FY 2011 COMMUNITY BENEFIT NARRATIVE REPORT

prepared by Chester River Hospital Center

December 2011

for

The Health Services Cost Review Commission (HSCRC)

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

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
47	2,787	21620 Chestertown (Kent Co) 21661 Rock Hall (Kent Co) 21678 Worton (Kent Co) 21651 Millington (Kent Co & Queen Anne's Co)	Memorial at Easton Anne Arundel Medical Center Union Hospital	Kent 2.4% Queen Anne's 0.4% Caroline 0.4% Total 3.2%	Kent 11.5% Queen Anne's 3.2% Caroline 1.0% Total 15.7%

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.)

Chester River Hospital Center's (CRHC) primary service area (PSA) and community benefit area (CBSA) are the same, which includes Kent County, along with portions of upper (northern) Queen Anne's County. CRHC also serves portions of southern Cecil County and northern Caroline County, although not part of the community benefit area or primary services area. For the purposes of this report, all information and data represent Kent County.

Kent County, with a total population of 19,197, is bordered by Cecil County in the north, Queen Anne's county to the south, Delaware to the east, and the Chesapeake Bay on its west. According to the 2000 Census, the majority of the population is living in what is described as a rural area; no population is reported as living in an urban area. There were 117,372 acres of farm land reported in 2002, which makes agriculture one of the leading industries in Kent County. It has a higher percentage of the population aged 65 years and older. Kent County is unique in that nearly 21% of its residents are 65 years of age or older, which is 65% higher than Maryland's percentage and higher than other rural areas in the state by almost a quarter. This makes Kent County's population one of the oldest, aging populations in Maryland. Approximately 16% of the residents of Kent County are African-American/Black. The Hispanic population is growing, but accounts for only a small percentage of the population (approximately 546 of Hispanic origin).

Nearly 30% of the population is classified as low income, with 21% without insurance. Kent County ranked number one in the state for percentage of deaths related to Alzheimer's, a disease mostly associated with the aging population. The report also noted that Kent County has a higher prevalence of hypertension, high cholesterol, obesity and diabetes than Maryland. Children living on the Eastern Shore are more likely to have dental caries, yet less likely to have dental sealant or restoration than other parts of the state. Alcohol abuse and mental health diagnoses occur at significantly higher rates than the state average, too.

This is a rural area populated by active farmers and small, close-knit communities. Transportation is often a barrier for access to health care services.

Key characters and statistics about Kent County's population (*source Kent County Health Needs Assessment, 2009; U.S. Census Data 2000; U.S. Census Bureau, Small Area Income & Poverty Estimates, 2009*):

- Poverty among adults and children in Kent County has been increasing since 2000.
- Kent County has one of the highest populations of residents aged 65 years and older, while the age group made of children age 18 years and younger is decreasing.
- African-Americans/Blacks living in Kent County experience poverty at a disproportionately higher rate than other racial groups.
- Seasonal residents and recreational visitors to Kent County aren't accounted for in official estimates, but still use county health resources, including the emergency room and EMS; county tourism board unofficial estimates about 100,000 tourists visit Kent County each year.
- Nearly 40% of the population has public health insurance, such as Medicare and Medicaid; approximately 15% have no health insurance.
- Kent County has a higher reported prevalence of hypertension, high cholesterol and diabetes than Maryland.
- Kent County's total population of 19,197 reflects 546 people of Hispanic origin; 837 people with less than a 9^{th} grade education; 1,942 completing 9^{th}-12^{th} grades, but with no diploma; and 10.7% of the population below poverty level.

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).

Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age) *(Source: U.S. Census Bureau, 2000)*	**Kent County** Target Population: 19,197 total Male: 9,9192 / 47.9% Female: 10,005 / 52.1% White: 15,288 / 79.6% African American or Black: 3,343 / 17.4% Hispanic or Latino: 546 / 2.8% American Indian: 28 / 0.1% Asian: 103 / 0.5% Average/Median Age: 41.3
Median Household Income within the CBSA *(Source: American Community Survey, U.S. Census Bureau, 2009)*	**Kent County** $48,284
Percentage of households with incomes below the federal poverty guidelines within the CBSA *(Source: American Community Survey, U.S. Census Bureau, 2009)*	**Kent County** 5.2 % (families) 12.5% (individuals)
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml *(Source: American Community Survey, U.S. Census Bureau, 2009)*	**Kent County** 21%
Percentage of Medicaid recipients by County within the CBSA.	**Kent County**

(*Source: County Health Risk Factors http://county-health.findthedata.org/l/1205/Kent)*	18.06%
Life Expectancy by County within the CBSA. *(Source: Maryland Vital Statistics Annual Report 2009)*	**Kent County** 77.5
Mortality Rates by County within the CBSA. *(Source: Maryland Department of Health and Mental Hygiene, Maryland Vital Statistics Report 2002-2007)*	**Kent County** (per 100,000) Diseases of the heart 193.9 All Cancers 191.4 Lung Cancer 58.4 Breast Cancer 23.2 Accidents 35.7
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) (*Source: County Health Rankings, www.countyhealthrankings.org/maryland/kent; Housing Characteristics for the Region, U.S. Census Bureau, 2000; http://www.city-data.com/county/Kent_County-MD)*	**Kent County** **Access to healthy food** 44% **Quality of housing** Total housing units 9,410 Occupied housing units 7,666 Renter –occupied housing units 2,271 Median contract rent $676 (per month) Median contract rent for apartments: $676 Estimated median house/condo value: $262,962 Mean price for detached houses: $367,330 Mean price for townhouses or other attached units: $260,130 Mean price for mobile homes: $128,309 **Transportation** Vehicles available No vehicles 2% 1 vehicle 15.8% 2 vehicles 40.7%

	3 or more vehicles 41.5% Means of transportation to work: • Drove a car alone: 6,658 (73%) • Carpooled: 1,031 (11%) • Bus or trolley bus: 32 (0%) • Taxi: 8 (0%) • Motorcycle: 3 (0%) • Bicycle: 19 (0%) • Walked: 720 (8%) • Other means: 162 (2%) • Worked at home: 427 (5%) Average travel time to work 24.5 minutes Note: There is regional transportation system, Maryland Upper Shore Transit (MUST), which provides low cost service for many counties, including Kent County.
Other: Employment statistics *(Source: U.S. Bureau of Labor Statistics, www.bls.gov)*	Employment In the labor force 63.6% Not in labor force 36.4% Work in county of residence 73.5% Work outside county of residence 15.4% Work outside State of residence 11.1% Work at home 6 %

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health improvement plan (http://dhmh.maryland.gov/ship/);
(2) Local Health Departments;
(3) County Health Rankings (http://www.countyhealthrankings.org);
(4) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(5) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(6) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(7) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(8) 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;
(9) 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;
(10) Survey of community residents
(11) Use of data or statistics compiled by county, state, or federal governments; and
(12) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers.

Please note: Chester River Hospital Center, member of Chester River Health System, did not conduct a community health needs assessment, as described by the federal reform bill in FY 2011. Such an assessment is being conducted in FY2012 and will be fully implemented in FY2013.

The last time that Chester River Hospital Center participated in a formal community needs assessment was in calendar year 2008, with the full report compiled and published in May 2009 (*Kent County Health Needs Assessment* by Mid-Atlantic Association of Community Health Centers). This report has been utilized for the last three fiscal years to identify the needs of the community served Chester River Hospital Center, along with information provided both of our local health departments Kent and Queen Anne's counties.

The information provided below reflects the standard assessment process, typically conducted each year by Chester River Hospital Center.

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.

   Chester River Hospital Center (CRHC) identifies the health needs for its primary service area (Kent County and northern Queen Anne's County) by utilizing the data available in the *Kent County Health Needs Assessment, May 2009.* Additional resources used to identify community health needs for FY 2011 include: the Maryland Department of Health and Mental Hygiene's State Improvement Plan (SHIP, http://dhmh.maryland.gov./ship); the *Healthy People 2020* guidelines (http://www.cdc.gov/nchs/healthy_people/hp2010.htm), Maryland DHHS; and county health rankings (http://www.countyhealthrankings.org). These data sources are used to guide and direct the community benefit plan activities for Chester River Hospital.

   CRHC also used data collected from its strategic plan. During FY2010, Chester River Hospital Center completed a strategic planning process from November 2009 through April 2010. The purpose of the strategic plan was to provide direction for Chester River Health System for the next three to five years. CRHS retained the services of a consultant and formed a planning committee to develop the strategic plan. The strategic planning process gathered input and information from a variety of community sources, including:

   - Interviews with Board members, medical staff, management and community members/leaders
   - Meetings/interviews with CRHS employees
   - Meetings/interviews with physicians
   - Consumer telephone survey (500 telephone interviews with area residents)
   - Consumer survey (438 community members completed a printed form survey)

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

   Chester River Hospital Center has relationships with the local health departments, including Kent County Health Department and Queen Anne's County Health Department. CRHC staff attends committee meetings at both health departments, enabling the exchange of information regarding the health of the community.

CRHC also has relationships with churches/church groups and spiritual leaders, including the Chester Valley Ministries Association and the Bethel African Methodist Episcopal Church and MOTA Program. Churches and church groups often host cultural diversity activities that are targeted to educate specific minority groups on cancer, diabetes and heart disease. This allows CRHC the opportunity to collaborate with other organizations throughout Kent County to address a variety of health concerns and needs.

Many of CRHC senior leadership are members of boards, community work groups and committees that target the health care needs of the community. This affords the opportunity for CRHC staff to exchange ideas and develop programs with these community organizations.

3. **When was the most recent needs identification process or community health needs assessment completed?**
   Provide date here. 05/01/2010

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

   *Chester River Hospital Center did participate in a health needs assessment process during 2008, which is when Kent County received a grant to examine the health need of its community. The grant was through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) Planning Grant. The grant brought together community residents and organizations to examine the needs of the community; determine a course of action to address the needs; and to examine the community health center model. The needs assessment was completed of staff of the Mid-Atlantic Association of Community Health Centers. Scott Burleson, VP of Chester River Hospital and Mary Jo Keefe, VP of Patient Care at Chester River Hospital, both participated in the needs assessment process.

   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.

I. COMMUNITY BENEFIT ADMINISTRATION

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

a. Does your hospital have a CB strategic plan?

___Yes
_X_No*

*Although CRHC does not have a separate Community Benefit Strategic Plan, CRHC has community benefit activities outlined in the Chester River Health System Strategic Plan. The CRHC CB strategic plan is part of the overall Chester River Health system Strategic Plan.

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 (please specify): VP of Patient Care Services, VP of Hospital, Board of Directors

ii. Clinical Leadership

1. ___Physician
2. _X_Nurse
3. _X_Social Worker
4. _X_Other (please specify): Clinical Community Outreach Educator

iii. Community Benefit Department/Team

1. _X_ Individuals Director of Marketing & Public Relations (1 FTE)
2. _X_ Committee
   - Sam Marinelli, Chief Financial Officer, CRHS
   - Donna Jacobs, Senior Vice President Government and Regulatory Affairs
3. _X_ Other (please describe): Department Managers and staff members from departments across CRHC meet two-three times each year to review the yearly CB activities calendar. The managers and

staff include: Sherrie Hill, RN, Cardiac Rehab Coordinator; Chrissy Nelson, RN, CDE, Diabetes Educator; Mary King, RD, LD, CDE, Dietician/ Dietary Supervisor; Kelly Bottomley, Radiology Manager/Women's Health Coordinator; Alicia Dodd, Lab; Josh Barnes, RN, Clinical Education Coordinator; Sam Ricketts, RNC, Community Outreach Coordinator.

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

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

II. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

a. Identified need: This includes the community needs identified in your most recent community health needs assessment.

b. Name of Initiative: insert name of initiative.

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

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

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

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

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

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

See attachment, labeled Table III.

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?

Major Needs Identified:

The primary community health needs identified include:

- Heart Disease
- Cancer (particularly Prostate Cancer and Breast Cancer)
- Diabetes
- High Blood Pressure (Hypertension)
- High Cholesterol
- Nutrition
- Overweight/Obesity
- Child/Adolescent Oral Health
- Tobacco Use/Smoking
- Alcohol/Binge Drinking/Underage Drinking
- Maternal, Infant & Child Health

All primary health needs are being addressed to the extent that available resources and clinical expertise allows. The CRHC community benefits plan is able to adequately address heart disease, prostate cancer, breast cancer, diabetes, hypertension, high cholesterol and oral health. Nutrition, overweight/obesity and maternal, infant and child health is addressed through educational classes. Tobacco use/smoking and alcohol/binge drinking/underage drinking are being addressed by other county agencies and organizations, including the Kent County Health Department.

Attachment, Table III, describes initiative undertaken to address the identified needs.

Table III

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Cancer Mortality (Prostate)	Annual Prostate Cancer Dinner and Free Screening	The primary objective of the Annual Prostate Cancer Dinner and Free Screening is to provide a free screening opportunity, to educate about prostate cancer, as well as build awareness about the benefits of early detection of prostate cancer. This initiative is open to all men, but focused outreach is on areas of county with a high African American /Black population. Spiritual leaders and churches are engaged. The free screening program offers both the PSA (prostate specific antigen) test and the DRE (digital rectal exam) exam. It is performed by one of our community physicians from CRHC's Medical Staff, a prostate cancer survivor himself. The Prostate Cancer Dinner provides an opportunity for the local male population to learn about prostate cancer in a casual format. The program includes a free dinner and features speakers, including a physician, prostate cancer survivors, and members of the prostate cancer support group. CRHC also hosts a free, monthly Prostate Cancer Support Group that features guest speakers on the topic of prostate cancer.	Multi-year initiative	Chester River Hospital Center is the lead host/sponsor of the annual Prostate Cancer Dinner and Free Screening. The Kent County Health Department also provides their cancer coordinator, who attends the Prostate Cancer Dinner. A private practice community physician from CRHC's Medical Staff conducts the screenings and reviews results. CRHC's Lab provides the PSA test results.	Prostate Cancer Dinner, September 15, 2010. Prostate Cancer Free Screening September 22, 2010.	Through this initiative 45 men were screened for prostate cancer. All participants received their screening results by mail and were instructed and encouraged to share their results with their primary care physician. All participants were provided with educational materials about prostate cancer and were informed about the Prostate Cancer Support Group. Uninsured participants are referred, if necessary, to the Kent County Health Department's Cancer Program.	CRHC is planning on continuing with this initiative. However, considering the new screening guidelines issued by the American Urological Association this past September 2011, portions of this program may be reviewed and revised for the future.

Table III

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Heart Disease, High Blood Pressure (Hypertension)	"The Beat Goes On" annual heart disease education event, held during the month of February, which is American Heart Month.	The primary objective for the annual heart disease education event, titled "The Beat Goes On", is to educate the community about heart disease and to build awareness about it. This program happens every February in honor of American Heart Month, building on the momentum that the American Heart Association's national advertising campaign creates. This is always a free event that features speakers that include a community cardiologist, as well as CRHC's Cardiac Rehab Nurse and hospital dietician. This year CRHC's new pharmacist spoke about the newest medications associated with heart conditions/heart disease. Discussion topics include heart disease, high cholesterol, high blood pressure, and obesity. Special attention is given to educating about preventative measures, including a healthy diet and exercise. Free blood pressure screenings are provided, not just at this event, but throughout the community during the month of February (churches, health fairs). Information is provided regarding the free monthly Mended Hearts Support Group.	Multi-year initiative	CRHC is the host/sponsor of this annual educational program. CRHC's Medical Staff cardiologist is a yearly presenter, and CRHC's Cardiac Rehab nurses provide additional health information and free blood pressure screenings. The Mended Hearts Support Group is invited to exhibit at this program.	February 22, 2011	A total of 58 community members attended this event. All participants were provided with educational materials about heart disease, as well as healthy nutrition information. Free blood pressure screenings were provided to the participants and they were invited to attend the upcoming Community Health Fair in Worton, on March 12, 2011, where free cholesterol screenings would be provided. CRHC uses health fairs typically to reach larger portion of service area/CBSA, which is when most free screenings are provided. Heart healthy food was provided, along with heart healthy recipes and tips on lowering sodium in cooking.	Yes. This program is repeated every February. In past year's specific populations were focused on, such as women , since heart disease, known as the "silent Killer", and kills more women in the US than all cancers combined. FY 12 program will focus on women.

Table III

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Diabetes	Annual educational program for American Diabetes Month, "Living with Diabetes"	The primary objective of this annual educational program is to educate the community about diabetes and to raise awareness about lifestyle changes that can prevent onset of type 2 diabetes. Kent County has a high incidence of diabetes, especially in the African American/Black community. CRHC's diabetes nurse/educator regularly speaks to church groups and other community organizations about diabetes. CRHC has a comprehensive educational and lifestyle-change program called "Managing Your Diabetes," which is led by the diabetes nurse/educator. CRHC diabetes nurse/educator also facilitates the free monthly diabetes support group. The diabetes nurse/educator hosts Diabetes Alert Day in March, providing free glucose screenings.	Multi-year initiative	CRHC hosts/sponsors this yearly program, but partners with Shore Health System, who has an endocrinologist on their Medical Staff. The endocrinologist speaks at CRHC's program.	November 30, 2010	A total of 45 people attended this event. Each participant provided with educational materials about diabetes, including nutrition information, and weight management information. All participants informed and encouraged to attend the Community Health Fair in Worton, on March 12, 2011, where free glucose screenings would be provided. CRHC uses health fairs typically to reach larger portion of service area/CBSA, which is when most free screenings are provided.	Yes, this initiative is continued each year.

Table III

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Cancer, Diabetes, Heart Disease, Obesity	Health Fair, held in new Kent County Community Center, Worton	This initiative focused on providing health information and free screenings for a variety of chronic diseases and cancers. The Health Fair was held at the new Kent County Community Center in Worton. Information and free screenings were provided for breast cancer, prostate cancer, heart disease, healthy nutrition, obesity, and diabetes. The Community Health Fair was open to all of the CRHC's service area/CBSA, but focus was put on the African American/Black community. Church bulletins and fliers, as well as print/radio advertising was utilized to target populations.	Will be a multi-year; planning for FY 12 Fair in March 2012	CRHC partnered with several community organizations and groups, including: Kent County Health Dept; Kent County Parks & Rec; and CATS (Citizens Against Tobacco Smoke, which is a group of citizens, primarily African American)	March 12, 9am-1pm	This first time initiative was very successful. 100 people attended. African Americans/Blacks accounting for approximately 40% of attendees. Not all attendees participated in the free, onsite screenings, but vouchers were provided for attendees to use at a later date for glucose and cholesterol screenings.	Yes, a March 2012 Health Fair has been planned.

Table III

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Underage Drinking/ Bunge Drinking	"Dew it Right Youth Rally"	The primary objective of this event was to provide the youth of our community with a healthy alternative to underage consumption of alcohol. The event was held on March 5 from 2pm-10pm at Chesapeake College. There were a variety of activities, demonstrations and displays for the youth, including Interactive games, guest speakers, bands, a mock ar crash.	Multi-year	CRHC partnered with Terry Ober, RESET and Mid-Shore Traffic Safety coordinator. CRHC supplied the staff for the mock crash /mock Emergency Room demonstration. CRHC was a sponsor of this event.	March 5, 2011.	Approximately 150 youth attended this event from Mid-Shore counties, including Kent. It provided youth with alternative activities, while educating about the dangers of underage drinking.	Yes, this event is in planning stage for 2012. CRHC will be a sponsor and participate in this event.

III. 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.

Chester River Hospital Center currently has the following gaps in the availability of specialist providers to serve patients in our service area, including but not limited to the uninsured:

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

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

Psychiatry – there are no psychiatrists serving our community and mental health is a significant need. We refer patients requiring inpatient treatment to surrounding facilities in Cambridge and Elkton; we refer outpatients to psychiatrists, social workers, counselors in private practice or to the Kent or Queen Anne's counties mental health departments, if the patients qualify for those services.

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

Cardiology – although there are two cardiologists on the medical staff at Chester River, which is an appropriate number according to our medical staff development plan. We transfer emergency cardiology cases primarily to University of Maryland Medical Center. We pay for cardiology coverage for one weekend a month and holiday weekends .

Orthopedics – although Chester River Hospital has an adequate number of orthopedic surgeons on the medical staff based on our medical staff development plan, we do not have continual emergency department coverage in this area. Orthopedic trauma cases are generally transported directly to Shock Trauma, bypassing our hospital. Emergency cases may be transferred to Union Hospital in Elkton. Inpatients are visited by our orthopedic surgeons following admission and patients who are

discharged from the Emergency Department are directed to follow-up with orthopedic physicians in their private practice.

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.

Chester River Hospital Center started a hospitalist program in August 2008 due to many local primary care/family practitioners who choose to no longer see patients in the hospital. The hospital incurs costs for additional physicians for on-call emergency services coverage. In addition, the hospital pays for some cardiology coverage about one weekend per month, as well as for services across multiple specialties. From November 15, 2010 through June 30, 2011, the hospital paid for coverage of a primary care physician in Galena, because the one physician serving the community left the area. To insure anesthesia coverage and services of indigent patient population, the hospital incurred additional costs. Recruitment efforts include recruiting for additional hospitalists, emergency physicians, urologists and other specialties.

IV. APPENDICES

To Be Attached as Appendices:

1. **Describe your Charity Care policy:**
    a. **Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix 1)**

For *example*, state whether the hospital:

- **posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;**
- **provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;**
- **provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;**
- **includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or**
- **discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.**

Appendix 1. Description of Charity Care Policy

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

Chester River Hospital Center is committed to providing excellent medical care to our patients regardless of their ability to pay for those services. This policy has been established to assist patients in obtaining financial aid when it is beyond their financial ability to pay for services received.

Chester River Hospital Center's registrars provide the hospital's patient financial assistance program packet to all self-pay inpatients and outpatients at the time of registration. Emergency department patients who are self-pay also receive this packet if their condition permits. Emergency department patients who are admitted are visited by the hospital's credit and collection officer while in the hospital, and the packet is provided to them at that time. The packet is also available by request. The forms are available in English and Spanish.

Signage is posted in the Emergency Department, registration and Business Office areas to notify patients of our patient financial assistance programs.

Chester River Hospital Center has engaged ROI, a firm which works with patients to help them qualify for medical assistance.

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

Chester River Hospital Center Policy, Patient Financial Services – Financial Assistance Program attached.

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

Appendix 3. Chester River Hospital Center's Mission, Vision and Value statements:

Mission Statement:

Chester River Health System, a member of University of Maryland Medical System, is an integrated rural delivery system dedicated to providing excellent and caring health services and facilities to the people of the Upper Eastern Shore.

Vision Statement:

Exceptional healthcare services in a caring environment.

Values:

Compassion: We attend to the needs of those we serve with tender care, empathy and equality.
Respect: We recognize the dignity and value of life in every stage and condition.
Excellence: We strive for the highest of personal and organizational standards.
Collaboration: We build relationships based on cooperation, commitment and teamwork.
Responsibility: We operate in an efficient manner to meet our fiscal and social obligations to the communities we serve.
Integrity: We conduct ourselves in an honest, fair and ethical manner.

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1. *POLICY*

a. This policy applies to Chester River Health Center ("CRHC"). CRHC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

b. It is the policy of CRHC to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

c. CRHC will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

d. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

e. CRHC retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications to the Financial Assistance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

2. *PROGRAM ELIGIBILITY*

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, CRHC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further CRHC commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, CRHC reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the CRHC primary service area are included in ***Attachment A***. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

b. Specific exclusions to coverage under the Financial Assistance program include the following:

   i) Services provided by healthcare providers not affiliated with CRHC (e.g., home health services)

   ii) Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Assistance Program.

      (1) Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

   iii) Unpaid balances resulting from cosmetic or other non-medically necessary services

   iv) Patient convenience items

   v) Patient meals and lodging

vi) Physician charges related to the date of service are excluded from CRHC's financial assistance policy. Patient's who wish to pursue financial assistance for physician-related bills must contact the physician directly.

c. Patients may become ineligible for Financial Assistance for the following reasons:

i) Refusal to provide requested documentation or providing incomplete information.

ii) Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to CRHC due to insurance plan restrictions/limits.

iii) Failure to pay co-payments as required by the Financial Assistance Program.

iv) Failure to keep current on existing payment arrangements with CRHC.

v) Failure to make appropriate arrangements on past payment obligations owed to CRHC (including those patients who were referred to an outside collection agency for a previous debt).

vi) Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

d. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section 3 below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

f. Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follow the sliding scale included in ***Attachment B***.

3. PRESUMPTIVE FINANCIAL ASSISTANCE

a. Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, CRHC reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only Financial Assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

i) Active Medical Assistance pharmacy coverage

ii) Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums)

iii) Primary Adult Care ("PAC") coverage

iv) Homelessness

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v) Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs

vi) Maryland Public Health System Emergency Petition patients

vii) Participation in Women, Infants and Children Programs ("WIC")

viii) Food Stamp eligibility

ix) Eligibility for other state or local assistance programs

x) Patient is deceased with no known estate

xi) Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

b. Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

i) Reside in primary service area (address has been verified)

ii) Lacking health insurance coverage

iii) Not enrolled in Medical Assistance for date of service

iv) Indicate an inability to pay for their care

v) Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

c. Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

i) Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

ii) Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance program until the Maryland Medicaid Psych program has been billed.

iii) Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4. ***MEDICAL HARDSHIP***

a. Patients falling outside of conventional income or presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program.

i) Uninsured Medical Hardship criteria is State defined:

(1) Combined household income less than 500% of federal poverty guidelines

(2) Having incurred collective family hospital medical debt at CRHC exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

(3) The medical debt excludes co-payments, co-insurance and deductibles

b. Patient balance after insurance

i) CRHC applies the State established income, medical debt and time frame criteria to patient balance after insurance applications

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c. Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in **Attachment B.**

d. If determined eligible, patients and their immediate family are certified for a 12 month period effective with the date on which the reduced cost medically necessary care was initially received

e. Individual patient situation consideration:

   i) CRHC reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

   ii) The eligibility duration and discount amount is patient-situation specific.

   iii) Patient balance after insurance accounts may be eligible for consideration.

   iv) Cases falling into this category require management level review and approval.

f. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, CRHC is to apply the greater of the two discounts.

g. Patient is required to notify CRHC of their potential eligibility for this component of the financial assistance program.

5. ASSET CONSIDERATION

a. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

b. Under current legislation, the following assets are exempt from consideration:

   i) The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.

   ii) Up to $150,000 in primary residence equity.

   iii) Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6. APPEALS

a. Patients whose financial assistance applications are denied have the option to appeal the decision.

b. Appeals can be initiated verbally or written.

c. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

d. Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

e. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration

f. The escalation can progress up to the Chief Financial Officer who will render a final decision.

g. A letter of final determination will be submitted to each patient who has formally submitted an appeal.

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7. PATIENT REFUND

a. Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration

b. Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

c. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8. JUDGEMENTS

a. If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, CRHC shall seek to vacate the judgment and/or strike the adverse credit information.

9. PROCEDURES

a. Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

b. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   i) Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

   ii) Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

   iii) CRHC will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

   iv) Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

   v) Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

c. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

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ii. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

iii. Proof of social security income (if applicable)

iv. A Medical Assistance Notice of Determination (if applicable).

v. Proof of U.S. citizenship or lawful permanent residence status (green card).

vi. Reasonable proof of other declared expenses.

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

d. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on CRHC guidelines.

i. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

(1) If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

(2) If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled.

(a) A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

e. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

f. The following may result in the reconsideration of Financial Assistance approval:

i. Post approval discovery of an ability to pay

ii. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to CRHC

g. CRHC will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

h. If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

DEVELOPER
Patient Financial Services Department, CRHC

Reviewed/Revised: 10-01-2010

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ATTACHMENT A

The following zip codes represent the coverage areas for the respective Entities:

21607, 21610, 21617, 21619, 21620, 21620, 21623, 21628, 21635, 21638, 21644, 21645, 21650, 21651, 21651, 21656, 21657, 21658, 21661, 21666, 21667, 21668, 21678, 21690

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ATTACHMENT B

Sliding Scale

		% of Federal Poverty Level Income										
		200%	210%	220%	230%	240%	250%	260%	270%	280-290%	300% - 499%	
Size of Family Unit	FPL Income	Approved % of Financial Assistance										
		100%	90%	80%	70%	60%	50%	40%	30%	20%	25% of Income	
1	$10,830	$21,660	$22,743	$23,826	$24,909	$25,992	$27,075	$28,158	$29,241	$30,324	$32,490	(3) $54,150
2	$14,570	$29,140	$30,597	$32,054	$33,511	$34,968 (2)	$36,425	$37,882	$39,339	$40,796	$43,710	$72,850
3	$18,310	$36,620	$38,451	$40,282	$42,113	$43,944	$45,775	$47,606	$49,437	$51,268	$54,930	$91,550
4	$22,050	$44,100	$46,305	$48,510	$50,715	$52,920	$55,125	$57,330	$59,535	$61,740	$66,150	$110,250
5	$25,790	(1) $51,580	$54,159	$56,738	$59,317	$61,896	$64,475	$67,054	$69,633	$72,212	$77,370	$128,950
6	$29,530	$59,060	$62,013	$64,966	$67,919	$70,872	$73,825	$76,778	$79,731	$82,684	$88,590	$147,650
7	$33,270	$66,540	$69,867	$73,194	$76,521	$79,848	$83,175	$86,502	$89,829	$93,156	$99,810	$166,350
8	$37,010	$74,020	$77,721	$81,422	$85,123	$88,824	$92,525	$96,226	$99,927	$103,628	$111,030	$185,050

Patient Income and Eligibility Examples:

Example #1	**Example #2**	**Example #3**
- Patient earns $53,000 per year - There are 5 people in the patient's family - The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159)	- Patient earns $37,000 per year - There are 2 people in the patient's family - The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882)	- Patient earns $54,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owes$13,500 (25% of $54,000)

Notes: FPL = Federal Poverty Levels