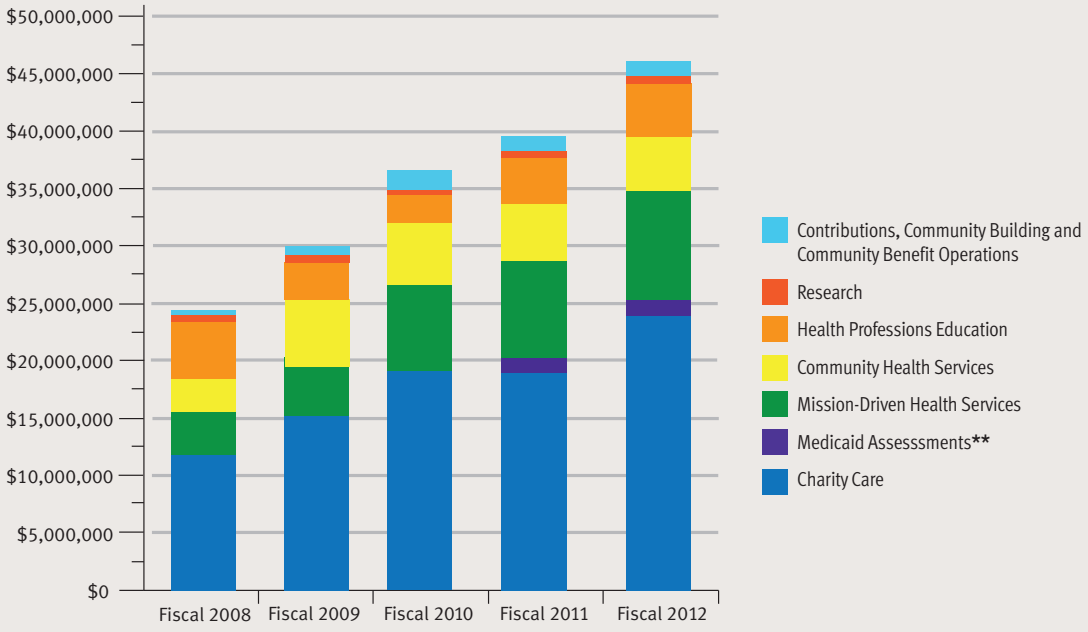
Highlights of Fiscal 2012 Quantifiable Community Benefits*

In fiscal 2012, Holy Cross Hospital provided more than $47 million in community benefit including more than $23 million in financial assistance.

	DIRECT COST	INDIRECT COST	OFFSETTING REVENUE	ENCOUNTERS	NET COMMUNITY BENEFIT
Charity Care *Providing services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay.*				25,289	$23,691,563
Medicaid Assessments** *Unpaid costs due to Medicaid shortfalls.*	$11,909,384	$0	$10,184,012	n/a	$1,725,372
Mission-Driven Health Services *Offering services that otherwise might not be available and are not expected to result in revenue.*	$5,410,899	$5,357,540	$767,446	51,058	$10,000,993
Community Health Services *Providing health screenings with links to treatment, as well as education, lectures and exercise programs.*	$3,618,275	$1,705,907	$293,344	220,301	$5,030,838
Health Professions Education *Hosting physician residency programs, training students of nursing and other disciplines, and operating a School of Radiologic Technology.*	$2,431,814	$1,677,679	$12,160	9,040	$4,097,333
Research *Participating in studies on health care delivery and clinical trials sponsored by government agencies, universities and foundations.*	$217,630	$150,158	$1,600	1,352	$366,188
Financial Contributions, Community Building and Community Benefit Operations *Providing administrative support for community benefit operations and supporting community organizations by providing in-kind services and hospital space.*	$1,317,089	$774,746	$0	20,840	$2,091,835
	$24,905,091	$9,666,030	$11,258,562	327,880	$47,004,122

A Tradition of Meeting the Needs of the Community

In the past five fiscal years, Holy Cross Hospital has provided more than $177 million in community benefit including more than $81 million in financial assistance.*



*Prepared according to guidelines established by the Maryland Health Services Cost Review Commission.

** Beginning in fiscal 2011, the Maryland Health Services Cost Review Commission required Maryland hospitals to account for Medicaid provider taxes for which hospitals do not receive offsetting revenue.

Approximately 120,000 adults who live in Montgomery County do not have health insurance.

We're Listening:

Research revealed that approximately 10 percent of Montgomery County residents and 15 percent of Prince George's County residents do not have health insurance. A lack of health insurance combined with the high cost of medical care and transportation challenges can decrease access to care and can lead to unmet health needs.

We're Responding:

The Transitional Care Program aims to link uninsured patients discharged from the hospital to a primary care provider at one of Holy Cross Hospital's three health centers, by providing coordination of care, ensuring health center follow-up, patient education, medication management, transportation assistance and links to self-care management programs. Key partners include Montgomery Cares, Suburban Hospital and MedStar Montgomery Medical Center.

We're Improving Health:

In fiscal 2012, 1,742 people met the Transitional Care Program criteria. Of the 1,258 with confirmed appointments within the first week of discharge or per discharge instructions, 1,126 (89.5 percent) kept their appointments. Of these patients, 632 became new health center patients. Compared to fiscal 2011, the readmission rate for the Transitional Care Program population decreased by 9.2 percent.

A Network of Health Centers Meet the Needs of the Uninsured and Ease the Transition from Hospital to Home

Approximately 120,000 adults who live in Montgomery County do not have health insurance. People who lack financial resources often postpone seeing a health care provider until their medical problems reach critical levels. As a result, they may require emergency services or more complex and expensive care.

"Holy Cross Hospital saw that the health care needs of uninsured adults were not being adequately met," said Elise C. Riley, MD, medical director, Community Care Delivery. *"The desire to help people who are underserved is at the heart of Holy Cross Hospital's mission, so we looked for ways to ease access to quality, affordable medical care for people who face financial barriers."*

Building a Network of Health Centers

To respond to this need, Holy Cross Hospital has opened three health centers that provide affordably priced care to low-income, uninsured Montgomery County adult residents.

In 2004, Holy Cross Hospital opened its first health center in the Health Sciences Center on Montgomery College's Takoma Park/Silver Spring Campus. In 2009, the second health center opened in Gaithersburg. In late April 2012, Holy Cross Hospital opened its third health center in Aspen Hill, which had more than 1,000 visits in the first two months. In 2012, the three centers together reached 100,000 visits since 2004.

"With the development of our network of health centers, we serve as one of the leading safety net providers in Montgomery County," said Calvin Robinson, executive director, Community Care Delivery. The health centers participate in Montgomery Cares, a public/private partnership that provides care to low-income, uninsured county residents through a network of clinics.

Access to Primary Care

The health centers provide follow-up care for emergency room and hospital visits, primary medical care, chronic disease management, behavioral health, preventive care, health education and annual screenings. Skilled medical professionals staff the centers, including physicians, nurse practitioners, physician assistants and registered nurses. Most of the staff are bilingual in English and Spanish, and interpretation and translation services are available for other languages.

"Our health centers redirect uninsured patients who need primary care away from very high-priced emergency care to a lower-cost outpatient alternative, which eases crowding in area emergency rooms and also helps control overall health care costs," said Robinson. *"But most importantly, the centers improve the quality, efficiency, continuity and equity of care that uninsured people receive."*

Easing the Transition from Hospital to Home for Uninsured Patients

After a hospitalization, patients sometimes return quickly to the hospital simply because they did not have an appointment with their medical provider or were unable to take care of themselves once they returned home – even if they received a specific diagnosis, appropriate treatment and instructions for follow-up care.

"It can be particularly challenging for uninsured patients to care for themselves after a hospitalization because they may not have the resources to access the follow-up care and support they need," said Dr. Riley.

In response to this need, Holy Cross Hospital launched the Transitional Care Program in fall 2010 to help uninsured patients successfully transition from the hospital to their home and to avoid re-hospitalization. Often the hospital identifies at-risk uninsured patients for special outreach even before they leave the hospital. A similar navigation program, the Emergency Department-Primary Care Connect (ED-PC Connect) project, has been in place at Holy Cross Hospital since 2009 to navigate uninsured patients from the Emergency Center to the health centers.

"Our hospital case managers review each person's diagnosis and medications prior to discharge to identify patients with special considerations," said Dr. Riley. *"For example, if an uninsured patient needs to see a physician quickly after discharge, the Transitional Care Program can help to ensure that the patient gets a timely appointment."*

A bilingual Transitional Care Program representative calls uninsured patients between one day and one week after discharge. *"During our follow-up calls, we educate patients about their hospital stay, ensure that they understand their diagnosis, confirm that follow-up appointments are made, and that the patients have the medications they need,"* said Wendy Friar, RN, vice president, Community Health.

The Transitional Care Program refers at-risk uninsured patients to their primary care clinic, if they have one, or to the Holy Cross Hospital health centers. The Transitional Care Program also provides patients with information about the hospital's community-based wellness education, exercise and chronic disease self-management programs.

"We educate and work with patients on how to self-manage their health conditions, and how to prevent other health problems in the future," said Friar. *"We care about people while they are in our hospital and while they are at home because our goal is to improve our patients' overall health and wellness."*

Senior Fit Improves Senior Health

Older adults are at high risk for heart disease and stroke, which are among the most widespread health problems in the nation. But they also are among the most preventable.

"Regular exercise is one of the most important ways to prevent heart disease," said Sarah McKechnie, manager, Community Fitness. *"Starting and maintaining a fitness regimen can be challenging for older adults, but Senior Fit provides a welcoming atmosphere with a spirit of teamwork that is highly motivating."*

Senior Fit is a free, conveniently located 45-minute multi-component exercise program for adults ages 55 and older of varying physical abilities. The program provides age-appropriate exercise classes to minimize symptoms of chronic disease and to improve strength, balance, flexibility and endurance. The program also encourages self-management of chronic diseases.

This best practice program operates according to the American College of Sports Medicine guidelines. Classes are taught by nationally certified fitness professionals who have experience working with seniors and people with chronic conditions. Participants are assessed twice a year using the evidence-based Rikli and Jones Senior Fitness Test to measure strength, speed, agility and flexibility.

"More than 3,500 people participate in Senior Fit classes in our community. It is a program where people come to stay fit and to encourage each other, and that is a powerful combination," said McKechnie.

In 2003, the National Council on Aging identified Senior Fit as one of the top 10 physical activity programs for older adults in the country. A year later, it was selected by the National Council on Aging as one of three sites for an impact study on exercise effectiveness in older adults.

We're Listening:

Older adults experience disproportionate rates of heart disease including congestive heart failure. Half of Montgomery County residents age 65 and older have high blood pressure.

We're Responding:

Each week, 68 Senior Fit classes are offered at 23 locations throughout Montgomery and Prince George's counties and the District of Columbia, through a partnership among Holy Cross Hospital, Kaiser Permanente, Montgomery County Department of Recreation, Maryland National Capital Parks and Planning Commission, local churches and Asbury Methodist Village. In fiscal 2012, Senior Fit enrolled 3,576 seniors and had 96,250 total encounters.

We're Improving Health:

Senior Fit participants are tested twice a year using the Rikli and Jones Senior Fitness Test, an evidence-based tool that measures functional fitness. Data from 2012 showed an increase in those who performed "above average" in lower body strength, speed and agility, upper body strength, and upper body flexibility. The data showed a decrease in "at risk" or "below average" scores for upper body flexibility. Participants also complete a qualitative evaluation that gathers information on satisfaction with program content, health status and demographic data.

In the past 20 years, obesity rates have doubled for adults and tripled for children.

Kid's Fit Makes Fitness Fun and Helps to Reduce Childhood Obesity

Obesity has been identified as a top health concern in Montgomery County, especially for African Americans and Latinos. Obese children are at greater risk for cardiovascular, orthopedic and other health problems later in life.

Since 2006 Holy Cross Hospital has offered Kid's Fit, a fitness program designed to reduce the rate of childhood obesity in Montgomery County. Kid's Fit is a free after school program for children ages 6 to 12 that includes exercise, information on healthy lifestyle choices and a nutritious snack. The program is held at four Housing Opportunities Commission sites and the Silver Spring Boys and Girls Club.

"Establishing healthy lifestyle habits early can lower a child's risk of becoming obese and developing chronic conditions," said Sarah McKechnie, manager, Community Fitness. *"Participants also gain a greater sense of self-confidence that they can achieve fitness goals through persistence and teamwork."*

"On May 12, 2012, 17 participants from Kid's Fit who attend class at our two Gaithersburg sites ran in their first Kids on the Run one-mile race. All children had to qualify to participate by being able to run 15 minutes without stopping," said McKechnie. *"Our Kid's Fit instructor trained the group and a Senior Fit participant recorded the finish times for the children. This was our first intergenerational event and it was the highlight of the year."*

In fiscal 2012, 141 children participated 5,288 times in Kid's Fit. The average participant age is 9 years old, and the majority of participants are African American/Black and Hispanic/Latino American. Each fall and spring, program participants take the evidence-based President's Challenge test to measure upper body strength (push ups), core strength (curl ups), speed/agility (shuttle run) and lower body flexibility (sit and reach).

We're Listening:

During the past 20 years, obesity rates have increased in the United States, doubling for adults and tripling for children. More than half of Montgomery County residents and more than 65 percent of Prince George's County residents are overweight or obese. Obesity levels are highest among African American/Black and Hispanic/Latino adults.

We're Responding:

The primary objectives of Kid's Fit are to increase awareness of healthy behaviors and to encourage regular physical activity to prevent or decrease obesity in children ages 6 to 12. Community partners include the Montgomery County Housing Opportunities Commission, and the Silver Spring Boys and Girls Club.

We're Improving Health:

Kid's Fit participants were evaluated in fall 2011 and spring 2012. The target for fiscal 2012 was to improve President's Challenge test scores by 5 percent. Overall scores for girls improved by 8 percent and overall scores for boys improved by 7 percent.

We're Listening:

Cancer is the second leading cause of death for both Montgomery County and Prince George's County residents and is the leading cause of death among Montgomery County Asians and Pacific Islanders. African American/Black women experience disparities in survival.

We're Responding:

The Komen Community Assisted Mammogram Program (K-CAMP) focuses on reducing disparities in breast health care among low-income, medically underserved, uninsured racial and ethnic minority women and men by providing high-quality, culturally competent outreach, education, screenings, navigation and case management services. Key partners include Community Clinic Inc.; Community Ministries of Rockville's Mansfield Kaseman Clinic; Diagnostic Medical Imaging, PA; Holy Cross Health Centers; People's Community Wellness Center; Proyecto Salud in Wheaton; Montgomery County African American Health Program; Montgomery County Asian American Health Initiative; CASA of Maryland Inc.; and Community Ministries of Rockville.

We're Improving Health:

In fiscal 2012, K-CAMP had 45,000 education encounters and provided 1,141 mammograms, 260 breast ultrasounds, 116 surgical referrals and 12 cancer diagnoses. The average time from diagnosis to treatment was three weeks. Case management and navigation services for abnormal findings were provided to 317 participants.

Improving Breast Health for Underserved Racial and Ethnic Minorities

Women of any income, race or ethnicity can develop breast cancer – one of the most common cancers.

"Women who are racially and ethnically diverse face documented disparities in care," said Shelly Tang, manager, Community and Minority Health. *"Women who are uninsured and have low incomes are more likely to be diagnosed with advanced breast cancer and are less likely to survive."*

Seeing the need to improve access to breast health care including education, screening, treatment and support services for low-income, medically underserved, uninsured or underinsured racial and ethnic minorities, Holy Cross Hospital developed the Komen Foundation Community Collaboration to Battle Breast Cancer (KFCC-BBC), also known as the Mammogram Assistance Program Services (MAPS) and Komen Community Assistance Mammogram Program (K-CAMP), in 2004.

"We target vulnerable community members where they live and work, providing culturally appropriate and linguistically sensitive breast health information with links to free breast care services," said Tang. *"Each year, outreach has expanded through the commitment of Holy Cross Hospital's ethnic health promoters, who are specially trained to provide target populations with culturally competent breast health education and links to appropriate resources."*

Since its inception, this program has provided more than 155,000 educational encounters to underserved community members focused on the importance of breast health and the early detection of breast cancer – including how to perform a breast self-examination. The program has provided more than 4,400 community members with free breast screenings.

In Montgomery and Prince George's counties, heart disease is the leading cause of death.

Linking People with Chronic Diseases to Strategies that Improve Quality of Life

Most people who have a chronic disease cannot fix it or make it go away. But how people choose to cope with it can make a big difference in their health and well-being.

"People who self-manage their chronic disease will very likely feel better," said Wendy Friar, RN, vice president, Community Health. *"They will gain better control of their condition, which will help them to avoid serious health issues that could result in emergency room visits or hospitalization."*

Since 2007, Holy Cross Hospital has offered Stanford University's evidence-based Chronic Disease Self-Management Program (CDSMP). *"The program helps people with chronic conditions, such as diabetes, arthritis or high blood pressure, to develop strategies to improve their overall health and quality of life,"* said Friar. *"The free class is six weeks long."*

The program is offered at multiple locations in the community, including five Housing Opportunities Commission of Montgomery County sites, the Holy Cross Hospital Health Center in Silver Spring, and Holy Cross Hospital Senior Source, an active aging center in Silver Spring.

"We link appropriate patients to this community-based wellness program at the time they are discharged from the hospital or when they are seen at our health centers," said Friar. *"This self-care program empowers patients and may prevent unplanned visits to medical providers, the emergency room or hospital, and improve the health status of our community."*

Holy Cross Hospital was selected to be a partner in a two-year (2010-2012) statewide grant to increase the number of CDSMP workshops offered in Maryland. Funding was provided by American Recovery and Reinvestment Act funds administered by the Maryland Department of Aging. Holy Cross Hospital created a toolkit to help other hospitals with the rollout of CDSMP workshops and to foster community partnerships to strengthen the health promotion and prevention network of service providers in Maryland.

We're Listening:

In Montgomery County and Prince George's County, heart disease is the leading cause of death, and men and African-Americans are disproportionately affected by heart disease mortality. Diabetes is the ninth leading cause of death in Montgomery County and the fourth leading cause of death in Prince George's County, and disproportionately affects African American/Black adults.

We're Responding:

Our Chronic Disease Self-Management Program focuses on enabling participants, who have one or more chronic diseases, to build self-confidence and to assume a major role in self-managing their chronic health conditions. In fiscal 2012, 15 workshops were held with 237 participants having 922 encounters, and 61 percent of participants attended at least four out of six sessions.

We're Improving Health:

At the completion of each workshop, participants are asked to complete a self-evaluation survey on their improved healthy behaviors, positive changes in health status, increased self-efficacy, better communications with health providers and fewer unplanned visits to physicians and emergency rooms. These indicators are collected and reviewed to evaluate the effectiveness of the program.

2012 Community Health Needs Assessment

In 2011, Holy Cross Hospital identified unmet community health needs by conducting a community health needs assessment in collaboration with the Montgomery County Healthy Montgomery Community Health Improvement Process (healthymontgomery.org). The hospital also analyzed needs assessments and data about the market, demographics, socio-economic factors and health service utilization, and participated in community coalitions, commissions, committees, boards, partnerships, advisory groups and panels.

In 2012, the needs assessment was amended to include priorities established by the Healthy Montgomery Steering Committee. Unmet community health needs have been identified in the six areas described in the chart on the following page. In addition, there are three overarching themes that address each priority area: lack of access, health inequalities and unhealthy behaviors.

Each year, Holy Cross Hospital invites the advice of an external review committee, which consists of the Montgomery County Department of Health and Human Services director, Montgomery County's Public Health officer and community representatives with expertise in public health, health disparities, social determinants of health and other health-related topics to review its community benefit plan and provide recommendations for the hospital's community benefit focus. The hospital's activities focus on positively impacting the health of our community with a continuum of care that is tailored to meet the unique needs of women, infants, seniors, and racial, ethnic and linguistic minorities.

Holy Cross Health's board of trustees approves an annual community benefit plan and the Mission and Strategy Committee of the board provides quarterly oversight. The CEO Review Committee on Community Benefit and senior management council monitor and evaluate performance. The hospital's annual operating plan and budgeting process include designated targets and expenditures dedicated to community benefit. The complete 2012 Community Health Needs Assessment and Multi-Year Community Benefit Implementation Strategy are available on the hospital's website, www.holycrosshealth.org.

Financial Assistance

Holy Cross Hospital is committed to reducing financial barriers to health care services for people who are poor or underinsured. The hospital's financial assistance policy establishes 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.

The policy covers all medically necessary services rendered by the hospital and by hospital-based physicians. Eligibility is based on a patient's household income and accumulated net assets. Once eligibility is established, the patient remains eligible for six months thus eliminating the need for reapplication at each admission.

In fiscal 2012, Holy Cross Hospital provided more than $23 million in financial assistance through 25,289 encounters with community members.

Healthy Montgomery Priority	Holy Cross Hospital's Multi-Year Response to Unmet Need			Holy Cross Hospital's Method of Evaluation
	Lack of Access	Unhealthy Behaviors	Health Inequities	
Cancer A leading cause of death; 50% more African American/Black women die from breast cancer than White women	• Minority and Community Outreach: Mammogram Assistance Program screening mammograms, navigation, biopsy, ultrasound and surgery	• Minority and Community Outreach: Mammogram Assistance Program breast education and self examination	• Minority and Community Outreach: cancer outreach, screening and prevention programs	• Number of mammograms • Number of breast cancers found • Number of cancer education encounters • Number of cancer screenings for at-risk minorities
Diabetes A leading cause of death for African American/Black women; disparities	• Health centers in Silver Spring, Gaithersburg and Aspen Hill	• Senior Source: Diabetes Prevention Program (DPP) • Community Fitness: Chronic Disease Self-Management Program (CDSMP)	• CDSMP and DPP classes offered in Spanish	• Number of visits • Progress on diabetes indicators • Number of pre-diabetics advancing to diabetics • Reduction in hospital admissions and readmissions • CDSMP and DPP encounters
Cardiovascular Health A leading cause of death; half of seniors have high cholesterol levels	• Health centers in Silver Spring, Gaithersburg and Aspen Hill	• Community Fitness Program: Senior Fit	• Minority and Community Outreach Program: ABCS Block Grant	• Semi-annual fitness assessments • Progress on heart failure indicators • Number of education encounters • Number of people referred to health centers • Number of people with kept appointments
Obesity More than 50% in Montgomery County are overweight or obese	• Health centers in Silver Spring, Gaithersburg and Aspen Hill • OB/GYN Clinic	• Community Fitness Program: Kid's Fit	• OB/GYN, Perinatal and Community Fitness: Obesity in Pregnancy Programs	• Semi-annual fitness assessments • Number enrolled in obesity in pregnancy programs
Maternal and Infant Health Opportunities to improve maternity care processes and outcomes within subpopulations	• OB/GYN Clinic • Maternity Partnership Program	• Perinatal community education classes	• OB/GYN Clinic • Maternity Partnership Program	• Number of admissions to Maternity Partnership • Number of perinatal class encounters • Percent low birth weight • Reduction in infant mortality

About Holy Cross Hospital
Holy Cross Hospital is one of the largest hospitals in Maryland. Founded in 1963 by the Congregation of the Sisters of the Holy Cross, today Holy Cross Hospital is a 442-bed, not-for-profit teaching hospital caring for more than 196,000 patients each year. Holy Cross Hospital offers a full range of inpatient, outpatient and community-based health care services, with specialized expertise in women and infant services, senior services, surgery, neuroscience and cancer. Holy Cross Hospital is a member of Trinity Health of Novi, Michigan, one of the largest health systems in the country.

Mission, Values and Role
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 Health 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's community benefit, contact Wendy Friar, vice president of Community Health and community benefit officer, at **301-754-7161** or **friarw@holycrosshealth.org**, or Kimberley McBride, manager, Community Benefit, at **301-754-7149** or **mcbrik@holycrosshealth.org**.

HOLY CROSS HOSPITAL
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