Civista Health Community Benefits Reporting Narrative
FY 2010

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

129 Licensed Beds and 8600 inpatient admissions (including births).

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

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

See Attachment A "Profile of Charles County". *
Note – The Charles County Community Health Needs Assessment is in the process of being conducted and will be completed first quarter 2011.

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (*based on* ***IRS Schedule H, Part V, Question 2).The following are examples of how community health needs might have been identified:***

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

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

Civista Medical Center, in partnership with the Charles County Department of Health, has conducted a Needs Assessment of Charles County every 5 years. Beginning 2011,

in accordance with new regulations, the Needs Assessment will be conducted every 3 years. The data included in this report was collected in 2006 and the updated assessment is in process and due to be completed in 2011. This survey includes responses from health care providers as well as community residents. Additionally, The Charles County Community Foundation, in cooperation with Civista Medical Center, Charles County Department of Health, The United Way of Charles County and the Charles County Government conducted a Priority Needs Assessment for Charles County in 2008. In April 2009, the Charles County Local Management Board conducted a Needs Assessment. The Maryland Physician data is from the Maryland Health Commission's 2008 report. The data from all of these reports is included in the Needs Assessment update and is shared with all of the members of Partnerships for a Healthier Charles County (PHCC) of which Civista Health is a founding member. PHCC consists of more than 60 community member organizations from a broad spectrum of health-related services and includes representatives from State and Local Government. The Steering Committee of PHCC consists of leadership from four community organizations in addition to Civista Health; Charles County Public Schools, College of Southern Maryland and the Charles County Department of Health.

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

1. **Leading causes of death (Highest mortality among African Americans)**
    a. **Malignant Neoplasm**
    b. **Diseases of the Heart**
2. **Rising infant mortality rate**
3. **Rising obesity rates**
4. **Physician shortages in 83 specialties with projection to 87 specialties in 2010.**

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

***see Attachment B**

Civista Medical Center's Community Benefit Program consists of the following decision makers:

- **The Board of Directors**
- **Executive Management Team**
- **Community Benefits Leadership Team (Health Promotions, Finance)**
- **Community Benefits Reporters**

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

Civista Medical Center sponsors the following community initiatives:

1. **Approved Cancer Program by the American College of Surgeons, Commission on Cancer as a Community Hospital Cancer Program; Cancer Subcommittee of**

Partnerships for a Healthier Charles County; Free cancer screening and education programs for prostate, breast, cervical and colorectal cancer; with outreach targeted to the uninsured and African American populations; Participation in the Tobacco Education Program; Support of the Charles County Department of Health's Colorectal Cancer and Prostate Detection and Treatment Program; Sponsorship of Faith Based Community Health Fair targeting African American churches; Partnership agreement with the American Cancer Society

2. **Hospital subsidized community Prenatal clinic; Staff participation in the Fetal Infant Mortality Review Board;**
3. **WE CAN! (Ways to Enhance Children's Activity and Nutrition) program for 8-13 year olds sponsored by Civista in partnership with the Charles County Department of Health.**
4. **Physician recruitment efforts through funded Physician Recruitment position at Civista Medical Center; Staff participation in groups such the Maryland Healthcare Roundtable, Maryland Healthcare Commission; Management Agreement with University of Maryland Medical System**

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

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

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

Assessment of the success of initiatives will be provided with the 2011 Charles County needs Assessment Survey.

1. **Prostate Cancer Screening September 2009: PSA and digital rectal exams were provided to all participants free of charge; Focused outreach on areas of county that have a high African American population; Partnership with traditionally African American Groups such as the Bel Alton Alumni Association and Delta Zeta Sorority; Evaluation provided by the Charles County Department of Health**
    a. **Screened 94 men**
    b. **Results: 3 men with 7 abnormal DRE and 26 abnormal PSA**
    c. **Evaluation: Participants with any abnormal findings are contacted to ensure follow up with provider; Uninsured participants are referred for follow up and treatment, if necessary through the Charles County Department of Health Prostate Cancer Program**

2. **Prenatal Clinic – ongoing: Civista provides the only prenatal clinic for uninsured and underinsured pregnant women in the County and provided services for 156 patients in FY 10; Clinical services, education and follow up are provided by Civista Medical Center staff and physicians. Clinic providers participate on the Charles County Fetal Infant Mortality Board for review and evaluation of outcomes.**
3. **WE CAN! Childhood Obesity Program: Free family education program to increase physical activity, proper food choices and decrease screen time for 8-13 year olds and their families; Grant is provided to the Charles County Department of Health through the National Institutes of Health and sub-granted to Civista Health for provision of the curriculum. This is year 2 of a 3-year block grant. Data is collected and will be evaluated in partnership with the Charles County Department of Health.**
    a. **Served 72 children and their families in FY 2010**
    b. **Evaluation/Results : See Attachment C 1 and C 2**
4. **Physician Recruitment – Recruitment of physicians to Charles County concentrating in the high priority areas of the 83 specialties lacking; Physician recruiter retained by Civista; Evaluation by number of physicians successfully recruited and placed.**
    a. **In November 2009, Civista Health signed Management Agreement with University of Maryland Medical System with physician recruitment as major initiative.**
    b. **According to the Maryland Health Commission, 83 physician specialties are in shortage in the Southern Maryland area. Of particular lack in Charles County is Obstetrics and Gynecology. In 2009, only 6 OB/GYN physicians were providing care at Civista– 4 of whom are employed by Civista Medical Center and also provider care for prenatal clinic for the uninsured and underinsured. The rising infant mortality rate in Charles County raised the recruitment of OB/GYN practitioners to priority one. Recruitment efforts are ongoing for other physician specialties are ongoing for orthopedics, oncology, general surgery and gastroenterology.**

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

See Attachment D "Gaps Narrative"

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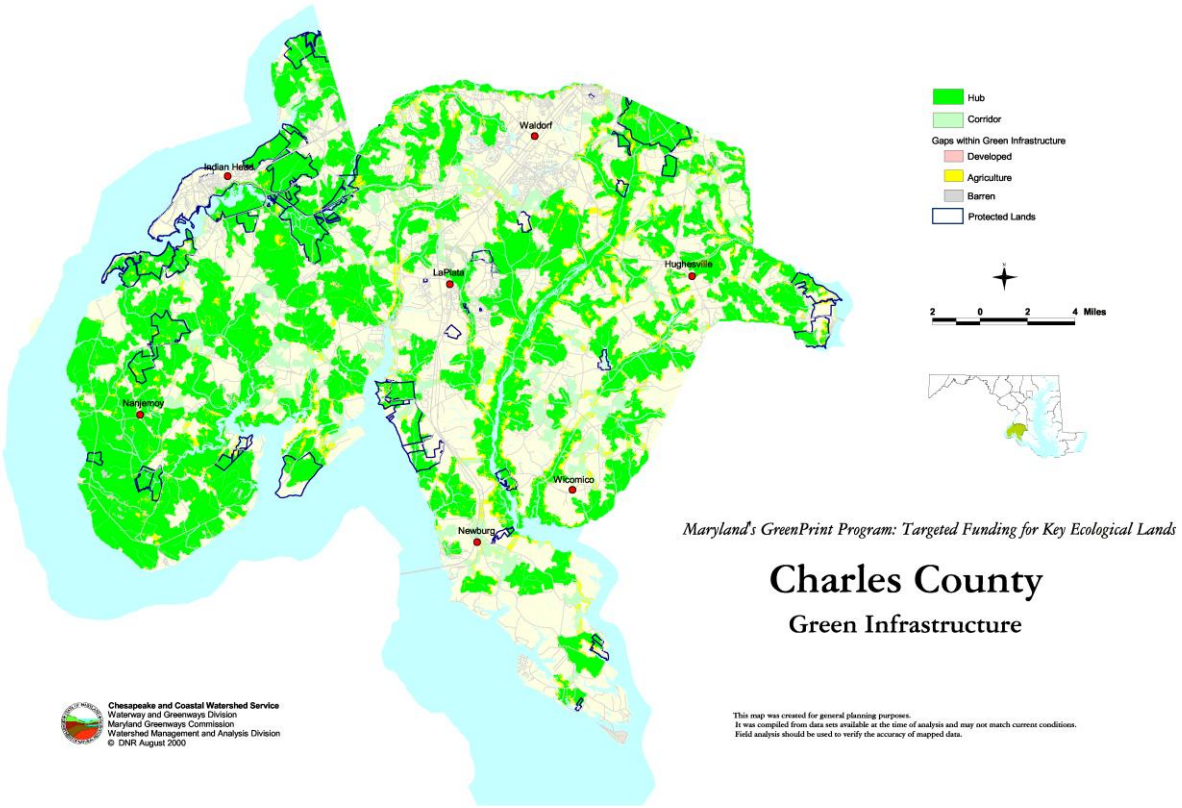
9. If you list Physician Subsidies in your data, please provide detail.
See Attachment E "Shortages by Region" and Attachment F "FY 2010 Workforce Development Costs"

Profile of Charles County

Charles County is mostly a rural county located on the Southern Maryland Peninsula, bordered by Prince George's County to the north, Calvert County to the east, and St. Mary's County to the south. Charles sits about 15 miles south of the Washington Capitol Beltway, 18 miles from Washington, D.C, and 54 miles southwest of Baltimore.

The northern part of the county is the "development district" where commercial, residential and business growth is focused, so that the remainder of the county can retain its rural character. The major communities of Charles County are La Plata, the county seat; Port Tobacco, Indian Head, and the planned community of St. Charles. The main commercial cluster is Hughesville-Waldorf-White Plains.



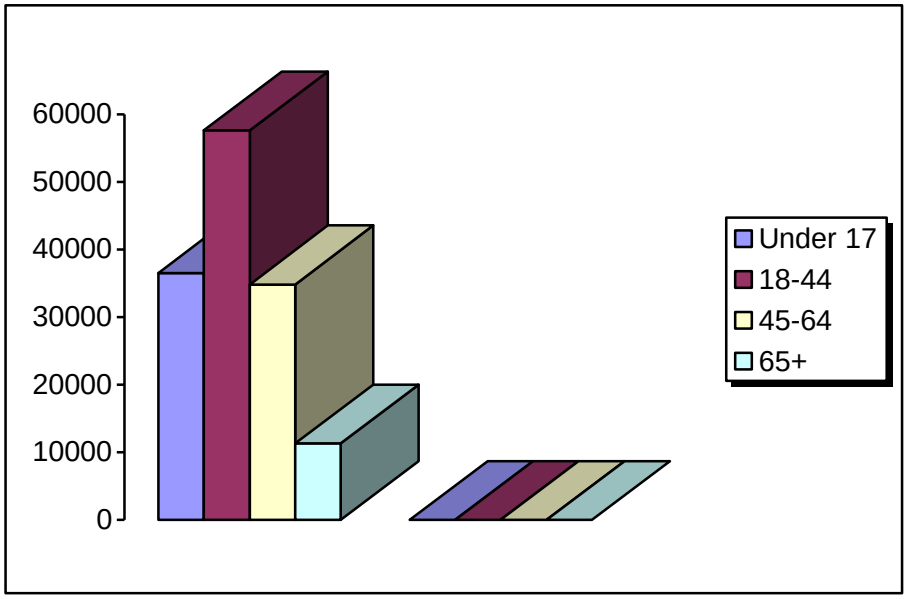
Source: 2003 dnr.maryland.gov

There are three nursing homes in Charles County, two are located in La Plata and one is located in Waldorf. In addition to the nursing homes there are two adult day care centers one in La Plata and one in Waldorf. These facilities provide care for the elderly citizens of Charles County, assisting family members by providing day time activities for those elderly citizens still in the home families. The County has one 129-bed hospital—Civista, located in the county's seat, La Plata.

Demographics

Charles County continues to experience rapid growth, expanding its population from 47,678 to 120,546 in the 2000 census. Current U.S. Census estimates are that the population now exceeds 140,444. This magnitude of growth can be seen in the change in population density, with an increase of 15% in the period from 2000 to 2005. While there are only 307 people per square mile over the total area of Charles County, there are 821 people per square mile of developed land. The population density is concentrated mainly in the northern end of the County. The census describes a population that is young, with a medium age of 35 years, and approximately 26% is under the age of 17, 41% is between the ages of 18-44, 25% is between the ages of 45-64; and 8% of the county's population 65 or over.[2]

Charles County Population by Age-group, 2006



Source: Maryland DHMH 2005Vital Statistics Report

The average household size is 2.85 with the average family size 3.23. The marital status of the county for males is 15, 962 never married, 28,913 now married, 1,467 separated, 924 widowed, and 5,680 divorced. For females 17,792 never married, 28,699 now married, 1,796 separated, 4,018 widowed, 5,563 divorced. All numbers refer to residents 15 years and over. [13]

In 2006 the types of households in Charles County included 54% married couples, 23% other families, 19% people living alone, and 4% other nonfamily households. The geographic mobility of residents in Charles County showed that 86% had been in the same residences, only 7% had moved to another residence in the county, 4% moved out of the county, 3% moved to another state, and 1% moved out of the country. [13]

Population:

Charles County Population Data

Population Data	Charles County	Maryland
Population, 2000	120,546	5,296,486
Population, 2006	140,416	5,615,727
Male, 2006	48.7%	48.4%
Female, 2006	51.3%	51.6%

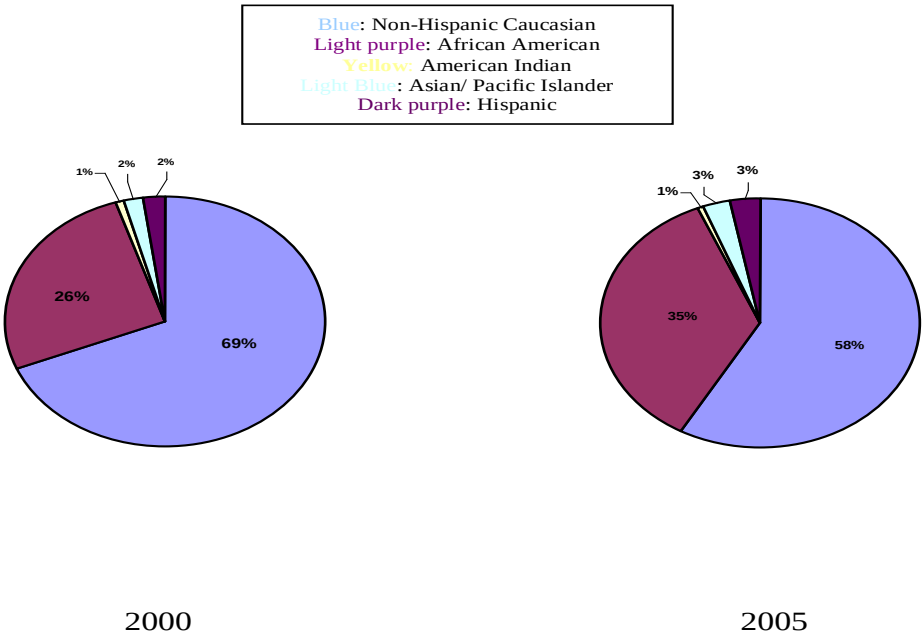
Source: 2006 Maryland Vital Statistics Report and US Census Bureau:
2006 American Community Survey

The minority population in the United States as well as Maryland continues to grow each year. In 2004, more than 32% of the total US population was racial or ethnic minorities. In 2004, the minority population in Maryland made up 39.6% of the population.[1]

In 2004, racial and ethnic minorities made up 39.4% of the total county population. Charles County ranks fifth among the 24 Maryland jurisdictions in terms of the largest minority population. The county minority population is also significantly higher than the minority population in the other Southern Maryland jurisdictions: Calvert County with 16.3% and St Mary's County with 19%.[1]

And the minority population within the county continues to grow each year. In 2005, the Charles County minority population comprised 41.5% of the total population (Refer to graph below). It remained the fifth highest percentage among the Maryland jurisdictions, but it exceeded the Maryland state average percentage of 40.3%.[2]

Race of Charles County Population, 2000 versus 2005

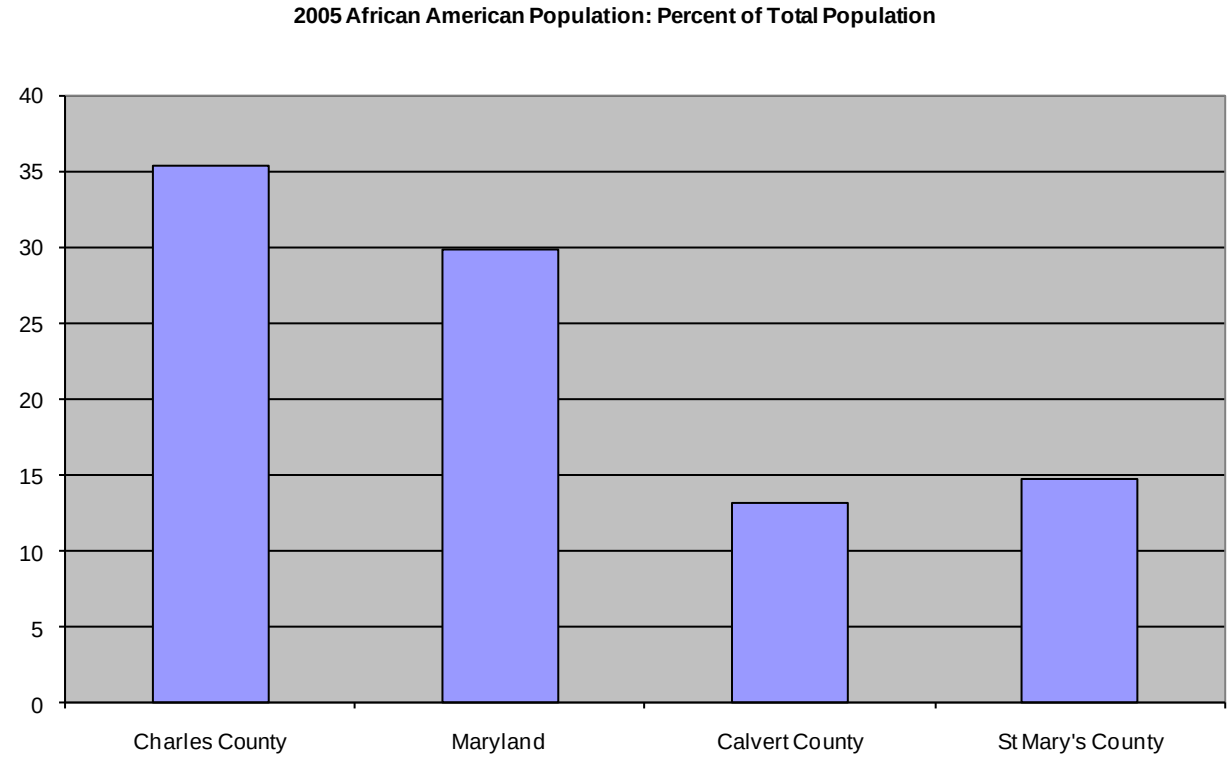


2000 2005

Source: Maryland Department of Health and Mental Hygiene. 2005 MD Vital Statistics Report.

The African American population is the largest minority group within the state of Maryland as well as Charles County. African American comprised 75% of the Maryland minority population and approximately 85% of the Charles County minority population.

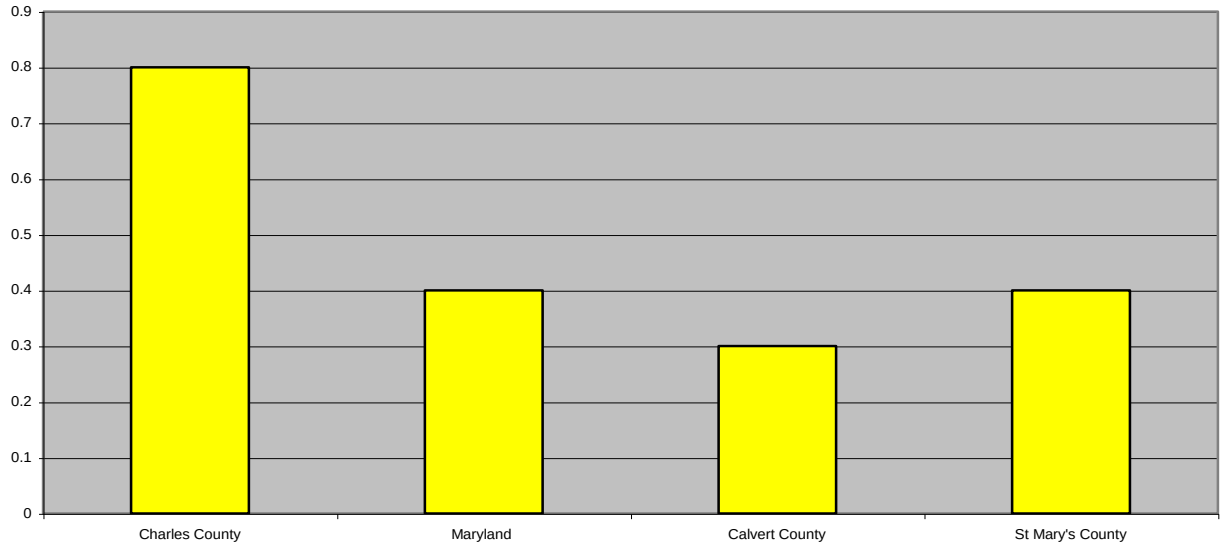
The African American population continues to grow within the county population. In 2005, they accounted for 35.4% of the total county population. This is the 4th highest percentage among the 24 Maryland jurisdictions. This percentage is much higher than the percent for the other Southern Maryland jurisdictions: Calvert County: 13.1% and St Mary's County: 14.8%. These differences are statistically significant ($p>.05$). It is also greater than the Maryland state average of 29.9%, though the difference is not statistically significant ($p< .05$). [1]



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Though the American Indian/ Alaskan Native population makes up a very small percentage of the total county population, Charles County has the highest proportion of this minority than any of the jurisdiction in the state of Maryland. American Indians and Alaskan Natives make up 0.8% of the total county population. This is double the Maryland state average of 0.4%. It is also much higher than the other Southern Maryland jurisdictions: Calvert County: 0.3% and St Mary's County: 0.4%.[1]

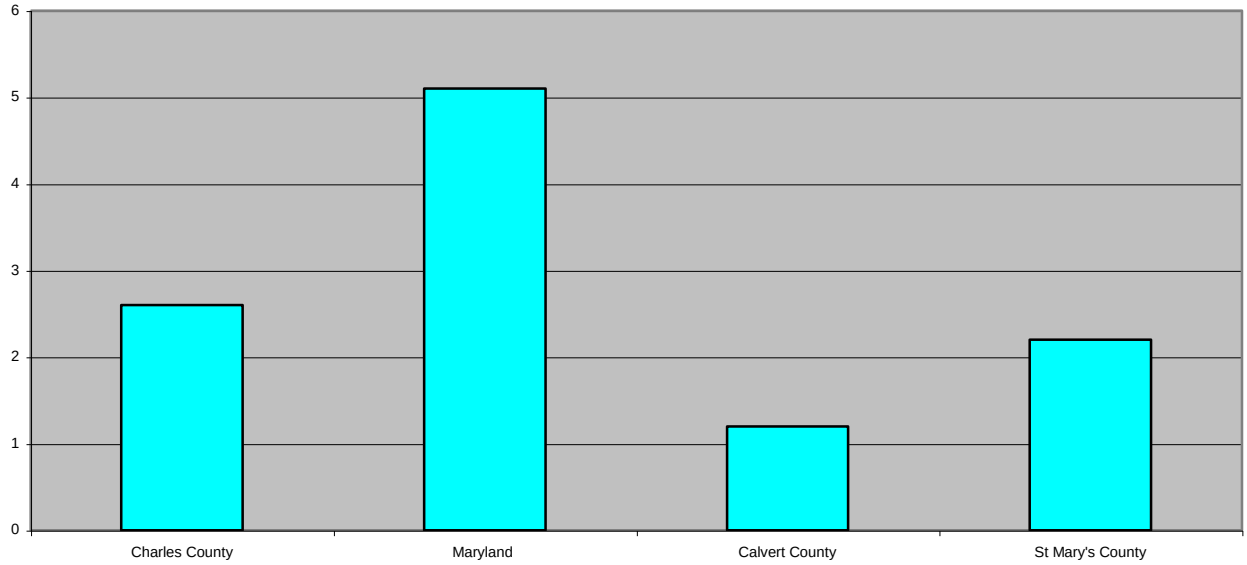
2005 American Indian/Alaskan Native Population: Percent of Total Population



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

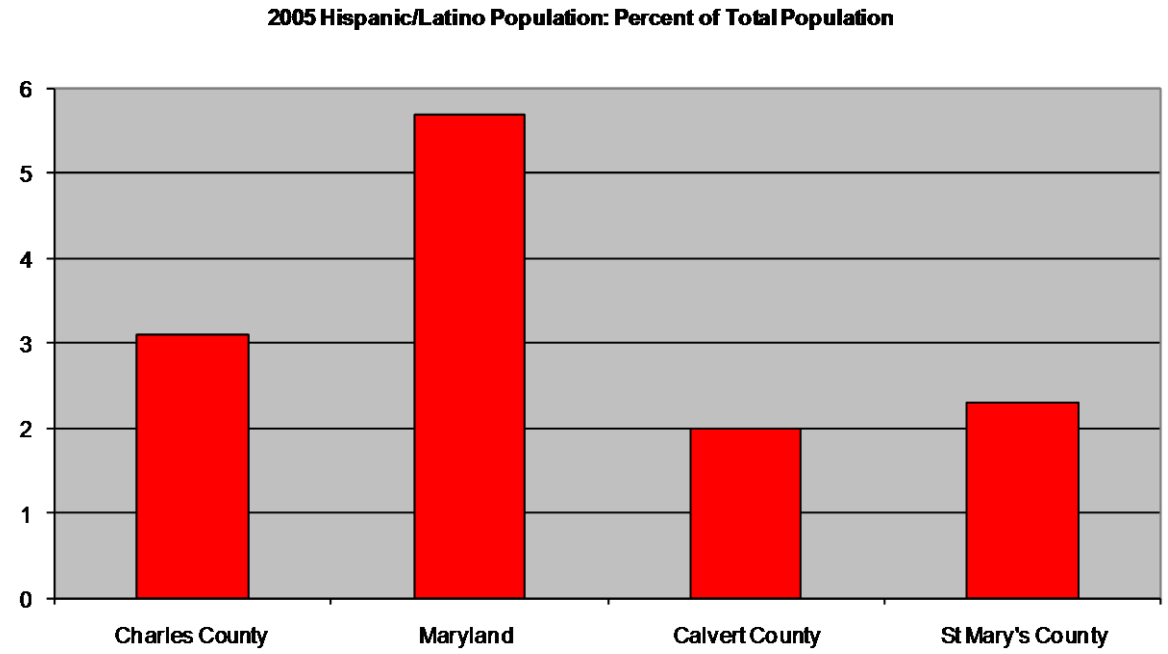
The presence of Asians and Pacific Islander continues to increase within Charles County as well. According to the 2005 Maryland Vital Statistics Report, Asians and Pacific Islanders made up 2.6% of the total Charles County population. This is the seventh highest percentage among the Maryland jurisdictions. This is the greatest percentage among the Southern Maryland jurisdictions: Calvert County: 1.2% and St Mary's County: 2.2%. It is however less than the Maryland state average of 5.1%, which may be skewed by the large presence of Asians and Pacific Islanders in large Maryland counties.[1]

2005 Asian/Pacific Islander Population: Percent of Total Population



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

The Hispanic and Latino population is becoming a significant minority within Charles County. This minority now comprises 3.1% of the total county population. This percentage is the seventh highest among the Maryland jurisdictions; however, this is lower than the Maryland state average of 5.7%, which is high due to larger counties such as Montgomery County where Hispanics make up 13.6% of the total county population. The Charles County Hispanic population is the largest among the Southern Maryland jurisdictions: Calvert County 2.0% and St Mary's County 2.3%.[1]



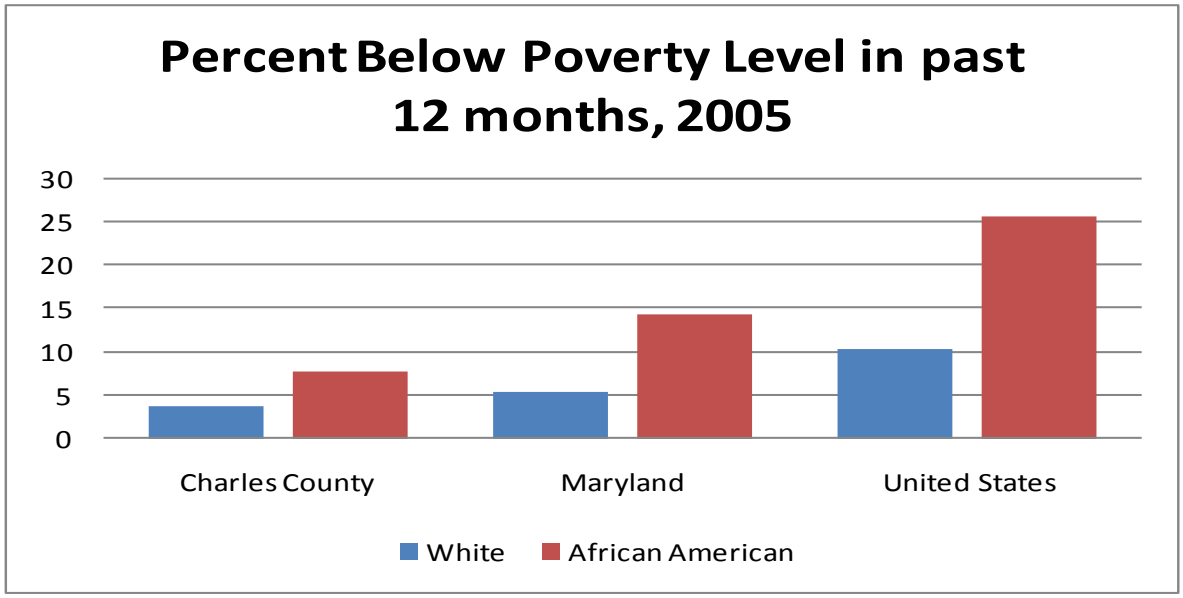
Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Socio-economic Characteristics:

Employment and economic indicators for the county are strong. In 2006 the employed population for 16 years and older was 108,609. The commute to work includes 56,379 vehicles driven alone, 8,084 vehicles used for carpooling, 5,459 individuals use public transportation (excluding taxicabs), 546 individuals walk, 348 individuals use other means, and 2,421 individuals work from home.[13]

Income:

In 2006, the mean household income was $95,033.[13] Charles County has a rate of 6.4% of all families who were living below the poverty level in 2006. African Americans were twice as likely to report that they were below the poverty level as Whites in the county. However, the rates of poverty in Charles County are significantly lower than the Maryland average rate and the United States rate. Poverty rates for Asians, American Indian/ Alaskan Native, and Hispanics could not be calculated due to small sample sizes.[3]



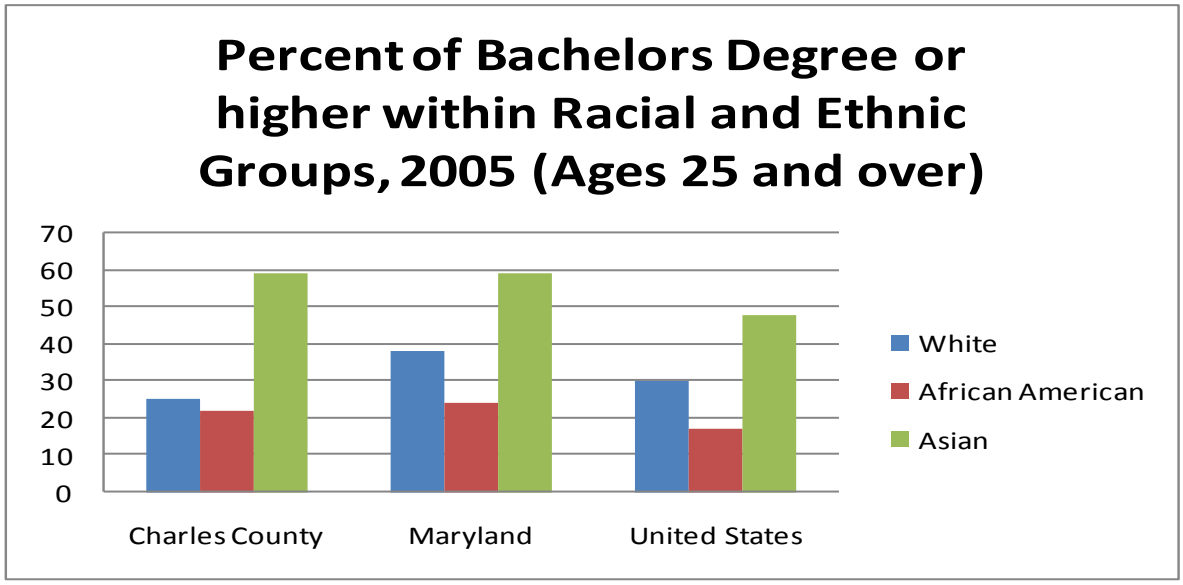
Source: 2005 American Community Survey, US Census Bureau

Economic Indicators	Charles County	Maryland
Average Household Income, 2006	$95,033	$83,367
Persons below poverty, 2006	6.4%	7.8%
Homeownership rate, 2006	79.2%	69.4%
In labor force, 2006	73.5%	69.2%

Source: 2006 Maryland Vital Statistics Report and US Census Bureau: 2006 American Community Survey

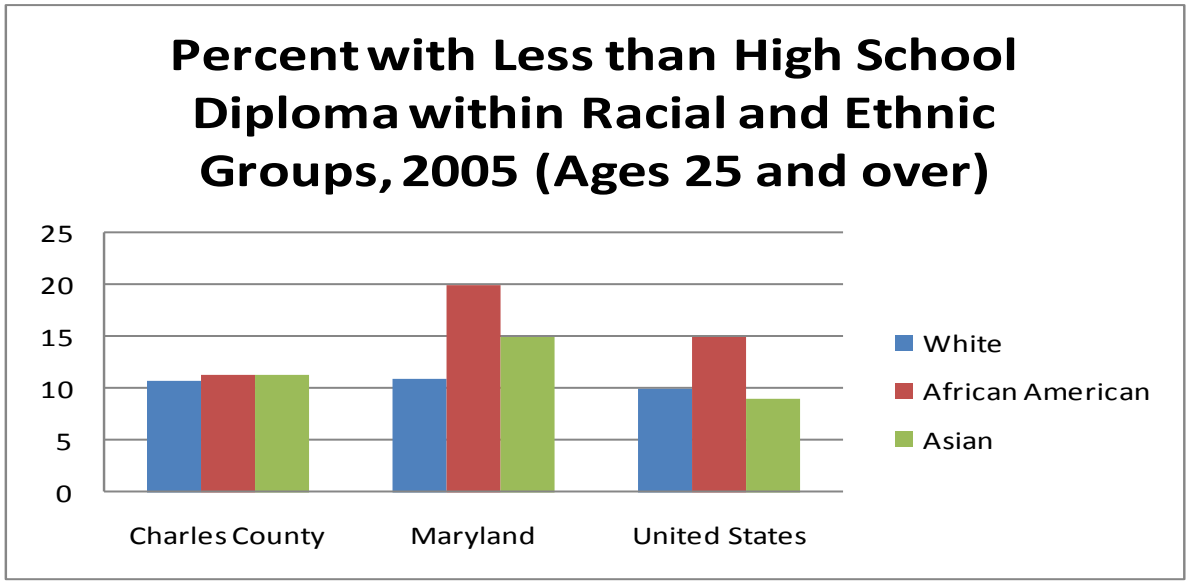
Educational Attainment:

Within Charles County, the number of individuals with a bachelor's degree or higher in the White and African American populations is less than the Maryland average. The percentage of college educated African American residents in Charles County is higher than the United States average and only slightly below the Maryland state average. For the Asian population, the Charles County percentage is exactly the same as the Maryland state average and higher than the United State average. Educational attainment statistics were not available for the American Indian/Alaskan Native and Hispanic populations due to small samples sizes.[3]



Source: 2005 American Community Survey, US Census Bureau

There are no visible racial disparities in the percentage of individuals who have less than a high school diploma. The percentage for Whites, African Americans, and Asians was approximately 11 percent.[3] The rate among the White population was similar on a county, state, and national level. The rate for the African American population was less on a county level than the state and national averages. The rate for the Asian population was less than the national average though slightly higher than the state average.



Source: 2005 American Community Survey, US Census Bureau

Mortality:

<u>All Cause Mortality</u>:

From 1999-2003, Charles County like most jurisdictions within Maryland, has a lower all-cause mortality rate than the Maryland state average rate and the national rate. However, mortality rates are higher for African Americans than Whites in every Maryland jurisdiction as well as the state, and the nation.[4]

The Charles County African American all-cause mortality rate is the 4th lowest among the Maryland jurisdictions. It is actually lower than the White all-cause mortality rate for several Maryland jurisdictions such as Somerset County and Baltimore City.

When comparing the White and African American rates on a county level, there are no statistically significant differences in the all-cause mortality rates. The percent excess in the African American all-cause mortality rate compared to the White all-cause mortality rate in Charles County is the smallest in the state. The African American death rate is only 4.1% greater than the White death rate. This is significantly smaller than the Maryland state average excess of 30.8%.

Leading Causes of Death

Cause of Death	Charles County Number, 2006	Charles County Number, 2004-2006	Charles County Rate 2004-2006*	Maryland Number, 2006	Maryland Number, 2004-2006	Maryland Rate 2004-2006*
All Causes	841	2568	862.2	43491	130426	789.0
Cancers	202	662	215.7	10336	30831	186.6
Diseases of the Heart	199	599	211.6	11191	34026	205.7
Accidents	46	126	33.5	1424	4187	25.0
Chronic Lower Respiratory Diseases	46	127	46.3	1827	5618	34.9
Cerebrovascular Diseasess	34	128	46.8	2358	7535	45.9
Diabetes mellitus	31	95	32.3	1230	4025	24.5
Septicemia	17	65	21.0	964	3105	18.9
Influenza & Pneumonia	17	68	25.8	1091	3429	20.8
Certain conditions originating in the perinatal period	17	39	**	365	1101	**
Alzheimer's Disease	12	41	17.1	908	2767	16.9
Intentional self-harm (suicide)	12	39	9.9	485	1441	8.5

*All rates calculated per 100,000 population
**Rates not available
Source: 2006 Maryland Vital Statistics Report

Diseases of the Heart:

From 1999-2003, Charles County had lower heart disease death rates for African Americans and for Whites than the Maryland state average rate and the United States rate. The Charles County African American heart disease mortality rate was the 11th lowest in the state. On the county

level, the Charles County African American heart disease death rate was higher than the White heart disease death rate, though there was not a statistically significant difference ($p<.05$).[4]

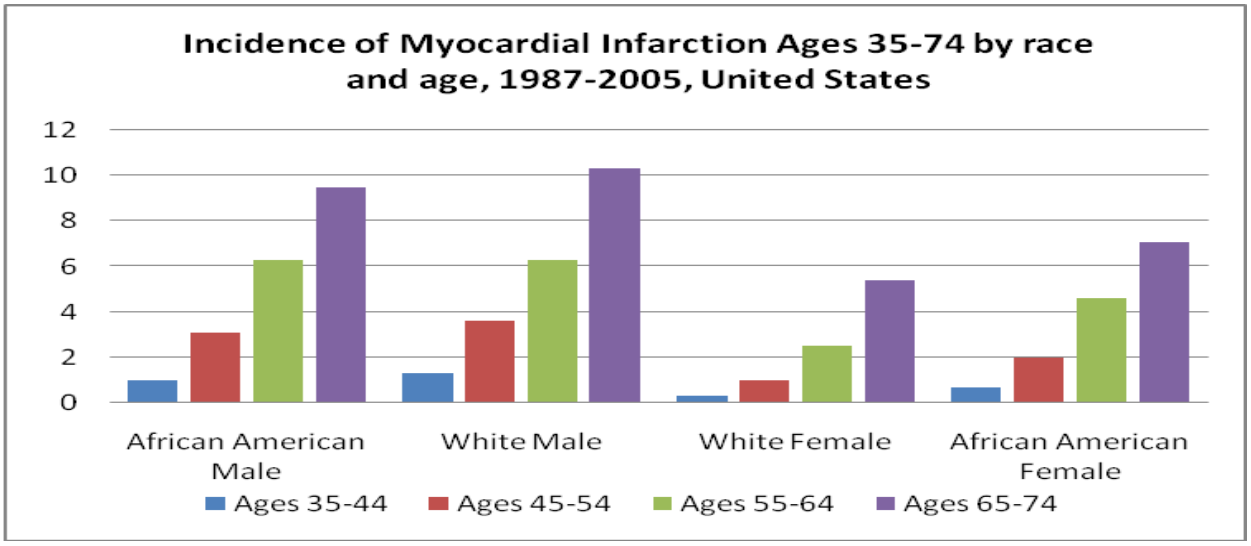
Heart disease is the leading cause of death in the state of Maryland and the second leading cause of death in Charles County. According to the 2005 Maryland Vital Statistics Report, the age-adjusted average death rate for diseases of the heart in Charles County from 2003-2005 was 224.2 per 100,000, which is slightly higher than the Maryland state average rate of 218 per 100,000. [2]

For Maryland African Americans, the mortality rate from diseases of the heart is much higher than the mortality rate for any other racial group in Maryland. In 2005, the African American age-adjusted death rate for diseases of the heart was 253.3 per 100,000 compared to 200.9 per 100,000 for Caucasians. When comparing by gender, African American males have the greatest death rates from heart disease. The 2005 age-adjusted death rate for black males was 301.6 per 100,000, while the 2005 age-adjusted death rate for white males was 244.1per 100,000. African American females are also at an increased risk of death from heart disease. The 2005 age-adjusted death rate for diseases of the heart for black females was 216.2 per 100,000, which was significantly higher than the 2005 age-adjusted death rate for white females at 166.3.[2]

Historically the death rates for African Americans have been higher for heart disease than Caucasians. The heart disease death rates have been slowly decreasing over the past decade for both races, but there is a still a racial disparity in the heart disease death rates between blacks and whites. The difference in the death rates for blacks and whites is actually increasing over the years. This is true regardless of gender. T he biggest difference in rates can be seen when comparing the male populations.

Using data from the 2005 Maryland Health Services Cost Review Commission, Ambulatory and Hospital Discharge Data and the 2005 Maryland Vital Statistics Report, relative risks for hospitalization and mortality from heart disease were calculated between Maryland African American males/White males and Maryland African American females/White females. African American males were 1.18 times more likely to be hospitalized for heart disease than white males, and 1.24 times more likely to die from heart disease than white males. African American females were 1.51 times more likely to be hospitalized for heart disease than white females, and 1.30 times more likely to die from heart disease than white females.[1]

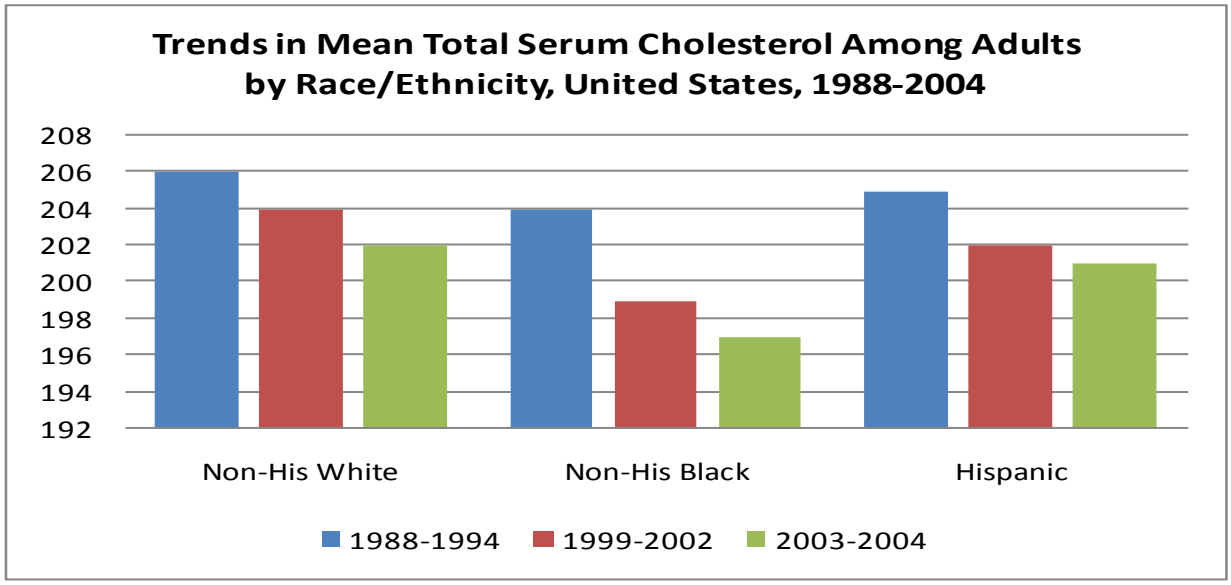
Higher mortality rates for heart disease in African Americans are in part related to the fact that the disease occurs more frequently in African Americans. The following figure shows that incidence (the rate of new cases) of heart attack (myocardial infarction) is higher in African Americans that in Whites in the United States.



Source*: American Heart Association, Heart Disease and Stroke Statistics 2007 Updated.*

Analogous Maryland data on incidence of heart disease are not available. Prevalence data for heart attack in the BRFSS shows that prevalence is similar between African Americans and Whites. However, prevalence data can be misleading regarding disparity in disease occurrence. If a disease has higher incidence in a minority group and also has poorer survival in that group, prevalence may be similar. That is despite higher rates of new disease, and lower rates of survival in the minority group. Therefore, similar disease prevalence for a condition where minorities have higher mortality is not reassuring.

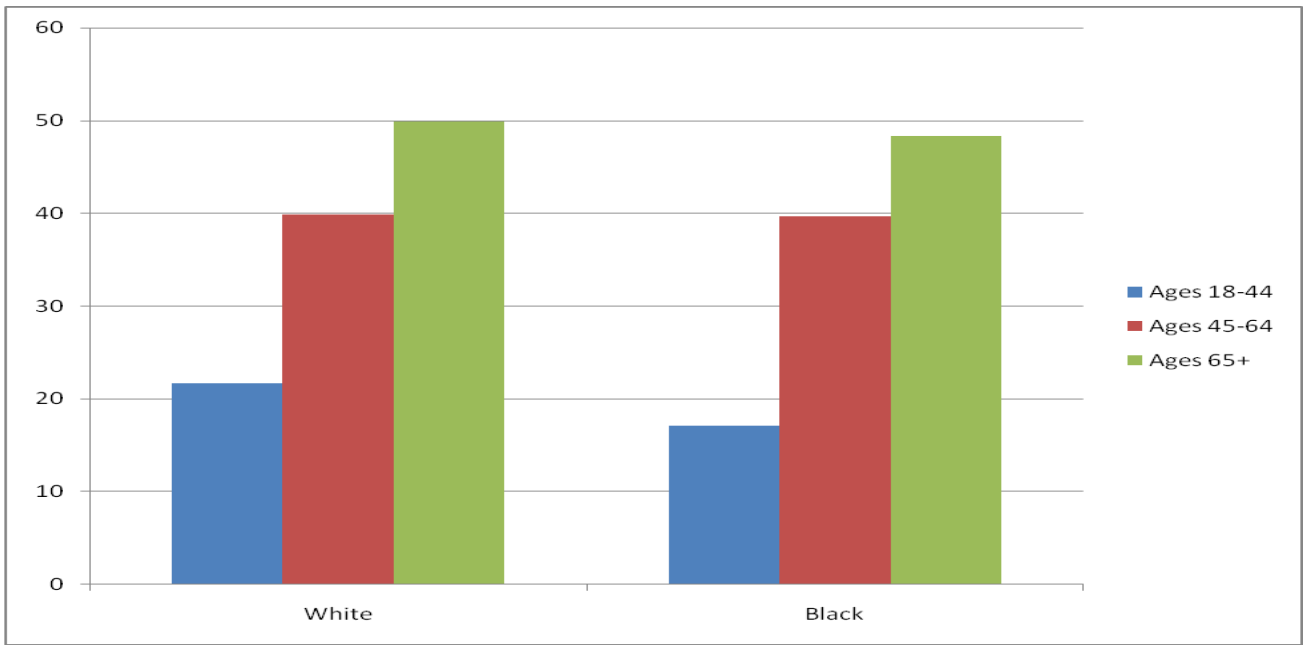
Higher occurrence of heart disease reflects differences in risk factors for heart disease. African Americans have higher rates of hypertension (high blood pressure) and diabetes than whites. Survey data in the U.S. does not show a difference in cholesterol levels.



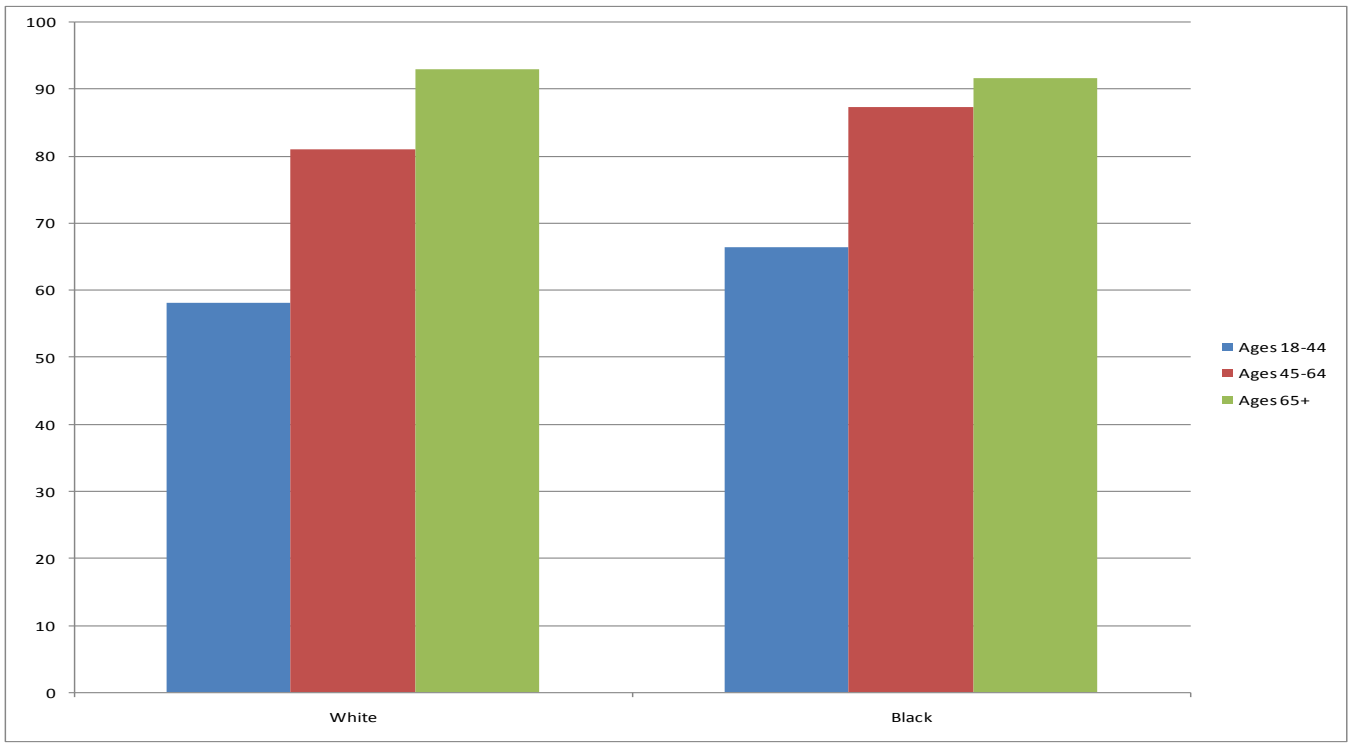
Source*: American Heart Association, Heart Disease and Stroke Statistics 2007 Updated.*

BRFSS survey data in Maryland does not show a difference in the number of adults reporting a diagnosis of high cholesterol between African Americans and Whites. Rates of cholesterol testing are also similar for the two groups.[5]

Prevalence of High Cholesterol by Race, Maryland BRFSS, 2001 and 2003 pooled



Percent with Cholesterol Test in Last 2 Years, Maryland BRFSS, 2001 and 2003 pooled

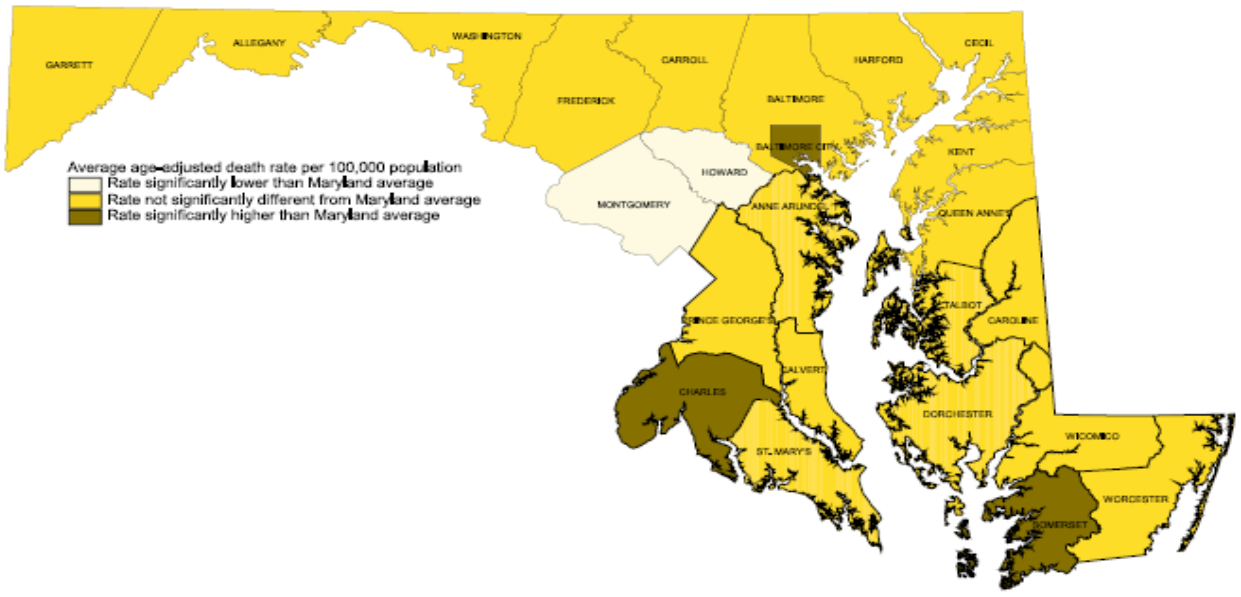


Cancer:

Cancer is the second leading cause of death in both the U.S. and in Maryland. The age-adjusted cancer death rates have been declining for both Whites and African Americans in Maryland, although African Americans have experienced a steeper decline in rates than Whites. Progress has been made in reducing the cancer disparity. In 1996, African Americans had 28 percent higher cancer mortality rates than Whites, while in 2005 the age-adjusted cancer mortality rate for African Americans in Maryland was 12 percent higher than for Whites. The difference between African American and White cancer mortality rates in 2000 was 44 deaths per 100,000, while in 2005 the difference was 22 deaths per 100,000. This represents a 50% reduction of the cancer mortality disparity in Maryland from 2000 to 2005.[1]

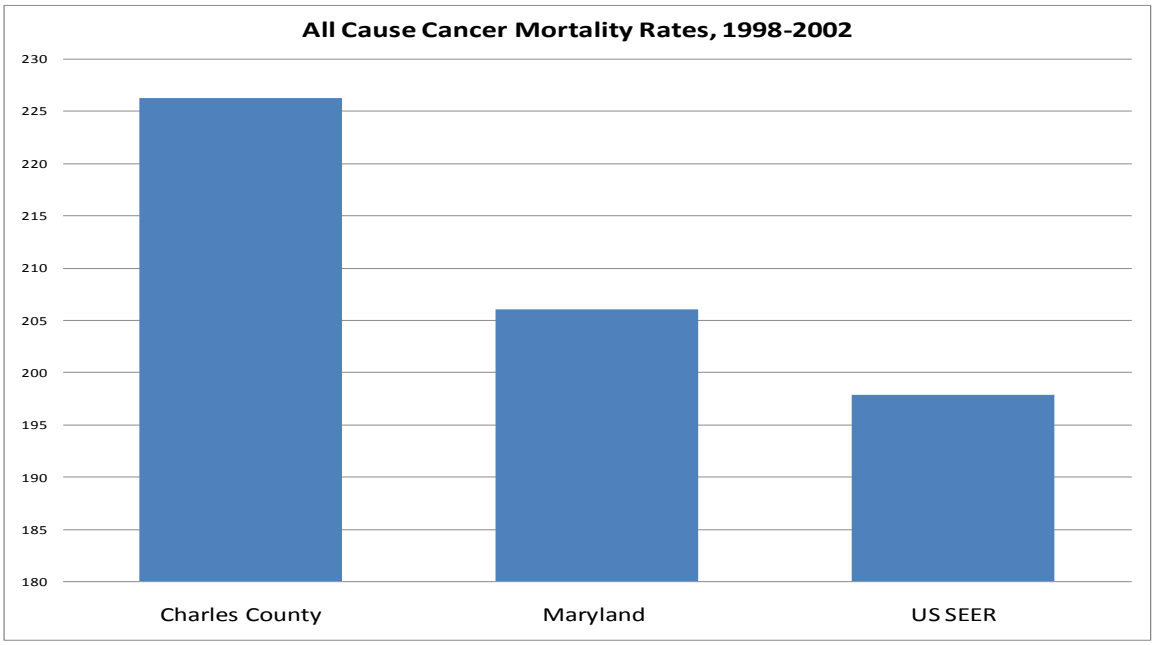
The same patterns of decline in cancer mortality rates have been seen in Charles County. In 2004, cancer was the leading cause of death in Charles County. The age-adjusted death rate for overall cancer from 2003-2005 in Charles County was 222.4 per 100,000.[2] This rate exceeds the state overall cancer death rate of 190 per 100,000. For 1998-2002, lung and bronchus cancer incidence in Charles County is 66.9 per 100,000 and mortality is 59.9 per 100,000. On a county level, both the incidence and mortality rates for overall cancer and lung/bronchus cancer have decreased since the previous cancer report data. The county incidence rate for lung/ bronchus cancer has dropped below the State incidence (68.0); however, the county mortality rate has remained slightly higher than the state mortality (58.1) rate for lung/bronchus cancer.[6]

Comparison of County Age-adjusted Death Rates* for Malignant Neoplasms with the Maryland State Average, 2003-2005.



When comparing cancer mortality among racial groups, there was a reversed disparity for cancer mortality between the periods of 1999-2003. The White cancer mortality rate (approximately

230 per 100,000) is slightly higher than the African American cancer mortality rate (approximately 225 per 100,000), though the difference is not statistically significant.[4] The White cancer mortality rate exceeds the state average rate and is one of the highest among all of the Maryland jurisdictions. The African American cancer mortality rate is the sixth lowest among the Maryland jurisdictions and is well below the Maryland and national rates.



Source: 2005 Maryland Vital Statistics Report

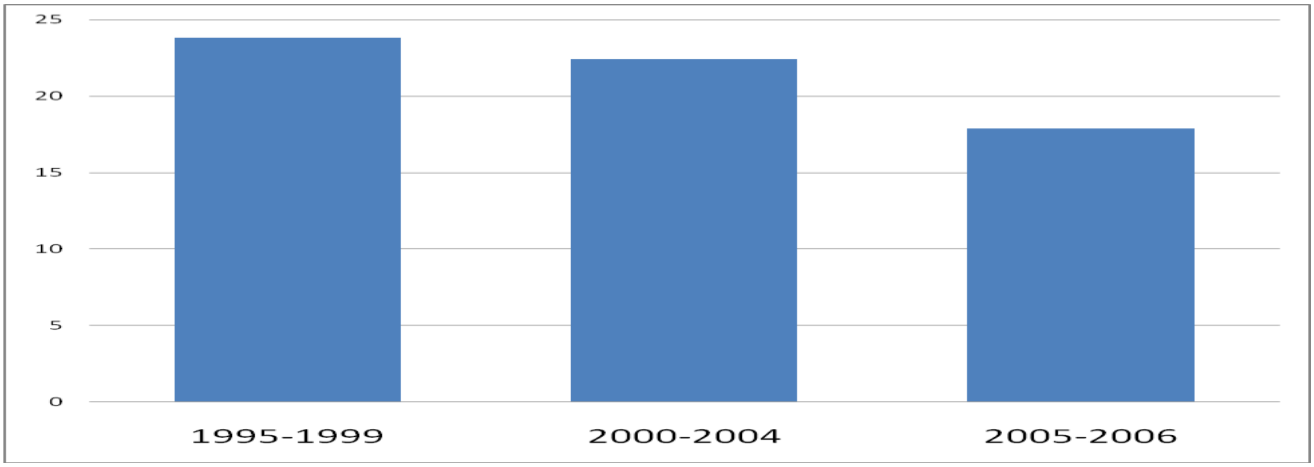
Cigarette smoking is a well-known risk factor for many types of cancer. Among the Maryland jurisdictions, Charles County had the 6th lowest rate of tobacco use by minority youth in 2000 and dropped to the 4th lowest rate in the state in 2002. Charles County ranked 13th in 2000 and 15th in 2002 for highest rates of tobacco use by minority adults. In 2000, the state rates for tobacco use among minority youth and minority adults was less than the county rates; however, the county rates fell below the state rates by 2002.[7]

Prevalence of Any Tobacco Use by Minority Under-age Youth and Minority Adults, Statewide and Charles County, 2000 vs. 2002

Year	Youth	Adults
State – 2000	18.8%	20.6%
State – 2002	16.8%	19.1%
Charles – 2000	21.8%	21.8%
Charles – 2002	16.6%	18.5%

Source: 2002 CRF Tobacco Use in Maryland

Prevalence of Current Smoking, Charles County, Maryland BRFSS, 1995-2006



Site-Specific:
A table is presented below with the site-specific incidence and mortality rates for Charles County and the state of Maryland for 2004 and the United States for 2001. Charles County is number one in the state for new cases of prostate cancer. Charles County has consistently held the highest prostate cancer incidence rate in Maryland for the last decade. The county has higher death rates for lung, prostate, colorectal, and oral cancers than the United States.

Site	2004 Charles County Incidence Rate*	2004 Maryland Incidence Rate*	2001 US Incidence Rate*	2004 Charles County Mortality Rate*	2004 Maryland Mortality Rate*	2001 US Mortality Rate*
Lung/Bronchus	469	475.3	468.8	239.6	209.9	195.6
Colorectal	54.5	55.7	51.8	27.7	23.1	20
Female Breast	121.4	132.8	134.8	32.5	28.5	25.9
Prostate	221.1	178.6	176.8	49.6	34.3	29.1
Oral	8.4	10.7	10.4	**	3.1	2.7
Melanoma of Skin	12.8	16.9	18.7	**	2.5	2.7
Cervical	8.9	8.3	7.9	**	2.8	2.7

Source: 2006 CRF Cancer Reports.
*Rates per 100,000 population.
** Rates based on cells with 25 or fewer cases are not presented.

<u>Prostate:</u>

Incidence:

In the United States, the African American population is at an increased risk of developing prostate cancer. Nineteen percent of, or 1 in 5, all African American men will develop prostate cancer in their lifetime.

In Maryland, health disparities among the African American population have also been observed. In 1999, the prostate cancer incidence rate among white Maryland men was 157.4 per 100,000; for African American men in Maryland, the prostate cancer incidence rate was 226.8.[6]

However, for the Southern Maryland region these differences in prostate cancer incidence rates among races have not been noticed. In 1998, the incidence rates among the white and African American populations in Southern Maryland were similar. In 1999, the prostate cancer incidence rate among the African American population was less than the rate among the white population for the Southern Maryland region.

Table 1: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1998

1998	White Males	Black Males
Southern Maryland	166.3	167.9
Maryland	121.1	187.2

Source: 2006 CRF Cancer Report

Table 2: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1999

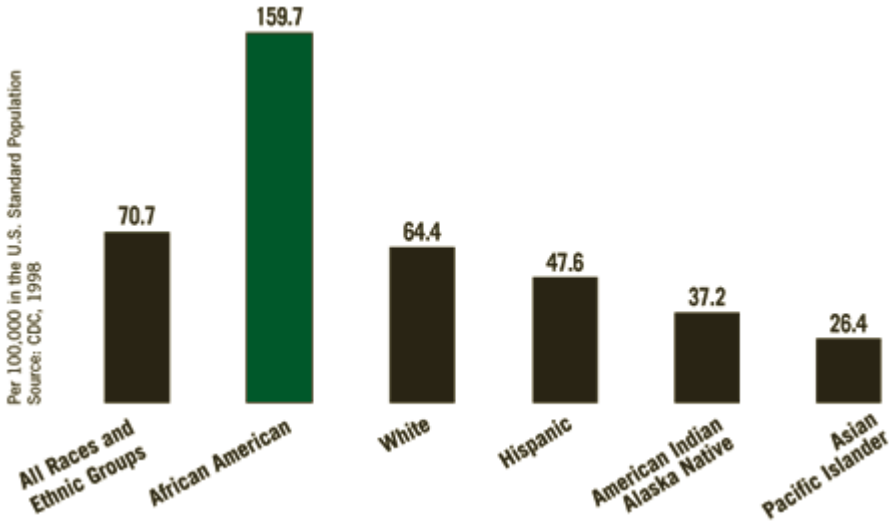
1999	White Males	Black Males
Southern Maryland	171.3	159.6
Maryland	157.4	226.8

Source: 2006 CRF Cancer Report

Mortality:

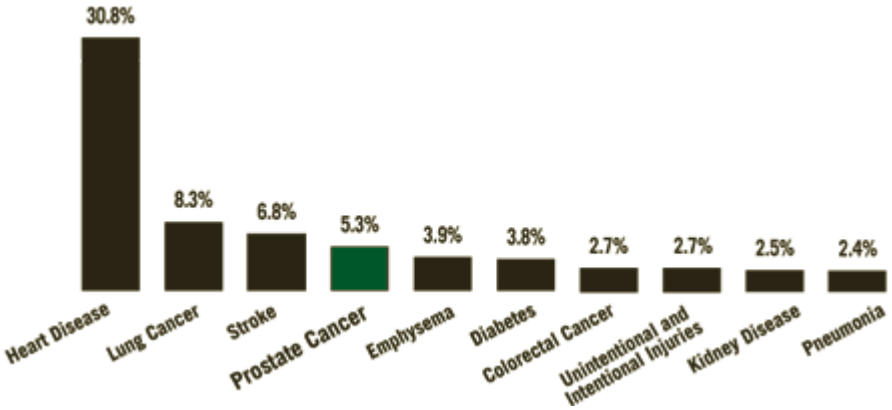
African American men are more likely to be diagnosed with prostate cancer at an advanced stage and more likely to die from the disease than white men. The death rate for prostate cancer among African American men over the age of 45 years is 159.7 per 100,000. This is statistically higher than the death rate for all races of 70.7 per 100,000.[8]

Prostate Cancer Death Rates by Race/Ethnicity in Men Aged 45 and Above



African American men have a 5% chance of dying from prostate cancer; it is the fourth leading cause of death in African American men over the age of 45 years.

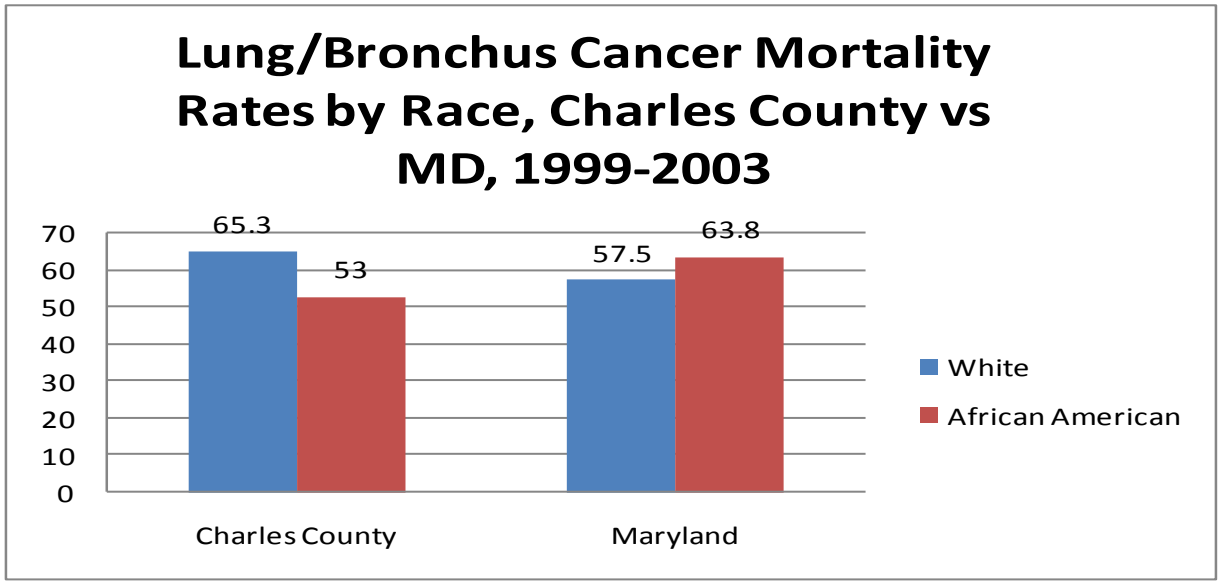
Top Ten Causes of Death among African American Men over Age 45



Prostate cancer mortality rates in Charles County are higher than the national mortality rates. However, they appear to be following the same trends as the state mortality rates.

<u>Lung/Bronchus</u>:

Lung cancer is the most fatal form of cancer, and the Charles County lung/bronchus mortality rate is the highest among all county-level cancer site death rates. Unlike the minority disparity seen on the state level, Charles County has experienced a reverse disparity with the White lung cancer death rate higher than the African American rate.

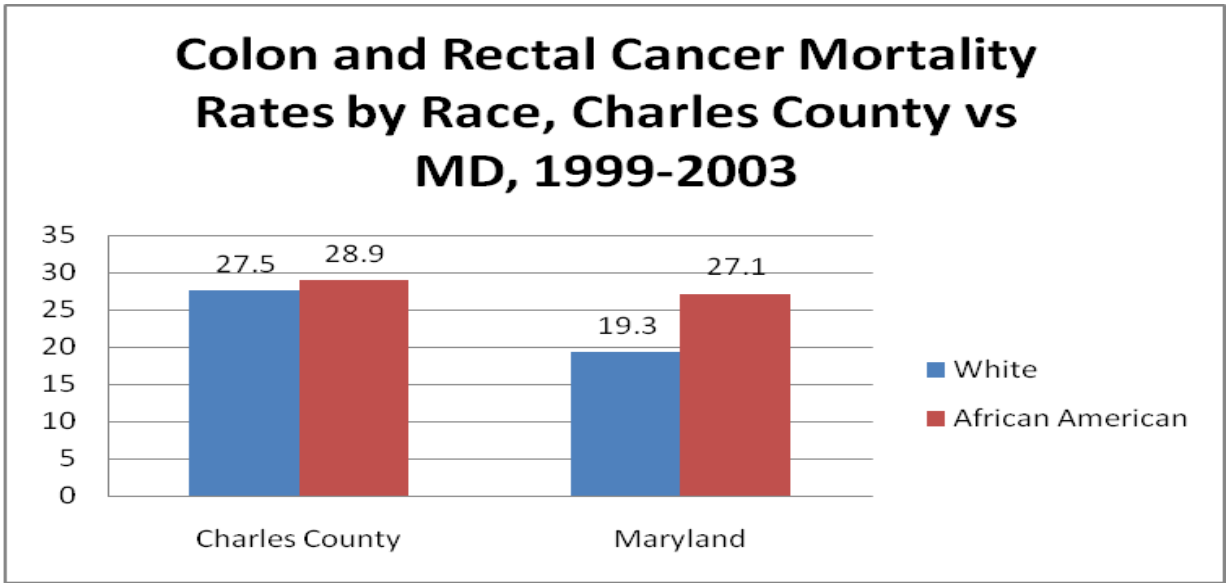


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

*Rates per 100,000 population.

Colon and Rectal Cancer:

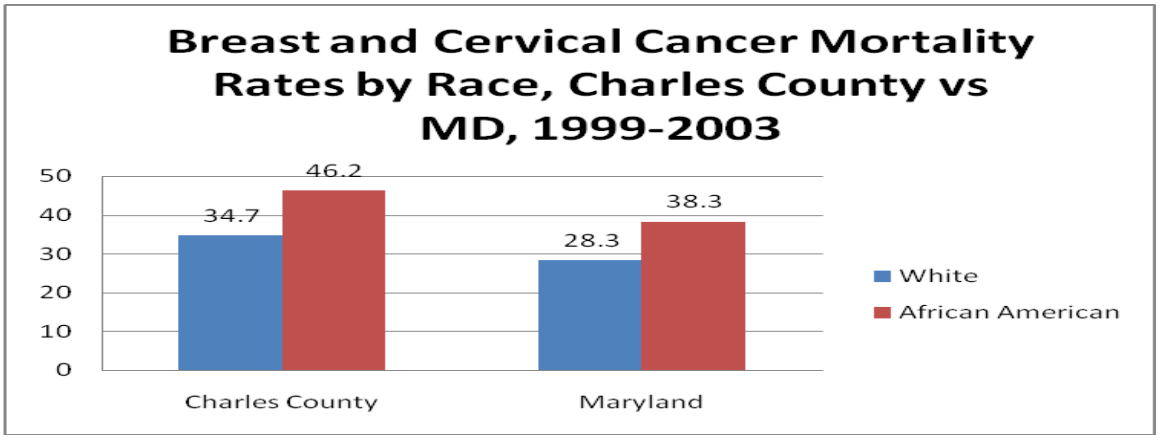
In Maryland, there is a small disparity in terms of Colon and Rectal Cancer deaths, with African Americans experiencing high rates of mortality. However, on a county level, Charles County has not seen the same patterns. The rates for both the White and African American populations are similar. Charles County has the smallest difference in mortality between the White and African Americans than any other jurisdiction in the state.



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities
*Rates per 100,000 population

Breast and Cervical Cancer:

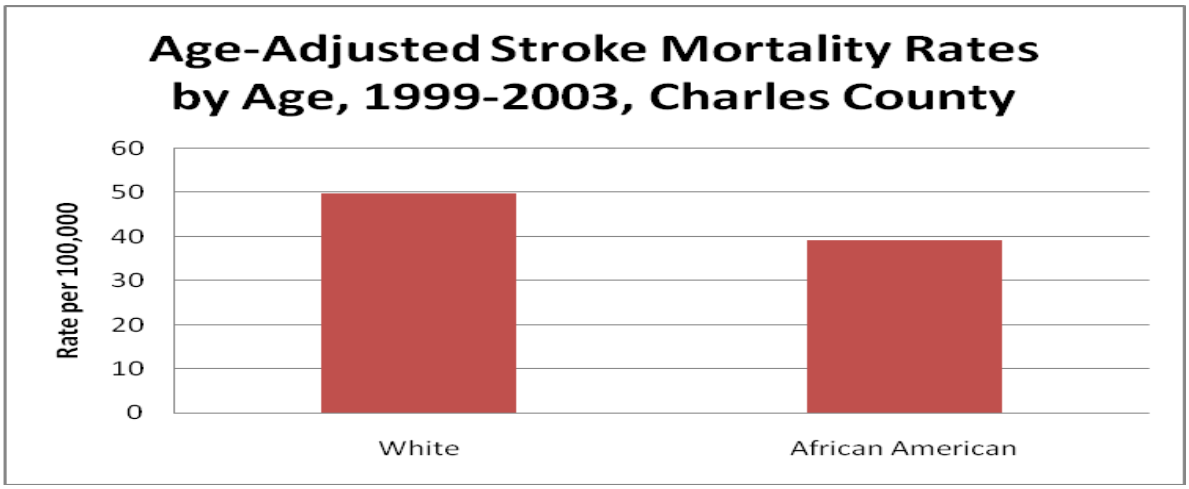
Disparities are visible between the African American and White populations on a county and state level for breast and cervical cancer mortality. The Charles County African American breast and cervical cancer mortality rate is significantly higher than the rate for the Charles County White population. The excess difference in the disparity is higher on a county level (11.5) than on a state level (10).



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities
*Rates per 100,000 population.

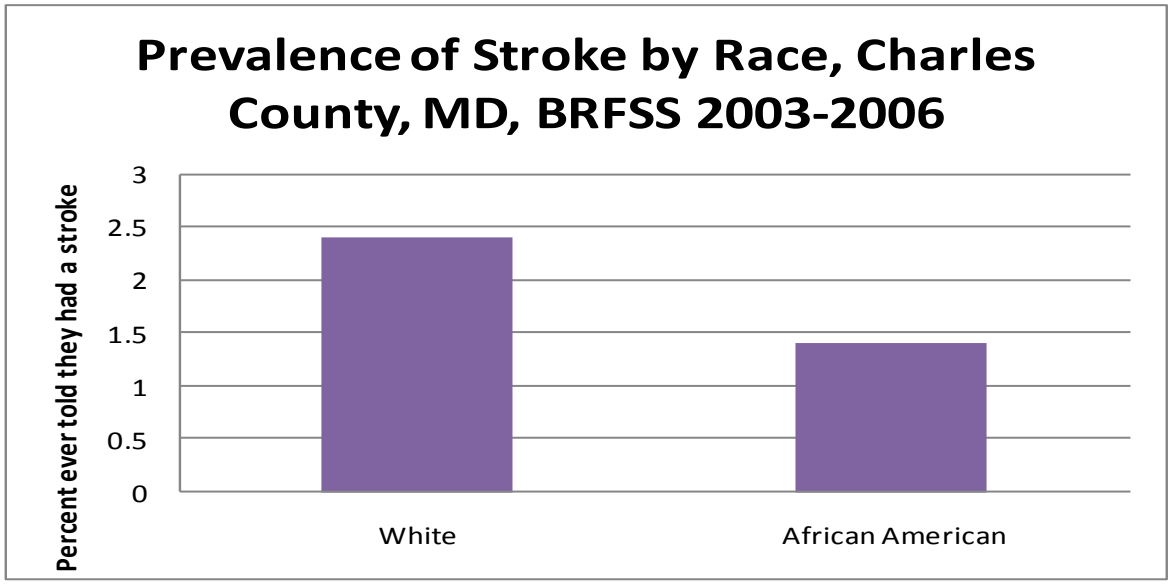
Stroke:

Stroke incidence and mortality are often seen at an increased rate among the African American population. This disparity has been observed on the state and national level. However, the same patterns of disparity are not observed on the county level. From 1999-2003, the Charles County White mortality rate was 27% higher than the African American stroke mortality rate and 13% lower than the Maryland statewide White stroke mortality rate. Additionally, Charles County had the lowest African American stroke mortality rate among all of the Maryland jurisdictions.[1]



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Using 2003-2006 pooled data from the Maryland Behavioral Risk Factor Surveillance System, a county prevalence of stroke can be estimated. Respondents are asked if they have ever been told by a doctor that they had a stroke. Again, a reversed disparity can be seen. Approximately 2.4% of White respondents from Charles County answered "Yes" that they had been told by a doctor that they had a stroke. Only 1.4% of the African American respondents from Charles County answered "Yes" to the same question.[5]



High blood pressure is a risk factor for stroke. The estimated prevalence for high blood pressure can be approximated by using the Maryland Behavioral Risk Factor Surveillance System (BRFSS) data. One of the questions asks participants if they have ever been told by a doctor that they have high blood pressure. The responses for each racial group are presented in the table below. Several years of data have been included to increase the sample size and to demonstrate any trends in the prevalence of high blood pressure.

According to the self-reported data from the BRFSS, Whites have the highest levels of high blood pressure in the county. The percentage of African Americans reporting that they have high blood pressure is lower than the percentage of individuals reporting high blood pressure in the White population.[5] This is true for all years of data presented. However, it should be noted that the percentage of respondents reporting hypertension increased from 2001-2004 to 2005 regardless of race. The estimated prevalence could not be determined for other racial groups due to small sample sizes.

Charles County BRFSS: Have you ever been told that you have High Blood Pressure? 2001-2004 and 2005	**(%)**	**(%)**
Percentage that responded "**Yes**"	2001-2004	2005
Charles County African Americans	31.3	34.9
Charles County Caucasians	33.6	44.7

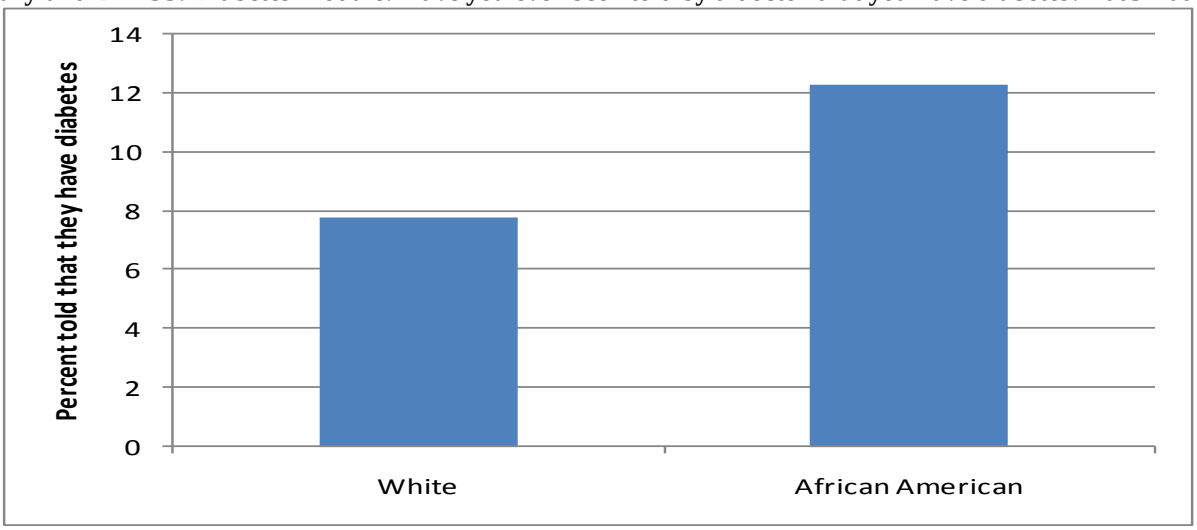
Diabetes:

Incidence:

An estimated prevalence of diagnosed diabetes can be determined on a county level using 2005-2006 Maryland BRFSS data. The data from the question, "Have you ever been told by a doctor

that you have diabetes?" was combined into a two-year period in order to increase the sample size and therefore increase the reliability of the statistics. Disparities can be seen between the African American and White population. The African American population has a significantly higher percentage of people with diabetes than the White population.

Maryland BRFSS: Diabetes Module: Have you ever been told by a doctor that you have diabetes? 2005-2006



The Center for Preventive Health Services at the Maryland Department of Health and Mental Hygiene combined five years of BRFSS data for diabetes and then weighted the responses to reflect the total Maryland and Charles County populations. The table below presents the five-year average prevalence of diagnosed diabetes for Charles County and Maryland defined by gender, race, and age from 2000-2004.

The average prevalence of diabetes in Charles County is lower than the state prevalence (4.2 vs. 6.9). The diabetic prevalence among males is significantly lower for Charles County (2.7% of the total Charles County population) than the state average prevalence of 7.3% of the total MD population. However, for females, the average prevalence is similar between Charles County and the state of Maryland (5.7% vs. 6.5%). Females in Charles County are nearly three times more likely to have been diagnosed with diabetes than Charles County males. [9]

When comparing the average diabetic prevalence by race, the percentage of diabetics within the total black population is higher than the percentage of diabetics in the total white population. The prevalence of diabetes for all races in Charles County is lower than the prevalence among all races for the state of Maryland. However, the number of African Americans in Charles County has increased in recent years. From 1998-2002, 854 African Americans were diagnosed with diabetes in Charles County; from 2000-2004, the number of African Americans with diagnosed diabetes increased to 1103 persons. [9]

When comparing the prevalence of diabetes among age groups, the highest diabetic prevalence falls within the elderly population over the age of 65 years. This is true for Charles County and for the state of Maryland, though the Charles County diabetic prevalence for this age group is below the state prevalence. The prevalence of diagnosed diabetes within the 65+ age group has increased over the past few years. The 1998-2002 five-year diagnosed diabetes prevalence for

Charles County was 12.1%, with 990 people affected. The 2000-2004 five-year prevalence has increased to 12.3%, with 1083 people affected. The prevalence estimates of diabetes within the other age groups (18-44 and 45-64) for Charles County are below the state of Maryland. [9]

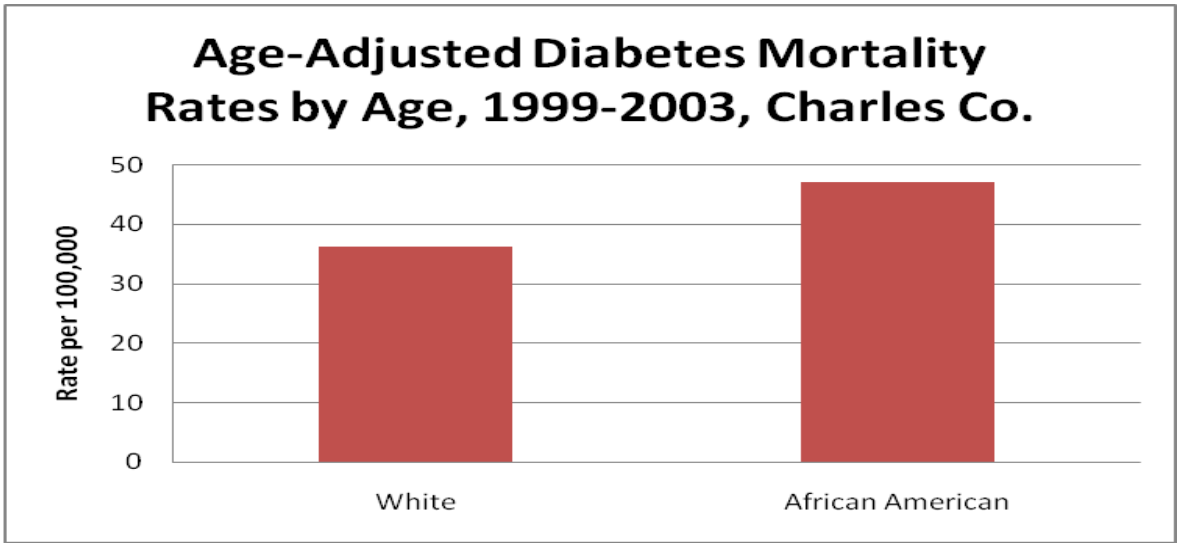
2000-2004 Five-Year Average Prevalence of Diagnosed Diabetes in Charles County and Maryland

		Gender		Race			Age	
Region	Total	Male	Female	White	Black	18-44 yrs	45-64 yrs	65+ yrs
Charles County	3716 (4.2%)	1222 (2.7%)	2493 (5.7%)	2612 (4.6%)	1103 (5.4%)	817 (1.6%)	1767 (6.5%)	1083 (12.3%)
Maryland	278713 (6.9%)	140246 (7.3%)	138467 (6.5%)	151775 (6.1%)	96598 (9.7%)	53040 (2.5%)	125652 (9.6%)	96225 (16.4%)

Source: Diabetes in Maryland. Maryland DHMH: Family Health Administration.

Mortality:

Disparities seen in Charles County for diabetes incidence are also evident in the county levels of mortality due to diabetes. The greatest mortality ratio disparity for African Americans compared to Whites in Charles County is with diabetes, where African Americans have a 30% higher death rate than Whites. [1]

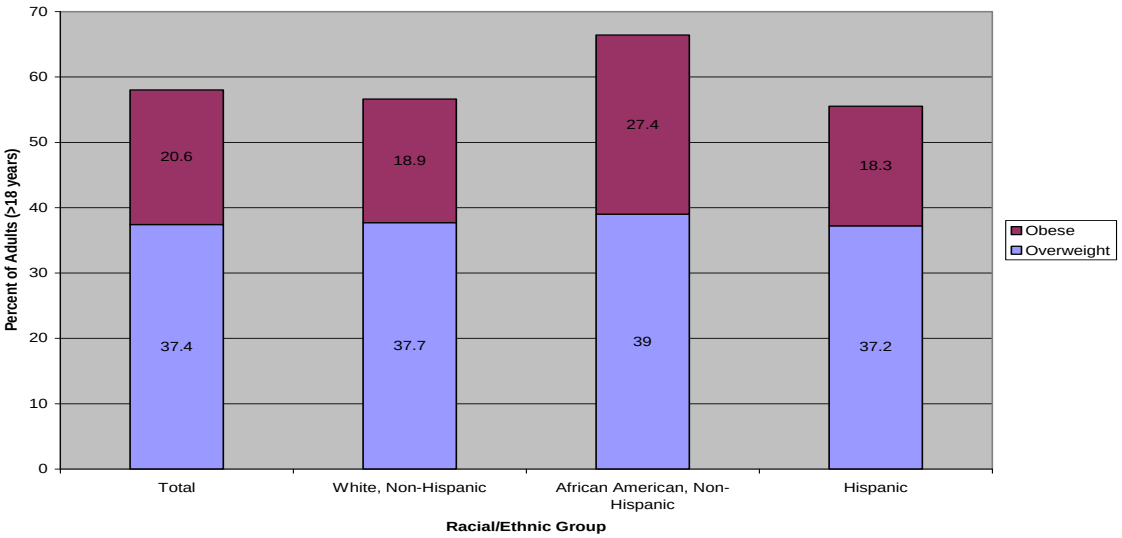


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Obesity:

Obesity is a known risk factor for many chronic diseases and conditions. When comparing among racial and ethnic groups, the prevalence of overweight and obesity was higher for African American Marylanders than for White or Hispanic Marylanders. African Americans experienced higher rates of obesity than Caucasians or Hispanics.

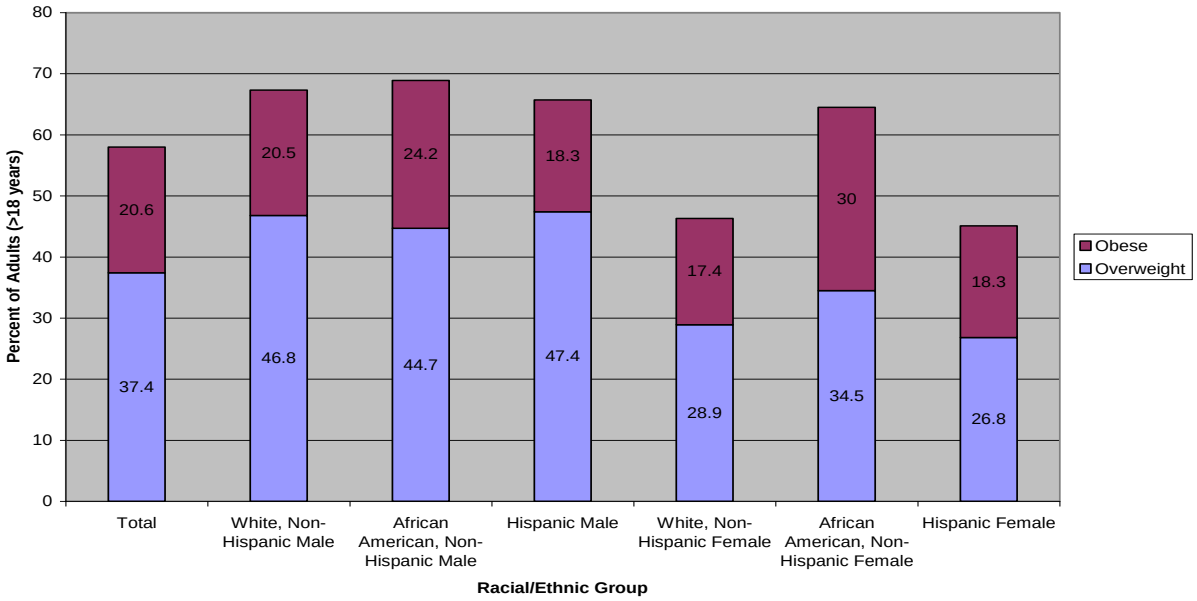
Figure 1: Prevalence of Overweight and Obesity by Race/Ethnicity in Maryland, 2001-2003



Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

The prevalence of overweight and obesity in Maryland was higher among African American women compared to White or Hispanic women. Among males, the prevalence of overweight was comparable across racial groups; however, obesity prevalence rates were higher among African American males in Maryland than White or Hispanic males. African American women were more likely to be obese than African American men. However, white men were more likely to be obese than white women. For the Hispanic population, the obesity prevalence was the same for both men and women in Maryland.

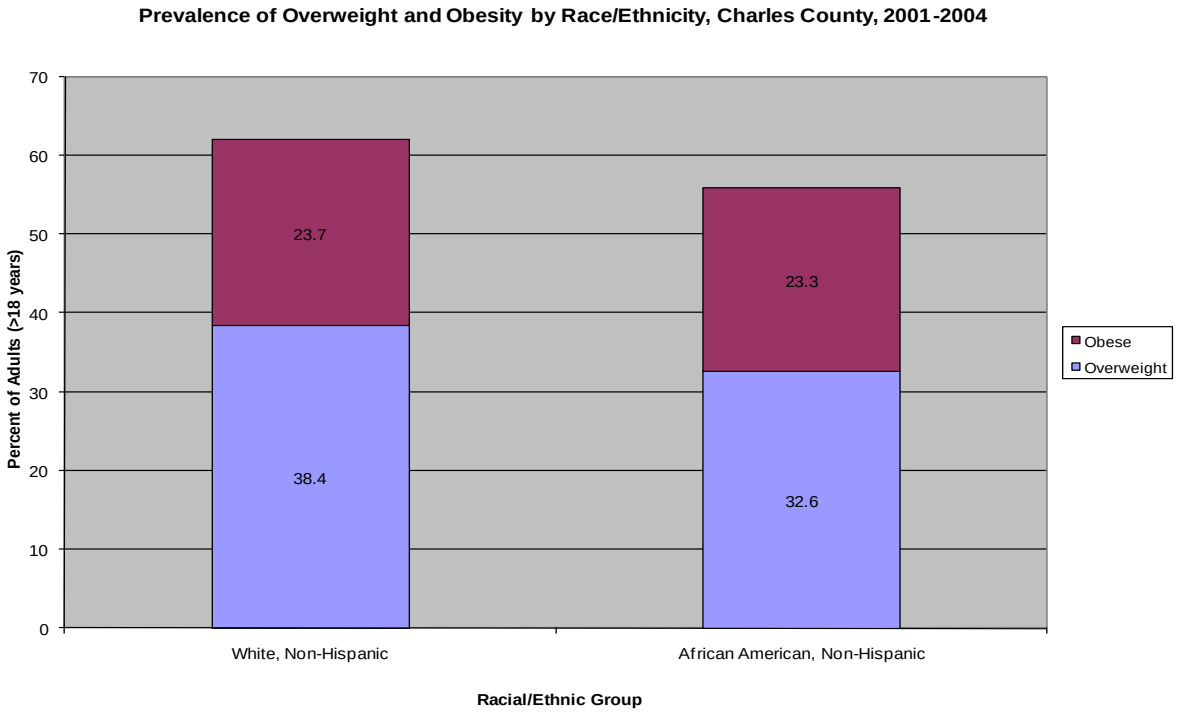
Figure 2: Prevalence of Overweight and Obesity by Race/Ethnicity and Gender in Maryland, 2001-2003



Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

Obesity prevalence rates have increased in Charles County over the last decade. Several years of data were aggregated together to increase the sample size to a more statistically stable level. Data are compared by 3 year time periods. The prevalence of obesity among Charles county adults was 15-19% during 1995-1997. By 2001-2003, the prevalence of obese adults had increased to 20-24% of the Charles county population. [10]

When comparing overweight and obesity rates in Charles County by race, the disparities seen on the state level are not observed. The obesity rates for the White and African American population are similar. A reversed disparity is seen when comparing rates of overweight individuals. There is a slightly higher rate in the county's White population than the African American population. [5]



Source: Maryland Behavioral Risk Factor Surveillance System

HIV/AIDS:

Maryland has the 19th highest total population among the 50 states and the District of Columbia. However, in 2004, Maryland was 9th in the US for the cumulative number of AIDS cases at 27,550 cases through 2004 and 4th for its cumulative AIDS incidence rate of 26.1 cases per 100,000.[11]

For Charles County, the 2004 HIV incidence rate was 5.8 per 100,000, and the 2004 AIDS incidence rate was 6.6 per 100,000. The Charles County 2004 HIV prevalence rate was 91.3 per 100,000, and the 2004 AIDS prevalence rate was 72.2 per 100,000.[11]

	2004 HIV Incidence Rate	2004 AIDS Incidence Rate	2004 HIV Prevalence Rate	2004 AIDS Prevalence Rate
Maryland	40.5	24.4	308.5	241.3
Charles County	5.8	6.6	91.3	72.2

Source: Maryland 2005 HIV/AIDS Annual Report

However, Charles County makes up 58% of the total HIV/AIDS cases in the Southern Maryland region. Among the increases in the incidence rates of HIV, the biggest increases have been seen in the African American population. African Americans currently make up 66% of the total HIV/AIDS cases in Southern Maryland. African Americans make up approximately 63% of the prevalent HIV cases in Charles County and 52.2% of the prevalent AIDS cases in the county.[11]

Distribution of Gender and Race/Ethnicity among Prevalent HIV Cases on December 31, 2004

Gender: **Race:**

Male	Female	Missing	White	African American	Hispanic	Other	Missing
63	46	1	20	69	2	0	19

Source: Maryland 2005 HIV/AIDS Annual Report

Distribution of Gender and Race/Ethnicity among Prevalent AIDS Cases on December 31, 2004

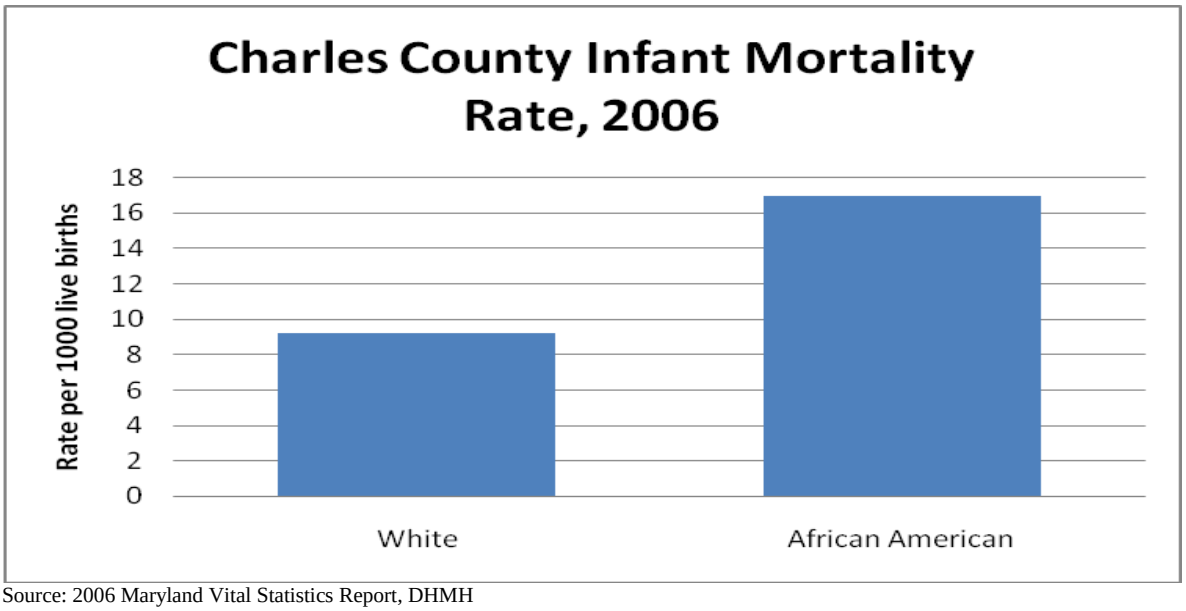
Gender: **Race:**

Male	Female	Missing	White	African American	Hispanic	Other	Missing
58	29	0	26	59	1	1	0

Source: Maryland 2005 HIV/AIDS Annual Report

Infant Mortality:

On a state and national level, infant mortality disproportionally affects the African American population. The same is true for Charles County. According to the 2006 Maryland Vital Statistics Report, infant mortality rates per 1000 live births are almost double for Charles County African Americans than for Charles County Whites.[12]



Source: 2006 Maryland Vital Statistics Report, DHMH

One of the hypothesized reasons for the increase in infant mortality among minorities is a lack of prenatal care. According to the 2006 Maryland Vital Statistics Report, Charles County minorities were more likely to report receiving late or no prenatal care than non-Hispanic Whites. The greatest percentage of late or no prenatal care was seen in the Asian/ Pacific Islander population.[12]

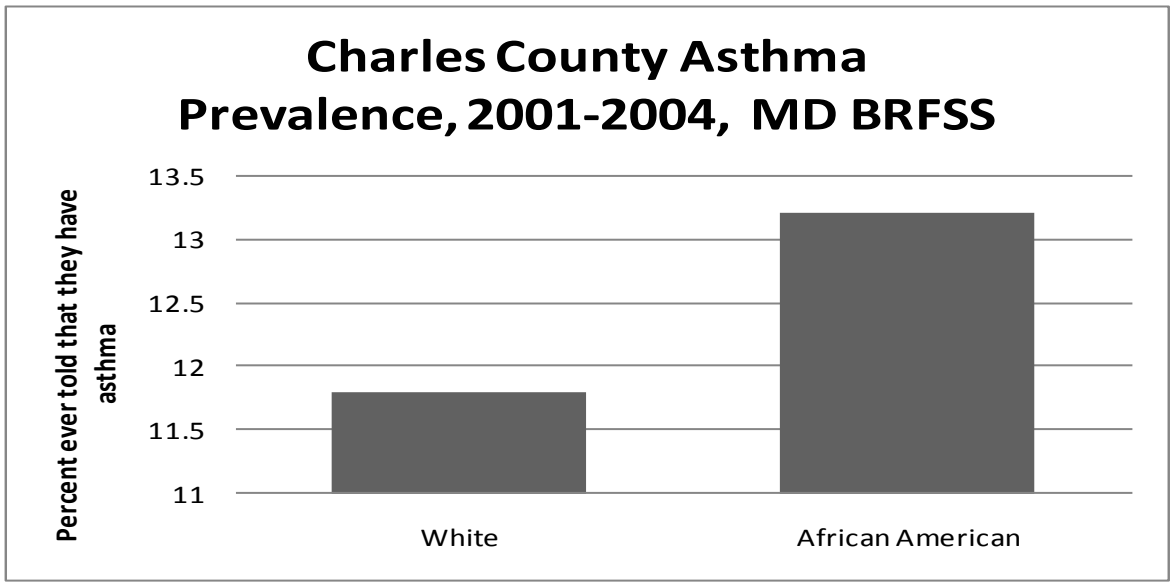
2006 BRFSS: Late of No Prenatal Care	Percent
White, Non-Hispanic	3.4
African American	6.6
Asian/ Pacific Islander	9.4
Hispanic	6.7

Source: 2006 Maryland Vital Statistics Report, DHMH

Asthma:

The prevalence of asthma in Maryland, from the Maryland BRFSS, is 1.2 times higher for African Americans that for Whites. Based on that, it might be expected that African American adults would experience 1.2 times as many asthma emergency department visits, asthma hospitalizations, and asthma deaths. However, African Americans experience 3.7 times as many asthma emergency visits, 2.6 times as many asthma hospitalizations, and 2.8 times as many asthma deaths. The disparity in these asthma consequences indicates that African Americans experience less treatment success in managing their asthma. Treatment success for asthma depends on access to care, quality of provider treatment planning, and the ability of patients to carry out their treatment plan at home (understanding of plan, affordability of medications and devices). It also depends on the ability to remove asthma triggers from the patient's environment. Individual differences in asthma severity and in patient responsiveness to or side effects from medications also influence treatment success. Elimination of the disparities in asthma outcomes will only occur when the disparities in asthma treatment success are eliminated.[1]

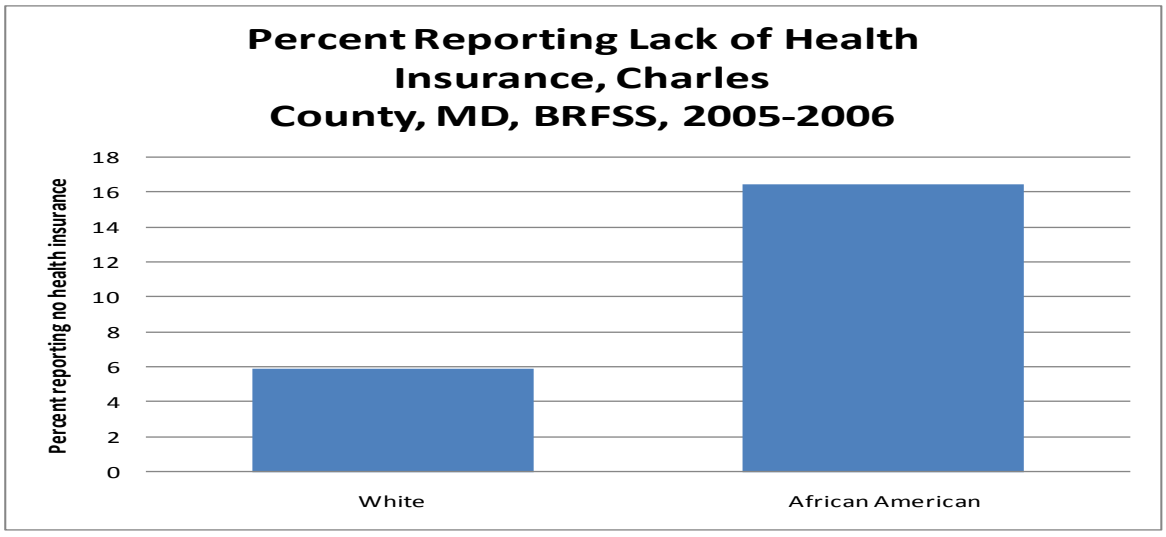
Estimates on a county level from the Maryland BRFSS data find that African Americans report slightly higher rates of diagnosed asthma than the White population.



Source: 2001-2004 Maryland Behavioral Risk Factor Surveillance System

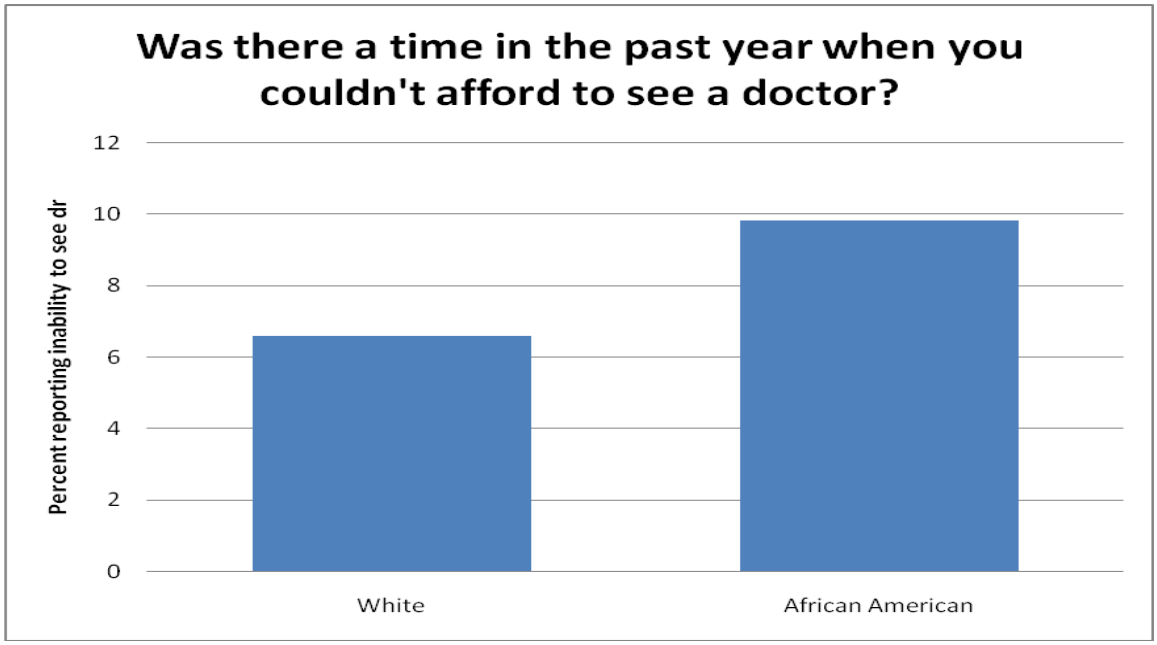
Health Insurance:

Disparities are often seen among racial groups in terms of health insurance rates. Using the 2005-2006 Maryland BRFSS data, a greater percentage of Charles County African Americans reported a lack of health insurance compared to the county's White population. The difference is more than double.[5]



Source: 2005-2006 Maryland Behavioral Risk Factor Surveillance System

Using the Maryland BRFSS data from 2005-2006 for the question "Was there a time in the past year when you could not afford to see a doctor?" another disparity is observed. Slightly more African Americans reported an inability to see a doctor due to money than Whites in the county.[5]



Source: Maryland Behavioral Risk Factor Surveillance System, 2005-2006

Information on health status was asked in the 2006 Maryland BRFSS. When stratified by race, African Americans are more likely to report having "Excellent" health; however, they are also more likely to report having "Fair" or "Poor" health.[5]

"How is your health in general?", Charles County, MD, BRFSS, 2006

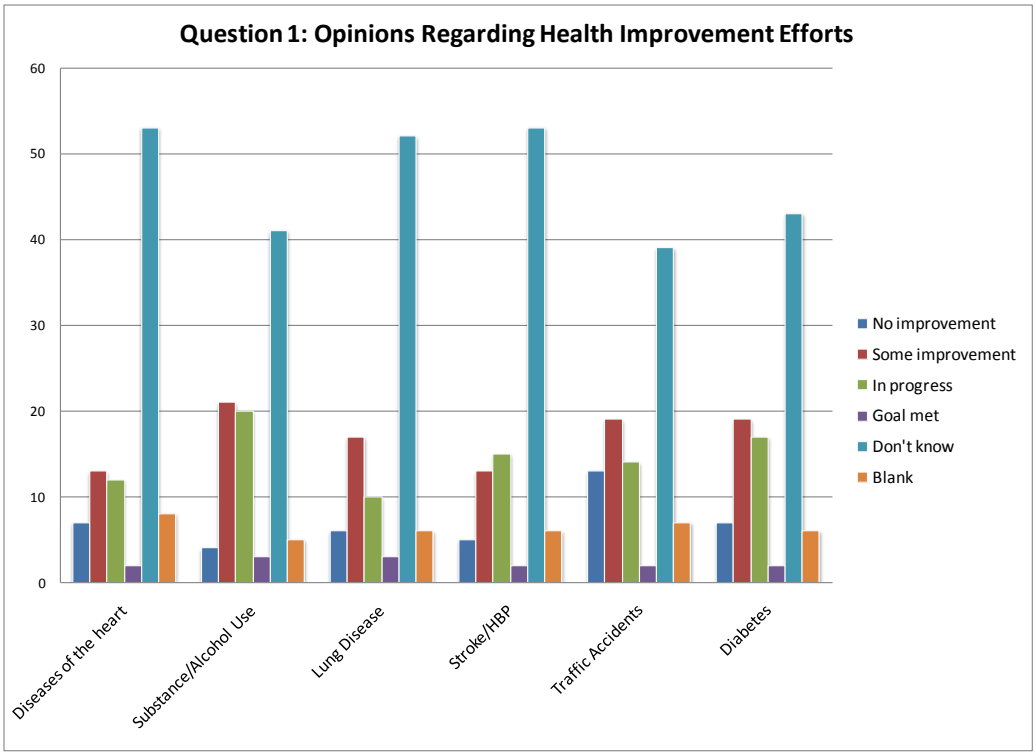
Health Status	Excellent	Very Good	Good	Fair	Poor
White	20.2%	41.3%	26.1%	8.3%	4.1%
African American	22.5%	37.1%	24.2%	9.7%	6.5%

2008 Survey Results

Cumulative Survey Results

As part of the latest community need profile for Charles County, a questionnaire was developed to ask health department professionals, community stakeholders, and health services clients their opinions on the status of health and health services within Charles County.
In order to identity the health achievements, obstacles, and significant problems within the county, 94 surveys were completed. These individuals represent the community's opinion on the status of health and improvements that need to be made. The results of those questionnaires are presented below.

Results
As seen from the chart below, the most common response to each question was "Don't Know." Traffic Accidents received the largest number of "no improvement" ratings. Substance and Alcohol Use received the largest number of "Some improvement" and "In Progress" responses. Each area received a small portion of "Goal Met" ratings. On the other hand, Heart Disease and Stroke/High Blood Pressure had the largest number of "Don't know" responses.



Question 1: Has there been improvement in preventive health education efforts in the following areas in Charles County?
Heart disease is the second leading cause of death in Charles County. The most common response was that they did not know if any improvement had been made in preventive health education efforts for heart disease. This answer was given by 56% of the cumulative group. Among those who did comment on the status of heart disease efforts, most felt that "some

improvement" had been made or that improvements were "in progress." This was true cumulatively as well as for each group individually.

Diseases of the Heart	Number	Percentage
No Improvement	7	7%
Some Improvement	13	14%
In Progress	12	13%
Goal Met	2	2%
Don't Know	53	56%
Blank	8	8%

Preventive health education efforts for substance and alcohol use have been long standing priorities at the health department. Just under half of the clients were not able to give a rating to this question and answered "don't know." Among those who expressed an opinion of the status of substance and alcohol use improvement efforts, most of the clients felt that "some improvement" had been made or that substance and alcohol use prevention efforts are "in progress". This was true cumulatively as well as for each group individually.

Substance and Alcohol Use	Number	Percentage
No Improvement	4	4%
Some Improvement	21	22%
In Progress	20	21%
Goal Met	3	3%
Don't Know	41	44%
Blank	5	6%

Lung disease caused by smoking is the third leading cause of death in Charles County. Slightly over half of the respondents (55%) reported that they did not know if any efforts had been made to improve chronic lower respiratory disease within the county. Among those who did rate the improvement status of lung disease, many perceived that "some improvement" has been made. The results cumulatively, for clients, and for health department employees found that "some improvement" had been made. Results for the community stakeholders fared more favorably as they felt that improvements were currently "in progress."

Lung Disease Caused by Smoking	Number	Percentage
No Improvement	6	6.5%
Some Improvement	17	18%
In Progress	10	11%
Goal Met	3	3%
Don't Know	52	55%
Blank	6	6.5%

Cerebrovascular disease, commonly known as stroke and high blood pressure, is the fifth leading cause of death in Charles County. Even among groups surveyed, little is known of the health education efforts within the county for stroke and high blood pressure. More than half of the

group answered that they "Don't know" about if there has been improvements in this field. Among those who rated the health education efforts, the most common response was that improvements are "in progress." This was true cumulatively, for clients, and for stakeholders. The most common answer for health department employees was that "some improvement" has been made.

Stroke/High Blood Pressure	Number	Percentage
No Improvement	5	5%
Some Improvement	13	14%
In Progress	15	16%
Goal Met	2	2%
Don't Know	53	57%
Blank	6	6%

Injuries, death, and hospitalizations due to traffic accidents continue to increase in Charles County. Among those rating this area, the responses were evenly distributed between "no improvements", "some improvement", and "in progress." This is true cumulatively and for clients. The most common response among stakeholders as well as health department employees is that "some improvements" have been made.

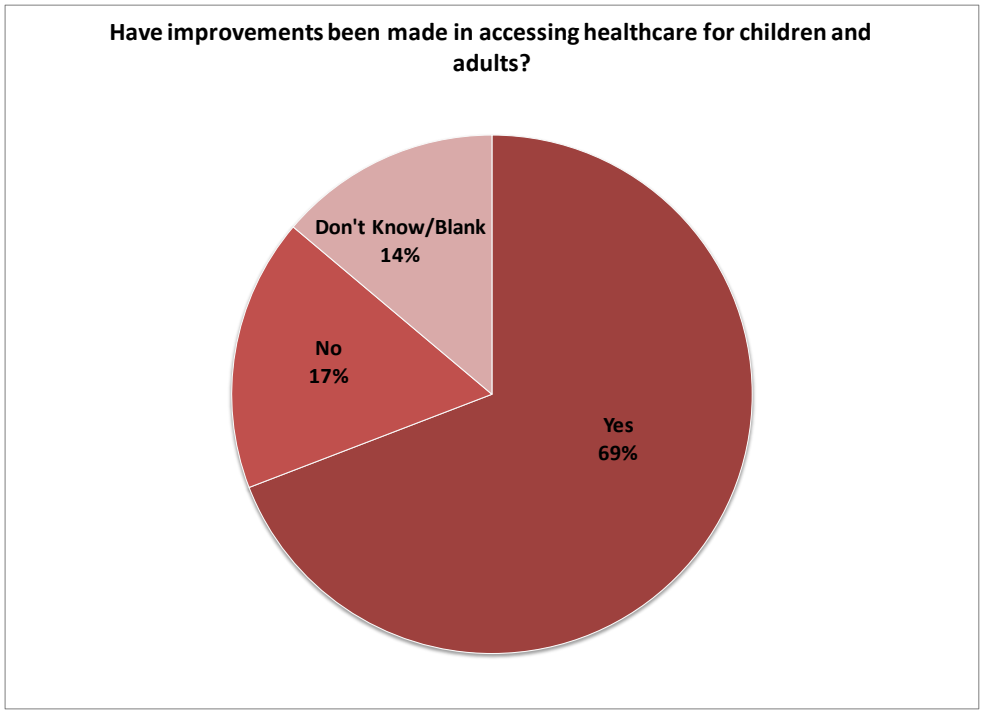
Traffic Accidents	Number	Percentage
No Improvement	13	14%
Some Improvement	19	20%
In Progress	14	15%
Goal Met	2	2%
Don't Know	39	42%
Blank	7	7%

Diabetes mellitus is one of the top ten leading causes of death in Charles County as well as a significant contributor to morbidity. Slightly over half of the respondents were knowledgeable about diabetes health education efforts and rated the improvement seen within the county. Among those who rated the improvements, respondents felt that "some improvement" had been made or that improvements were currently "in progress." This is true cumulatively and for all groups individually.

Diabetes	Number	Percentage
No Improvement	7	7%
Some Improvement	19	20%
In Progress	17	18%
Goal Met	2	2%
Don't Know	43	46%
Blank	6	7%

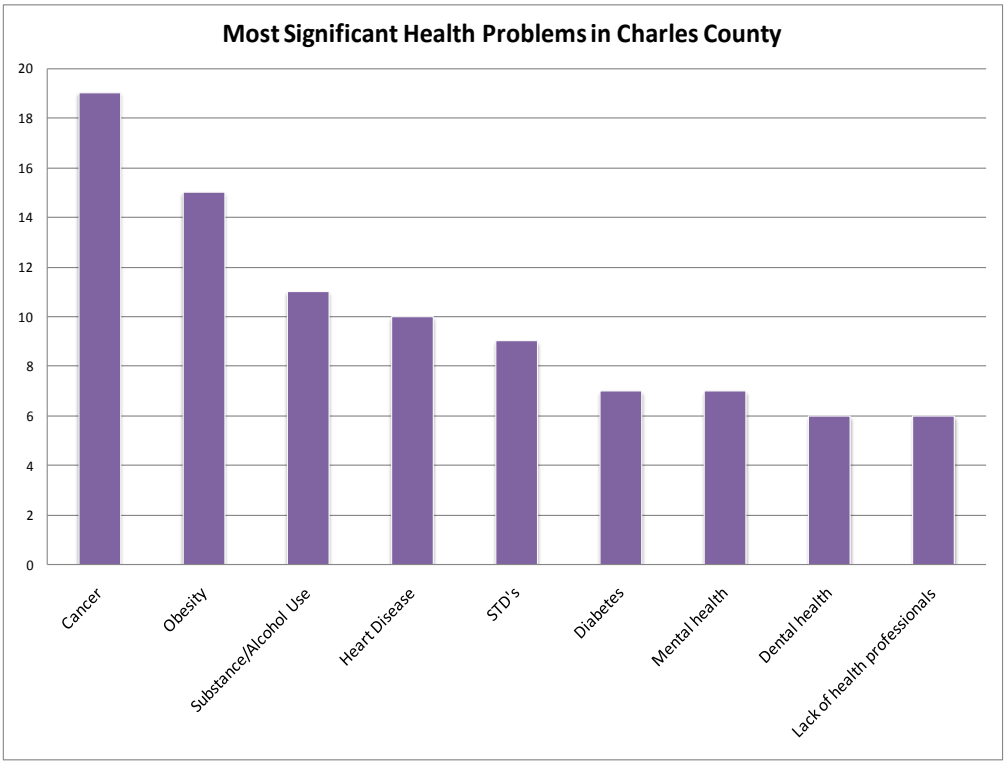
Question 2: Has there been improvement in accessing healthcare for children and adults?
Two thirds of the respondents felt that improvements have been made to increase access to healthcare for adults and children (69%). The same trends in response were seen for all groups individually and for the group cumulatively. The most commonly listed improvement was

medical assistance programs. Another commonly listed improvement was more accessibility to health care and dental services.



Question 4/9: What do you think are significant health problems in Charles County today?

The commonly listed health problem listed by the cumulative group was cancer (20%). It was closely followed by obesity and substance abuse. Cancer was the most common answer for the group cumulatively, for the stakeholders, and for health department employees. Sexually transmitted diseases were the most common answer for clients, followed by Cancer.



Conclusions:

The minority population is increasing rapidly in Charles County. But with increases in the minority populations, increases in minority health disparities have not been observed. For many chronic and communicable diseases, rates appear to be similar for both the White and African American population. The biggest health disparities have been seen for heart disease, breast and cervical cancer, and diabetes. For some conditions, reverse disparities have occurred, such as lung cancer and all cause cancer mortality and stroke mortality.

It should be noted that comparisons on a county level could only be done with the White and African American populations. Because they are the two largest racial groups within the county, data with large sample sizes are available for comparative purposes. Data for other races and Hispanic ethnicity often have small sample sizes which yield unreliable results.

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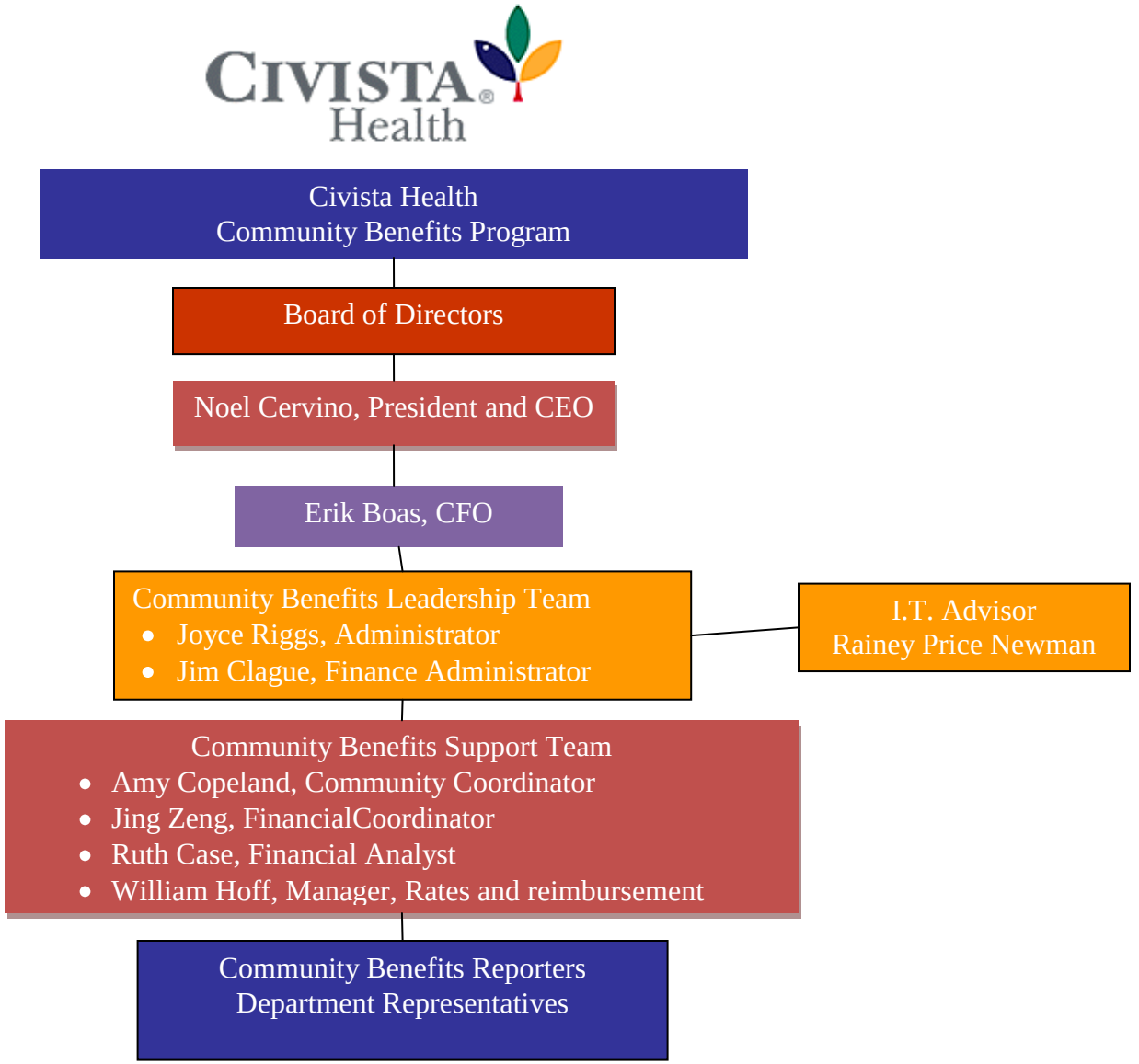

Civista Health
Community Benefits Program
Board of Directors
Noel Cervino, President and CEO
Erik Boas, CFO
Community Benefits Leadership Team
Joyce Riggs, Administrator
Jim Clague, Finance Administrator
I.T. Advisor
Rainey Price Newman
Community Benefits Support Team
Amy Copeland, Community Coordinator
Jing Zeng, FinancialCoordinator
Ruth Case, Financial Analyst
William Hoff, Manager, Rates and reimbursement
Community Benefits Reporters
Department Representatives

Charles County Department of Health

Childhood Obesity Prevention- F679N
4th Quarter Narrative
FY 2010

We Can!™Program

Participation:

The third *We Can!*™ class successfully began on April 22, at Milton Somers Middle School's Community Center in La Plata and ended on May 27, 2010. This quarter there was total of 50 initial registrants, which was astonishing. Of this number, 32 were officially enrolled (by having attended at least one class). The remaining 18 individuals (from nine families) did not attend citing schedule conflicts, or illness as the primary reason for deciding not to come. Many simply did not return telephone calls. Despite that, program staff found it very satisfying to see that each of the 32 participants who started the program successfully completed it. The class was made up of 14 parents/guardians and 18 children. Each class had an average attendance of 26 individuals (81%). Although regular attendance was very good, it became a challenge for a few of the families to come to some of the classes due to illness, school-related activities and other evening commitments as the program progressed.

The pre-class interviews that began in the third quarter proved to be very useful in collecting much of the pre-assessment information ahead of time. This allowed for more time to be spent on the first night of class for taking physical measurements, providing group instruction/discussion and engaging in physical activity.

Demographics:

There were20 females and 12 males. Since the program's inception the racial/ethnic diversity in each of the classes has been note worthy. This quarter's class in La Plata is the first where the Hispanic/Latino community has been represented. Of the total of 72 individuals enrolled, 60% were African American/Black, 38% were Caucasian/White and 2% were American Indian.

The families who participated have also been relatively affluent and with average gross household incomes of $50,000 - $74,000 or greater. Most of the parents also received some form of higher education. Seventy-seven percent (77%) either had some college/tech school or were college graduates. Four of the parents completed graduate school.

This fiscal year, the participants' area of residence and driving distance to each of the three program locations was not a major factor for enrollment and retention. Travel time for most was an average of 15-20 minutes. It was not surprising to see that over half of the families that participated this year reside in Waldorf, which is the most densely populated area of the county. The remaining participants were from La Plata and surrounding areas.

Access to Care:

There was no access to care issues/concerns this quarter. Everyone who participated had some form of health insurance coverage and was under the care of a physician or other health care provider. The majority was covered by an employer-based health insurance plan.

Co-morbidity Data:

Similar to the third quarter report, a significant number of participants had a family history of heart disease or stroke (75%), diabetes mellitus (65%) and high blood pressure or hypertension (59%). This fiscal year, the cardiovascular disease risk factor that was highest was for high blood pressure or hypertension at 72%. This year the top three self-reported medical conditions were childhood or adolescent obesity (15), high blood pressure or hypertension (13) and asthma (10). This quarter there was a variety of other self-reported medical conditions that were unique to this class. One of the parents was hearing-impaired and her two sons each had Aspergers Syndrome. After some searching, a sign language interpreter was found to accommodate the mother's needs. Another child had a bone disorder called Multiple Hereditary Exostoses in which bony tumors form on the bones near the joints. Fortunately, this did not prevent her from fully participating in the program. No one reported tobacco use.

Outcome Measures for Children Who Completed the Program:

Consistent with previous reports, most of the children (74%) were overweight or obese with the majority having a BMI >30, which put many into the $\geq 95^{th}$ percentile for the age/height/weight ratio. Although it is not reflected in the pre and post percentiles, several of the children and adults lost weight. Thirteen children lost an average of 2.6 pounds each and twelve adults lost an average of 5.1 pounds each. These changes did bring down their BMIs and put the children into lower growth percentiles. In the future, it may be more beneficial to for the report to show the BMI as well as the growth percentiles so as to demonstrate the changes that do occur. While the program message emphasizes maintaining a healthy weight, it was remarkable to see that people lost weight over the six-week period. When asked, many of the parents reported that they were making good strides at implementing much of what was being covered in class. They also remarked that the warmer weather made increasing their outdoor physical activity much more desirable.

At the close of the program, most of the children reported their health as being either "very good" or "excellent" and the majority of those who reported "poor" or "fair" health changed their rating to "good."

Nutrition (Fruit Intake): All of the children who reported having either "none" or "0-1" fruits eaten per day at the pre-test showed an increase in their fruit consumption. Thirteen who reported eating from 1-3 or more pieces of fruit daily on the pre-test increased to 15 who ate 1-3 servings or more per day.

Nutrition (Vegetable Intake): Of the seven who reported eating just "0-1" cups of vegetables on the pre-test, only two showed no increase. Seven who reported eating "1-3" cups daily on the pre-test more than doubled to 15 children on the post. One child reported eating 3 or more cups.

Beverage Intake: Half of the children (9) drank 100% fruit juice two times or less each day and only three drank it 3-5+ times per day. Six reported never drinking juice at all. The numbers also showed that the number of children who drank juice 1 time per day doubled to ten on the post-test. There was a small decrease in the amount of sugar-sweetened beverages consumed and there was also a decrease in the daily frequency in which they were drank.

Physical Activity: The majority of the children reported engaging in less than 60 minutes of physical activity per day on the pre-test and a small amount of progress was made at the post-test whereby 44% reported engaging in 60 minutes or more of daily physical activity.

Screen Time: In answering the question: "Do you have less than two hours of screen time per day?," less than half (6) reported "Yes" on the pre-test. A significant change was made from the pre-test to the post where 72% reported having less than two hours of screen time. This was a remarkable outcome for this group considering that many of the children we getting an average of four hours of screen time per day.

While many the children who completed the program did not meet the benchmarks for daily fruit and vegetable consumption and physical activity, they did make great strides at improving in each of these areas. A major measure of success is seeing our families and individuals make improvements and positive lifestyle changes that incorporate what they've learned in the program. That has certainly been demonstrated by their efforts and achievements - big and small.

Community Partnerships & Events

The staff of the Charles County Department of Health continued to work with the early childhood coordinator of the Local Management Board's Human Services Partnership in co-sponsoring their second annual **'Early Childhood Day'** outreach and education event that was held on April 24, 2010 at

Regency Furniture Stadium. The Department of Health was a Silver Sponsor for this event which allowed for a full page We Can! ad in the program's resource directory. This occasion welcomed over 600 attendees. , which included families, children, expecting moms, grandparents and educators. Each vendor provided a hands-on educational or artistic activity that parents and children could do together. At our display we offered families the opportunity to use our hula hoops to encourage family fitness. This activity turned out to be a big hit among the participants.

This quarter was very busy with a variety of events that were sponsored by the We Can! program. The first was our second **We Can! Fun Walk** that was held on May 15th at the Indian Head Rail Trail. This was a great day where approximately 70 people came out to enjoy the Trail and the beautiful weather. Some of our community partners (The Judy Centers, Charles County Parks and Recreation, University of Maryland Extension and Tri-County Youth Service Bureau) joined us in providing information displays and promotional items.

The next two We Can! sponsored events were both held on June 5th. The day began by celebrating **National Trails Day** at the Indian Head Rail Trail. The event was planned co-sponsored by the Department of Health and Charles County Parks and Recreation. Vendors included the Southern Maryland Audubon Society, the University Of Maryland College of Agriculture's Natural Resources Division, Tri-County Youth Services, University of Maryland Extension and of course the Department of Health and Park and Recreation.

That evening was our big event: **"We Can!™ Feature Night"** at the Southern Maryland Blue Crabs game at Regency Furniture Stadium in Waldorf. This event was probably the best one we've had this fiscal year. It gave the program the best exposure that it has ever received and reached an audience of over 800 people. All of the We Can!™ families that participated this year were invited to come and free tickets were given to the family of the child who got to throw out the first pitch. Before the game began, the children were invited to participate in what they call the "Field of Dreams" where they were allowed to go out onto the field and stretch with the players, do the "High Five Tunnel," receive some autographs and sing the National Anthem. In between innings the announcer read some announcements and slogans on We Can! and nutrition and physical activity.

Attachment D:

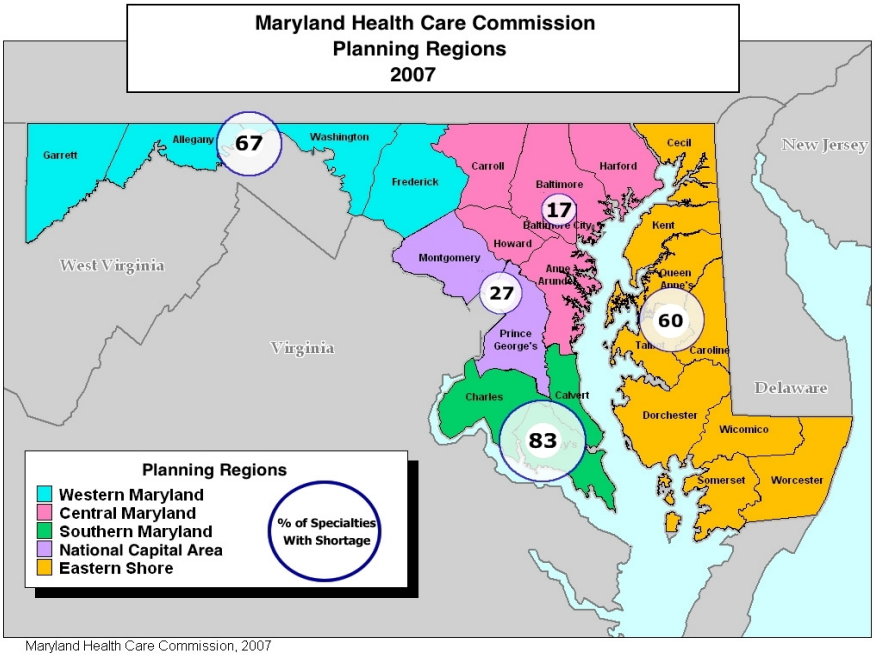
Statement of Access to Specialist Providers for the Uninsured

Civista Medical Center (Civista Health) relies on a combination of pathways to provide access to specialty care for uninsured patients:

- Inpatient specialty care is provided by hospitalists and other professional staff
- OB/GYN services are provided by staff obstetricians and gynecologists at an onsite prenatal clinic
- Physician specialists, as part of their facility privileges, agree to care for all patients who present in our facility regardless of ability to pay or status of health insurance.
- Other specialty services including, but not limited to dental care, mental health, primary care and substance abuse are provided by referral to other community entities such as Greater Baden FQHC, Health Partners Clinic, Nanjemoy Community Health Center, and Charles County Department of Health.
- Some specialties continue to present challenges due to lack of providers. Maryland Hospital Association 2008 Data reports Charles County with 83% of physician specialties with a shortage.

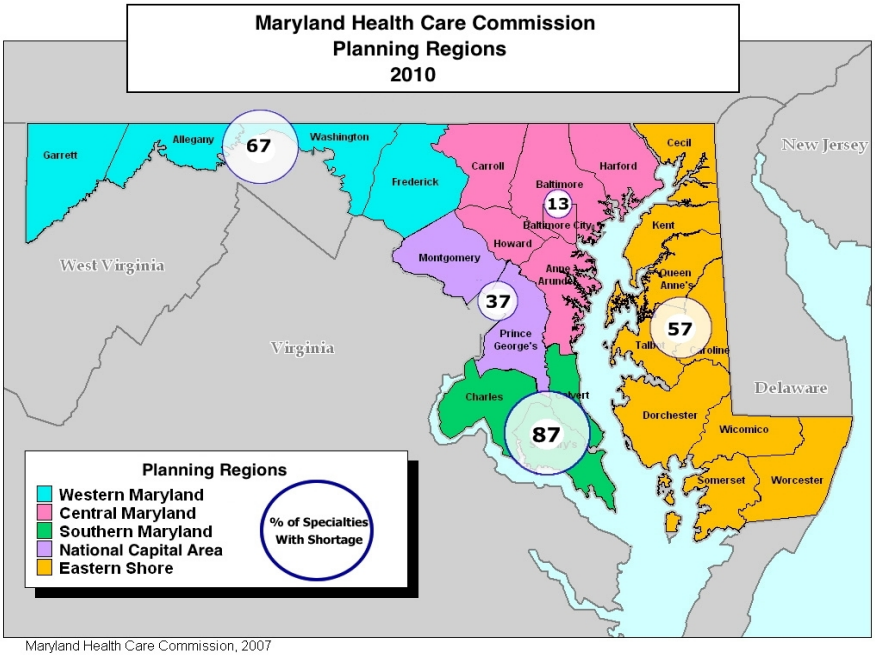
Much time and resource is devoted to maintaining a network of community providers for referral of uninsured patients through Civista's leadership in organizations such as Partnerships for a Healthier Charles County, Healthy Families, Healthy Start, United Way of Charles County, Health Partners, Red Cross, Hospice, Department of Social Services, and Charles County Department of Health.

Exhibit 1



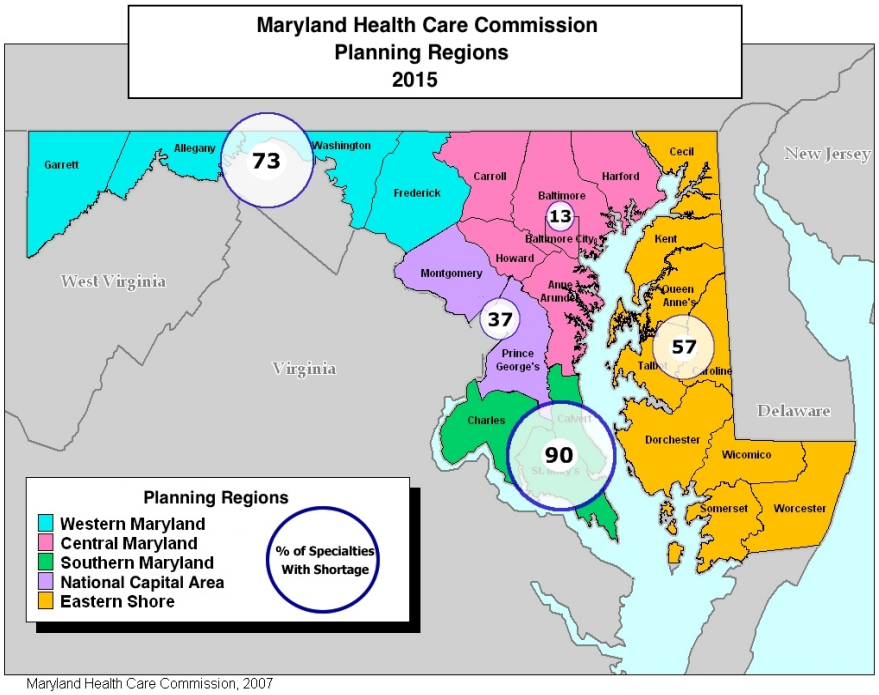
Maryland Health Care Commission, 2007

Exhibit 2



Maryland Health Care Commission, 2007

Exhibit 3



Maryland Health Care Commission, 2007

Exhibit 4
Summary of Physician Shortages for 2007

Specialty	2007				
	Capital	Central	Eastern	Southern	Western
Primary Care*:					
Medical Spec:					
Allergy					
Cardiology					
Dermatology					
Endocrinology					
Gastroenterology					
Hematology/Oncology					
Infectious Disease					
Nephrology					
Neurology					
Psychiatry					
Pulmonary Medicine					
Rheumatology					
Hospital Based:					
Anesthesiology					
Diagnostic Radiology					
Emergency Medicine					
Neonatology					
Pathology					
Physical Medicine					
Radiation Oncology					
Surgical Specialties					
General Surgery					
Neurosurgery					
OB/GYN					
Ophthalmology					
Orthopedic Surgery					
Otolaryngology					
Plastic Surgery					
Thoracic Surgery					
Urology					
Vascular Surgery					
Total	8	5	18	25	20
% of Shortages	26.7%	16.7%	60.0%	83.3%	66.7%

Legend:
Adequate Physician Supply
Borderline Physician Supply
Physician Shortage

*Physician only model, primary care physicians excludes hospitalists

12/14/2010
Civista Health, Inc
Selected Categories - Detail
For period from 7/1/2009 through 6/30/2010

	Monetary Inputs			Outputs
Category / Title / Department	**Expenses**	**Offsets**	**Benefit**	**Persons**
Community Building Activities (F)				
Workforce Development (F8)				
Charles County Commissioners				
Administration/Corporate Services (9600)	3,718	0	3,718	Unknown
CSM Nursing Recruitment				
Human Resources (9510)	399	0	399	4
Loan Guarantee - Physician				
Medical Staff Development (9680)	220,000	0	220,000	Unknown
Physician Shortage Task Force				
Administration/Corporate Services (9600)	100	0	100	Unknown
Recruitment				
Unknown (0)	68,523	0	68,523	Unknown
***** Workforce Development**	**292,740**	**0**	**292,740**	**4**
****** Community Building Activities**	**292,740**	**0**	**292,740**	**4**
Number of Activities 5 **Grand Totals**	**292,740**	**0**	**292,740**	**4**

General Information

Every February you must go to http://aspe.hhs.gov/poverty/ and click onto the HHS poverty guidelines. You take the figure that is listed on the guidelines and multiply it by 200% to get the guidelines Civista Medical Center uses. These figures are good for the 100% write offs.

To update the table for partial approval you multiply the federal poverty guidelines as follows:
1st column by 225%
2nd column by 250%
3rd column by 275%
4th column by 300%
These figures are good for the % write offs.

Financial Assistance is valid for **6 months** from the date of approval. It retro's back to any existing account whether it is Bad Debt or Final Billed. Do not write off an account that has a valid insurance on the account and is awaiting payment.

Financial Assistance is ONLY good for Civista Medical Center bills. Not valid for American Radiology, Laplata Physicians Services or the Doctor(s) that attended to the patient. Patient must call these places to make other arrangements for payment.

Patient MUST call Civista Medical Center whenever they get a bill to write off the amount. (You must verify from spreadsheet or notes in the system that patient is valid for those dates of services before writing off account).

Patient can reapply for financial assistance at anytime whether approved or denied. Approval is based off previous year tax return.

We will only accept the most current application for review. Any old or out of date application is not valid.

4 letters

Approved letter- use this letter when the patient has been approved for 100% write off. Use the date that the Collections Supervisor signs/dates the application for the approval. Valid for 6 months(Collections Supervisor signs) (example 1)

Approved % letter- use this letter when the patient has been approved for a partial write off. Partial write off's are also valid for 6 months
(Collections Supervisor signs) (example 2)

Pending letter- use this letter when a patient is missing documentation. Patient must get supporting documents back within 30 days, otherwise they must fill out a new application and provide proper documents for review.(Customer Service Representative or Collections Supervisor signs) (example 3)

Denied letter-use this letter when patient has been denied for financial assistance. (Collections Supervisor signs) (example 4)

RECEIVING AN APPLICATION:

-Patient can receive an application by calling and requesting one can be mailed to them or coming to the hospital to pick an application up.
-The patients account(s) must be noted that they mailed/received application.

Once we receive the application back you must:
-make sure patient proper filled out all sections of form, if not mail back to patient with the sections highlighted for them to properly fill out. Make sure to note account when you mail this back to them. Also send Pending letter stating what the patient needs to do.
-make sure the application has a signature and is dated.
-must have a copy of the approval or denial letter from Maryland Medical Assistance.
    -patient does not need to apply if:
        -Financial counselor has signed off on application stating the patient will not qualify for MMA.
        -if
        -if
-must have a copy of their most recent federal tax return. We need at least the first 2 pages of the tax return. This does not mean W-2's.
-must have copies of the 2 most recent pay stubs from patient.
    -patient must provide pay stubs for spouse if they are working also.
-If the patient is unemployed(or spouse) they must get a copy of the unemployment wage history from Department of Labor, Licensing, and Regulation
-If the patient is of age/disability to receive Social security, they must provide a copy of their award letter or a copy of their most recent check. If they do not have either but the money is deposited into a checking/savings account, a copy of the most recent bank statement will be valid.
-a copy of the most recent checking and/or savings account from the patient.

If the patient brings this information into the office, please make photocopies of any originals.

Pay Stubs
-must be the two most recent pay stubs
-must also include spouses pay stubs
-if child support is being paid then make sure we are not including that child on the application(this child more than likely is not part of the household).
-if patient is paid "under the table," patient must get the employer to write a letter of how much they get paid and how many hours per week they work.

Unemployment Wage History (see example 3)
-must be obtained if patient and/or spouse is not working.
-this shows the patients income for the last 2 ½ years of work. This will not show any income that was paid as "under the table" income

Social Security Award letter/check
-must have a copy of the award letter or most recent check from patient if they are of age or disabled and receive SS.
-if patient does not have either of the above, their most recent bank statement can be copied for proof of income from SS.

Bank statements
-must have a copy of the most recent checking and/or savings account
-a single applicant can have no more than $7500 and an applicant plus one can have no more than $15,000

Support letter
-required if patient is supported financial by someone else or if patient has no income
-letter needs to be written by the person(s) that provides food, shelter, etc.

Documents:

Application (see example 1)
-must be filled out completely, if not, highlight incomplete sections and mail back to patient with Pending letter.
-must be signed and dated by patient. If they have a spouse, spouse must sign application also.
-if there is a member of the household that should not be included on the application, they must be crossed off the application.
-use patient name for a search and also by their SSN to pull up any accounts that are outstanding.
-Financial counselor must sign on application if patient does not have to apply for MMA, otherwise patient must apply for MMA
-if patient monthly income documents do not match the application, question patient. such as SS check, spouses income, etc.
-make sure checking/savings or other accounts have attachments to the application show the same amount. A single applicant can have no more than $7500 and applicant plus 1 can have no more than $15,000.
-for other assets, make sure the patient fills this out. If the patient owns a home, pull up the value of the home on www.dat.state.md.us and click on Real Property to do a search. This will tell you information like when the patient purchased the home and for how much.

Approval or Denial letter from Maryland Medical Assistance (see example 2)
-patient can apply by going to the Department of Social Services or contacting our Financial Counselor.
-if patient is approved for MMA, must check all accounts/dates of service. Add MMA to any account that is now covered. We will only write off accounts that are Self Pay under the financial assistance program.
-review any denial letter from MMA to make sure it was not denied due to patient not providing the proper documentation. They must complete the process with MMA completely.

Tax Return
-must have most recent federal tax return.
-we only need a copy of the first 2 pages of the tax return.
-we do not need copies of the W-2
-make sure that anyone listed on the application is also listed on the tax return. Such as children, if the patient did not claim that child on the tax return, that child can not be included in the application for financial assistance.

Appendix 1 B:

Charity Care Policy Description

Civista Medical Center posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, other areas of the facility in which eligible patients are likely to present. In addition, the policy is available on the Civista website and is posted in the local paper twice each year.

CIVISTA HEALTH, INC.

TITLE: **GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM**

FUNCTION: Administrative

POLICY NUMBER: AD-0150

ISSUE DATE: 01/99

REVIEW/REVISED DATE:

Revised: 04/00
Revised: 07/03
Revised: 04/06
Revised: 04/10
Revised: 05/01
Revised: 01/04
Revised: 05/07
Revised: 06/02
Revised: 11/04
Revised: 05/08

APPROVED BY:

James Burke
Chair
Civista Board of Directors

Date

Noel Cervino
President & CEO

Date

Erik Boas
VP, Finance/CFO

Date

NOTE: This policy was previously LD-004 (as of 04/10).

Disclosure Statement

The shared drive is the official location for Organizational Policies and Procedures for Civista Medical Center. The original of this Organizational Policy and Procedure document with required signature is available for review during regular business hours by contacting the Information Technology Department at 301-609-4495. Civista Medical Center reserves the right to update or modify all policies, procedures, and forms at any time and without prior notice, by posting the revised version on this drive. **NOTE:** To ensure the integrity of these documents, each page is either scanned or converted and placed on this drive as a duplicate of the original.

ATTACHMENT I

FINANCIAL ASSISTANCE CHECKLIST

The following information must be submitted in order for your application to be considered:

- **A completed application (attached).**
- **If you meet the qualification guidelines for Medical Assistance, you are required to provide an Approval or Denial letter from Medical Assistance – apply directly with your county Department of Social Services for Medical Assistance.**

  Charles County Resident

  Charles County Department of Social Services
  200 Kent Ave
  LaPlata, Maryland 20646
  (301) 392-6400

- **Most current tax return.**
- **Your two most recent pay stubs.**
- **If you are unemployed, you must obtain a wage history statement from the unemployment office stating you have not received any wages.**

  Department of Labor, Licensing and Regulation
  (800) 827-4839

- **Proof of Income- social security award letter or copy of check.**
- **Copy of your most recent bank statement for your checking and savings accounts.**

If assistance is needed in completing information necessary to process your application, please contact our office at (301) 609-4403.

Return application and all required forms to:

Civista Medical Center, Inc.
Patient Financial Assistance
PO Box 1070
LaPlata, Maryland 20646

ATTACHMENT II

Steps to completing the Financial Assistance Application

The Financial Aid Application form must be written clearly and legible in ink. The patient or guarantor's signature is required. A Financial Aid Application can be completed on any patient who informs us that they cannot afford to pay for services rendered regardless of the financial class.

Family Size/Household Members

Enter the number of people living in the patient's household. If the person is an adult, the family size includes the applicant, their spouse, any minor children that are supported, and any adults for whom the primary individual is legally responsible. If the applicant is a minor (under 18 years old), the family size includes both parents (or parent's spouse), minor siblings, and any adults in the family for whom the parents are legally responsible. A pregnant woman counts as two family members. The hospital will not count a parent or spouse in their family size if that person has abandoned them. And the hospital will not count a spouse who does not support the applicant if they are separated or divorced. Make sure the patient is included. As a rule, the number of people within the household should be the same number of family members claimed on the Federal Income Tax Return.

Proof of Income (about your income)

The best proofs of income are the following documents:

- Federal or state income tax returns
- Paycheck stubs
- W-2 forms
- A letter from your employer on company letterhead stating your income, or a statement of your income from any government agency that provides you benefits
- If you are receiving Social Security benefits, you must show your annual statement from the Social Security Administration, or a copy of your Social Security check, or your bank statements from the three months before the hospital service that show the direct deposit of your check.

If the applicant does not have any of the above proofs of their income, then two (2) paycheck stubs from immediately before their hospital service will be accepted. If they do not have a paycheck stub, they may sign a paper attesting to what their income was for the last 12 months.

Limit on Money in the Bank

There are limits on the amount of property that can be owned by the applicant. On the date of the hospital service, a single person is not allowed to have assets that are worth more than $7,500. A family is not allowed to have assets more than $15,000. If the family has assets that are worth more than the asset limit on the date of hospital service, they may "spend down" their assets by paying toward their medical expenses until they reach the limit for financial assistance.

ATTACHMENT II (cont'd)

Definition of "Annual" or "Yearly" Income

Yearly Income: The sum of the total gross income of the household for the prior 12-month period. All types of income must be included:

- Salary (gross wages before taxes)
- Public Assistance (cash assistance)
- Social Security Benefits
- Unemployment Benefits and Workers' Compensation
- Veterans Benefits
- Alimony and Child Support
- Pension Payments
- Insurance and Annuity Payments

Definition of Assets

Assets are items that can be turned into cash. All the family's assets are counted toward the asset limits explained above. Assets include such things as cash, savings and checking accounts, certificates of deposits, stocks and bonds, Individual Retirement Accounts (IRA's), trust funds, and equity in any real estate that is not the residence that they live in. The hospital does not count the house they live in, their car, nor their furniture used as assets. But, other real estate that is not their home is included – rental property, a vacation home, a store, or property that was inherited, but is not lived in.

ATTACHMENT III

Civista Medical Center—Financial Assistance Application

TELL US ABOUT YOURSELF

Applicant's Name _____ Date of Birth _____
First Middle Last

Home Address _____
(include Street Address and P.O. Box)

_____
City State Zip Code

Home Number _____ Cell Phone Number _____

Social Security Number _____ US Citizen **YES** **NO**
Permanent Resident **YES** **NO**

Martial Status **Single** **Married** **Widow** **Divorced**

Spouse's Name _____ Social Security Number _____

HOUSEHOLD MEMBERS (List Dependents Name, Age and Relationship to Applicant)

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

MEDICAL ASSISTANCE

Do you receive any type of state or county assistance? **YES** **NO**

Have you applied for Medical Assistance? **YES** **NO**
If yes, what was the date you applied? _____
If yes, what was the determination? DENIED_____ APPROVED _____ SPEND DOWN _____
Medical Assistance Number _____

NOTE: Attach copy of Approval or Denial letter from Medical Assistance

ABOUT YOUR INCOME

Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

Spouse Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

ATTACHMENT III (cont'd)

FAMILY INCOME

	MONTHLY AMOUNT		MONTHLY AMOUNT
Employment (before taxes)	$ _____	**Spouse's Employment** (before taxes)	$ _____
Disability Benefits	$ _____	Veteran's Benefits	$ _____
Retirement/Pension Benefits	$ _____	Alimony	$ _____
Social Security Benefits	$ _____	Strike Benefits	$ _____
Public Assistance Benefits	$ _____	Military Allotment	$ _____
Unemployment Benefits	$ _____	Rental Property Income	$ _____
Farm or Self Employment	$ _____	Other Income Source	$ _____

Total Monthly Income $ _____

LIQUID ASSETS

CURRENT BALANCE

Checking Account	$ _____
Savings Accounts	$ _____
Stocks, Bonds, CD, or Money Market	$ _____
Other Accounts	$ _____
TOTAL	$ _____

OTHER ASSETS (If you have any of the following items, please list the type and approximate value.)

Home	Loan Balance $ _____	Approximate value $ _____
Automobile	Make/Model _____ Year _____	Approximate value $ _____
Automobile	Make/Model _____ Year _____	Approximate value $ _____
Boat/ATV	Make/Model _____ Year _____	Approximate value $ _____
Other Property	_____ (please specify)	Approximate value $ _____

TOTAL $ _____

MONTHLY EXPENSES

			MONTHLY AMOUNT
Rent _____	Mortgage	_____ (please check one)	$ _____
Utilities:	Telephone	$ _____	
	Electric/Gas	$ _____	
	Cable	$ _____	
	Water	$ _____	
	Trash	$ _____	Total Utilities $ _____
Car Payment(s)			$ _____
Credit Card(s)	_____ Name	_____ Name	_____ Name $ _____
Car Insurance			$ _____
Health Insurance			$ _____
Other Medical Expenses			$ _____
Other Expenses			$ _____
		TOTAL	$ _____

I understand that the information I have submitted is subject to verification by Civista Medical Center, Inc., and by signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ Applicant's Signature _____ Date

_____ Spouse's Signature _____ Date

ATTACHMENT IV

PATIENT FINANCIAL SERVICES

CREDIT LIMITS

Department Position	Credit Limit
Patient Accounts Supervisor	$15,000
Patient Accounts Manager	$25,000
Director, Patient Financial Services	$50,000
Chief Financial Officer	Above $50,000

ATTACHMENT V

Civista Medical Center
Effective Date - April 2010

NOTICE OF AVAILABILITY OF PATIENT FINANCIAL ASSISTANCE

Effective April 2010, to be eligible for 100% financial assistance, your family income must be at or below 200% the HHS Federal Poverty Guidelines based upon family size. Family size is based on those that are able to be claimed on income taxes via I.R.S. guidelines

Household Income
(Pick the column where the actual income is within the range listed)

Size of Family	100% Financial Assistance	80% Assistance (You Pay 20%)	60% Assistance (You Pay 40%)	40% Assistance (You Pay 60%)	20% Assistance (You Pay 80%)
1	Up to $21,660	$21,661 to $24,366	$21,367 to $27,074	$21,075 to $29,781	$29,782 to $32,490
2	Up to $29,140	$29,141 to $32,781	$32,782 to $36,424	$36,425 to $40,066	$40,067 to $43,710
3	Up to $36,620	$36,621 to $41,196	$41,197 to $45,774	$45,775 to $50,351	$50,352 to $54,930
4	Up to $44,100	$44,101 to $49,611	$49,612 to $55,124	$55,125 to $60,636	$60,637 to $66,150
5	Up to $51,580	$51,581 to $58,026	$58,027 to $64,474	$64,475 to $70,921	$70,922 to $77,370
6	Up to $59,060	$59,061 to $66,441	$66,442 to $73,824	$73,825 to $81,206	$81,207 to $88,590
7	Up to $66,540	$66,541 to $74,856	$74,857 to $83,174	$83,175 to $91,491	$91,492 to $99,810
8	Up to $74,020	$74,021 to $83,271	$83,272 to $92,524	$92,525 to $101,776	$101,777 to $111,030
For Each Addl. Person, add:	$7,480	$8,415 to upper limit	$9,350 to upper limit	$10,285 to upper limit	$11,220 to upper limit

If you think you may be eligible for Financial Assistance, please complete the attached application. Upon receipt of your completed application and required documentation, a determination will be made regarding your request. Prior approval for Financial Assistance does not constitute approval of Financial Assistance for subsequent services received from Civista Medical Center, Inc.

Return completed application and all required forms to:

Civista Medical Center, Inc.
Patient Financial Services
P.O. Box 1070
La Plata, MD 20646

Appendix 3

Mission and Vision Description:

Civista Health provides excellent care to each patient in a safe, caring and family-centered environment. Civista fosters a healthier community by providing service education and access to care in concert with other community organizations. The organization strives to be the preeminent healthcare provider for our community through enhanced facilities, technology and equipment, an excellent record of quality care and patient safety, a highly responsive emergency services delivery, a skilled workforce and excellent physician partners and financial health to assure funds for re-investment.

Appendix 4

Mission:

Civista Health is a not-for-profit healthcare system created to provide excellence in acute healthcare and preventative services in Charles County and surrounding communities.

Vision:

To be the best not-for-profit healthcare system in the State of Maryland.