COMMUNITY BENEFIT NARRATIVE

Effective for FY2012 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

December 13, 2012

BACKGROUND

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

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I General Hospital Demographics and Characteristics

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients (WAH), by County:	Percentage of Patients (WAH) who are Medicaid Recipients, by County:
271	15,663	20783 – Hyattsville 20912 – Takoma Park 20782 – Hyattsville 20903 – Silver Spring 20904 – Silver Spring 20901 – Silver Spring 20910 – Silver Spring 20740 – College Park 20902 – Silver Spring 20906 – Silver Spring 20737 – Riverdale 20011 – Washington 20705 – Beltsville	Holy Cross: 20904, 20906, 20902, 20910, 20901, 20903, 20853, 20877, 20783, 20705, 20874, 20912, 20878, 20706, 20895, 20774, 20707, 20852, 20886, 20708, 20770 Medstar Montgomery General: 20853, 20904, 20906 Suburban: 20852, 20878, 20895, 20902, 20906 Adventist Rehabilitation Hospital of Maryland: 20706, 20774, 20783, 20852, 20853, 20874, 20877, 20878, 20886, 20895, 20901, 20902, 20903, 20904, 20906, 20910, 20912, 20706, 20770, 20774	Montgomery County: 12.5% Prince George's County: 16.1%	Montgomery County: 13.1% Prince George's County: 10.7%

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

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

The Community We Serve

Washington Adventist Hospital primarily serves residents of Prince George's County and Montgomery County, Maryland. Below, Figure 1 shows the percentages of discharges by county for Washington Adventist Hospital:

County	**Percentage**
Prince George's	44.5%
Montgomery	40.3%
Washington, D.C.	6.4%
Other	8.8%

Figure 1. WAH discharges by county, 2011.

Approximately 80% of discharges come from our Total Service Area, which is considered Washington Adventist Hospital's Community Benefit Service Area "CBSA" (see Figure 2). Within that area, 60% of discharges are from the Primary Service Area including the following zip codes/cities:

20783 – Hyattsville, 20912 – Takoma Park, 20782 – Hyattsville, 20903 – Silver Spring, 20904 – Silver Spring, 20901 – Silver Spring, 20910 – Silver Spring, 20740 – College Park, 20902 – Silver Spring, 20906 – Silver Spring, 20737 – Riverdale, 20011 – Washington, and 20705 – Beltsville.

We draw 20% of discharges from our Secondary Service Area including the following zip codes/cities:

20706 – Lanham, 20707 – Laurel, 20708 – Laurel, 20712 – Mount Rainier, 20722 – Brentwood, 20743 – Capitol Heights, 20744 – Fort Washington, 20747 – District Heights, 20770 –

Greenbelt, 20774 – Upper Marlboro, 20781 – Hyattsville, 20784 – Hyattsville, 20785 – Hyattsville, 20850 – Rockville, 20853 – Rockville, 20866 – Burtonsville, 20874 – Germantown, 20877 – Gaithersburg, 20878 – Gaithersburg, 20886 – Montgomery Village, 20905 – Silver Spring, 20012 – Washington D.C., 20019 – Washington D.C. (see Figure 2).

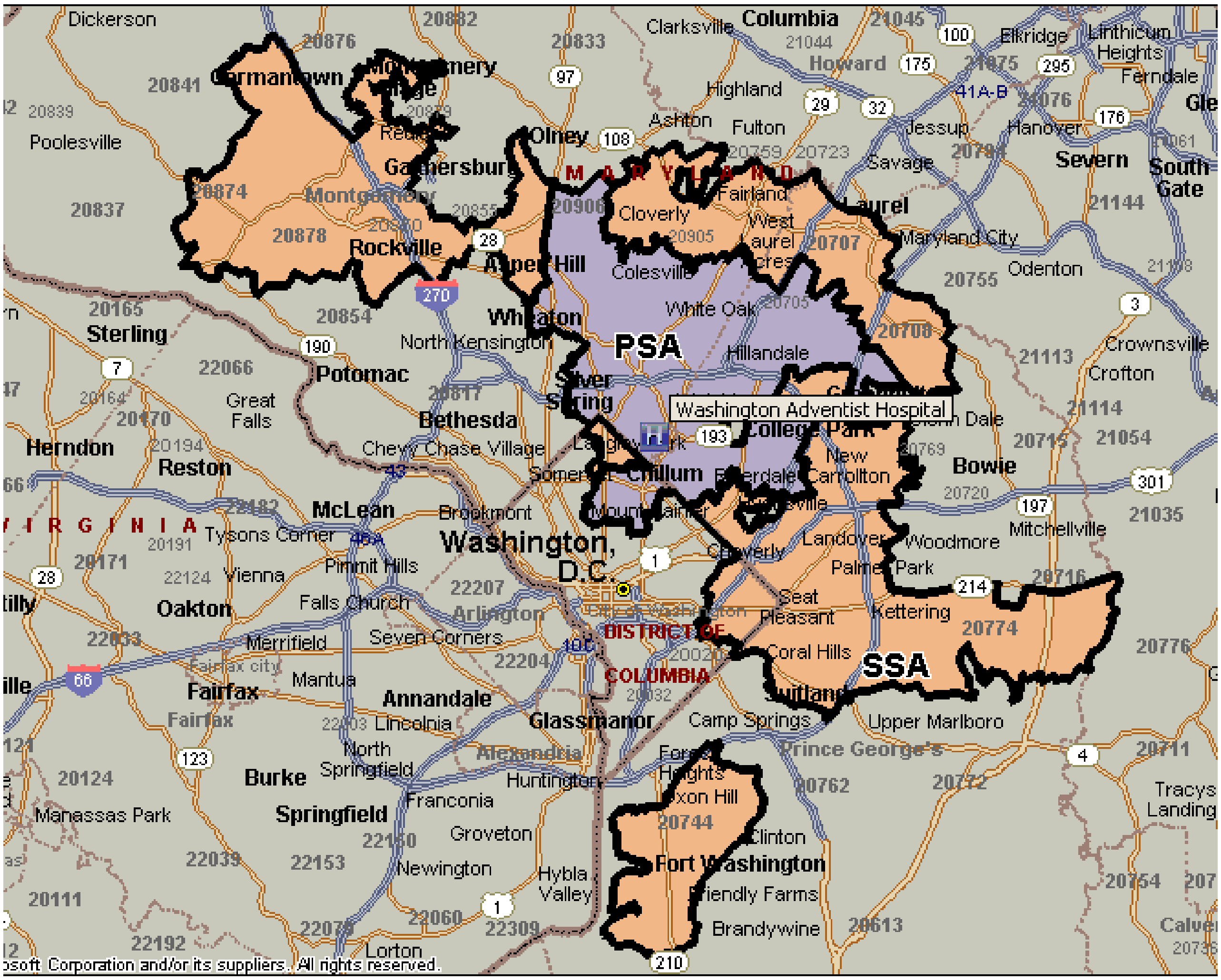


Figure 2. Map of Washington Adventist Hospital's Primary and Secondary Service Areas based on 2011 inpatient discharges

Our Community Benefit Service Area (CBSA), covering approximately 80% of discharges, includes 1,253,641 people, of which approximately 66.5% are minorities (see Figure 3 below).

	2011 Estimates				
	WHITE	**BLACK/AF AMER**	**ASIAN**	**NATIVE HI/PI**	**HISP/LAT**
Community Benefit Service Area (CBSA)	419,958	553,217	1,845	1,338	238,388
	33.5%	44.1%	0.1%	0.1%	19.0%
Primary Service Area (PSA)	186,853	172,498	885	567	144,409
	37.1%	34.2%	0.2%	0.1%	28.7%
Secondary Service Area (SSA)	233,105	380,719	960	771	93,979
	31.1%	50.8%	0.1%	0.1%	12.5%

Figure 3. Population estimates (2011) by race/ethnicity for Washington Adventist Hospital's Total Service Area (80% of discharges), Primary Service Area (60% of discharges) and Secondary Service Area (20% of discharges)

Population demographics are rapidly changing in the state of Maryland, particularly among residents living in Montgomery and Prince George's Counties. We serve one of the most diverse communities in the United States, constantly undergoing the economic, social and demographic shifts that result from an ever-changing, ever-growing population. Prince George's County is one of the state's most populous jurisdictions, with a population increase of 7.7 percent in the last decade to a total of more than 863,420 residents, making it the third most populated jurisdiction in the Washington metropolitan area[1]. Since 2000, it has experienced the second-largest population growth in Maryland, due largely in part to an increase in Hispanic residents. Every race or ethnicity, including black or African American, Asian and Pacific Islander, Hispanic or Latino, multiple races, and other races, has increased its presence in the past decade, except the white population, which has decreased by over 23 percent. The growth of the total population (all races/ethnicities combined) continues in the same upward trajectory it has seen since the county's inception.

[1] "2010 Census Summary for Prince George's County." *Prince George's County Planning Department.* http://www.pgplanning.org/Assets/Planning/Countywide+Planning/Research/Facts+Figures/Demographic/2010+Census+Summary.pdf

Prince George's County's foreign-born population has also steadily increased over the last two decades; from 2000 – 2007 it increased at the highest rate in Maryland – 199.9 percent compared to a state average of 70.7 percent[2]. Currently, 24 percent of the county's residents are foreign-born. One fifth of the county's households speak a language other than English at home, and over 15 percent of the population speaks English less than "very well." Spanish is the most frequently spoken language other than English, and among Spanish-speaking homes, about half speak English less than "very well."

Over the past decade, Montgomery County has become both the most populous jurisdiction in Maryland, the second largest jurisdiction in the Washington, DC metropolitan area, and the 42nd most populous county in the nation, with almost one million residents (U.S. Census Bureau, 2011). Racial and ethnic diversity has concurrently increased with this drastic increase in population numbers. Non-Hispanic whites now comprise only 49 percent of the population of Montgomery County, a decrease of more than 20 percent over the last two decades. For the first time, minorities account for more than half of Montgomery County's population, making it a "majority-minority" county. The percentage of Hispanics or Latinos in Montgomery County (17%) is more than double the percentage of Hispanics or Latinos in the state of Maryland (8%), and within the county, it outnumbers all populations other than non-Hispanic whites (U.S. Census Bureau, 2011).

According to the U.S. Census Bureau, Maryland is one of the top ten destinations for foreign-born individuals, and 41 percent of the foreign-born in Maryland reside in Montgomery County.[3] Montgomery County's foreign-born population has increased from 12 percent in 1980 to currently more than 30 percent.[4] Immigrants contribute greatly to our community, and our hospital providers are committed to understanding their needs and working to treat them in a culturally competent manner.

As racial and ethnic minority populations become increasingly predominant, concerns regarding health disparities grow – persistent and well-documented data indicate that racial and ethnic minorities still lag behind nonminority populations in many health outcomes measures. These groups are less likely to receive preventive care to stay healthy and are more likely to suffer from serious illnesses, such as cancer and heart disease.

Further exacerbating the problem is the fact that racial and ethnic minorities often have challenges accessing quality healthcare, either because they lack health insurance or because the communities in which they live are underserved by health professionals. As the proportion of racial and ethnic minority residents continues to grow, it will become even more important for

[2] "Immigration and the 2010 Census." *Maryland Data Center: Census.* http://www.census.state.md.us/Immigration%20and%20the%202010%20Census_final.pdf
[3] "Literacy, ESL and Adult Education." *Literacy Council of Montgomery County.* http://www.literacycouncilmcmd.org/litadultedu.html
[4] "Foreign-Born Population of Montgomery County Region, 1950-2000-Census Years." *Montgomery Planning.* 2000. http://www.montgomeryplanning.org/research/data_library/population/po34.shtm

the healthcare system to understand the unique characteristics of these populations in order to meet the health needs of the community as a whole. As a result, this report examines health status and outcomes among different racial and ethnic populations in Montgomery and Prince George's Counties, with the goal of identifying health disparities, achieving health equity, and improving the health of all groups.

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

Some statistics may be accessed from the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx) , the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf)

Table II Significant Demographic Characteristics and Social Determinants

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

Prince George's County Demographics:

Demographics	Prince George's	Maryland
Total Population*	863,420	5,773,552
Age*, %		
Under 5 Years	6.8%	6.3%
Under 18 Years	23.9%	23.4%
65 Years and Older	9.4%	12.3%
Race/Ethnicity*, %		
White	19.2%	58.2%
Black	64.5%	29.4%
Native American	0.5%	0.4%
Asian	4.1%	5.5%
Hispanic or Latino origin	14.9%	8.2%
Median Household Income**	$70,384	$70,017
Households in Poverty**, %	7.2%	8.6%
Pop. 25+ Without H.S. Diploma**, %	14.6%	12.1%
Pop. 25+ with Bachelor's Degree or Above**, %	28.8%	35.6%
Sources: * U.S. Census (2010), ** American Community Survey (2008-2010)		

(Source: http://dhmh.maryland.gov/ship/)

Montgomery County Demographics:

Demographics	Montgomery	Maryland
Total Population*	971,777	5,773,552
Age*, %		
Under 5 Years	6.6%	6.3%
Under 18 Years	24.0%	23.4%
65 Years and Older	12.3%	12.3%
Race/Ethnicity*, %		
White	57.5%	58.2%
Black	17.2%	29.4%
Native American	0.4%	0.4%
Asian	13.9%	5.5%
Hispanic or Latino origin	17.0%	8.2%
Median Household Income*	$92,451	$70,017
Households in Poverty**, %	6.3%	8.6%
Pop. 25+ Without H.S. Diploma**, %	9.6%	12.1%
Pop. 25+ With Bachelor's Degree or Above**, %	56.2%	35.6%
Sources: * U.S. Census (2010), ** American Community Survey (2008-2010)		

(Source: http://dhmh.maryland.gov/ship/)

Median Household Income within the CBSA:

$69,405

Source: Nielsen Population Estimates: Current Year 2011

Household income has a direct influence on a family's ability to pay for necessities, including health insurance and healthcare services. A wide body of research points to the fact that low-income individuals tend to experience worse health outcomes than wealthier individuals, clearly demonstrating that income disparities are tied to health disparities. Throughout the CBSA area served by Washington Adventist Hospital across racial and ethnic groups, non-Hispanic whites have the highest median household income, while blacks and Hispanics are more likely to live in poverty (see Figure 4) (U.S. Census Bureau, ACS, 2011). However, when looking at the state of Maryland as a whole, Asians have the highest median income. The median household income in Maryland in 2009 was $61,193, which is higher than the U.S. median of $50,221. The median household income in the CBSA of Washington Adventist Hospital is $69,405 but great income disparities exist when broken down by county and by racial/ethnic groups. White households in Montgomery County had a much higher median household income of $110,580, while black households in Prince George's County had a lower median household income of $46,318; Hispanic and black households had much lower median household incomes than white households in both Montgomery and Prince George's Counties (see Figure 4).

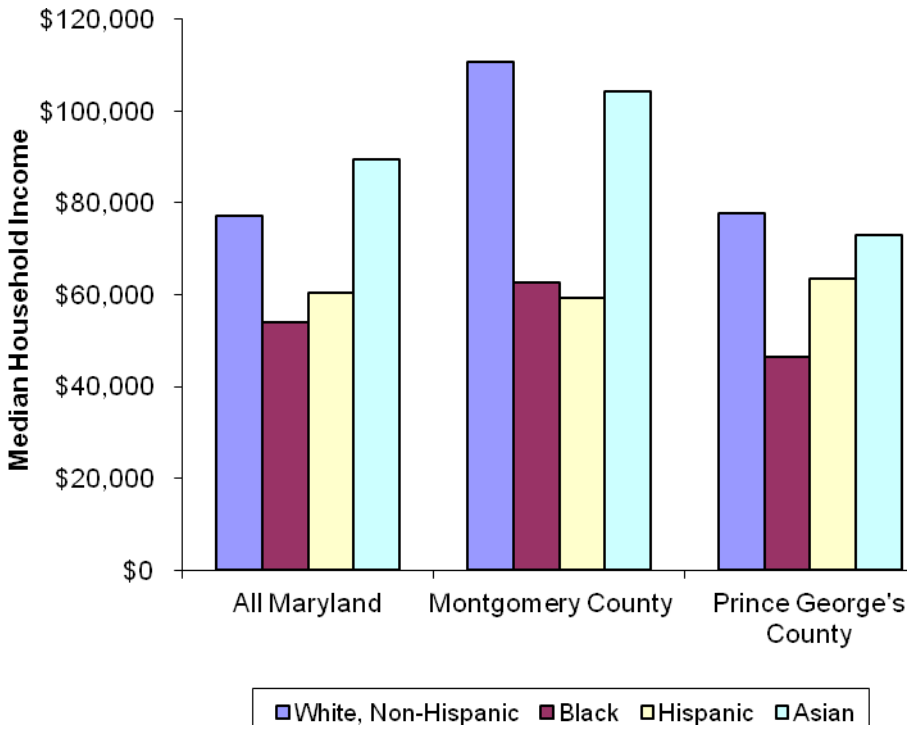


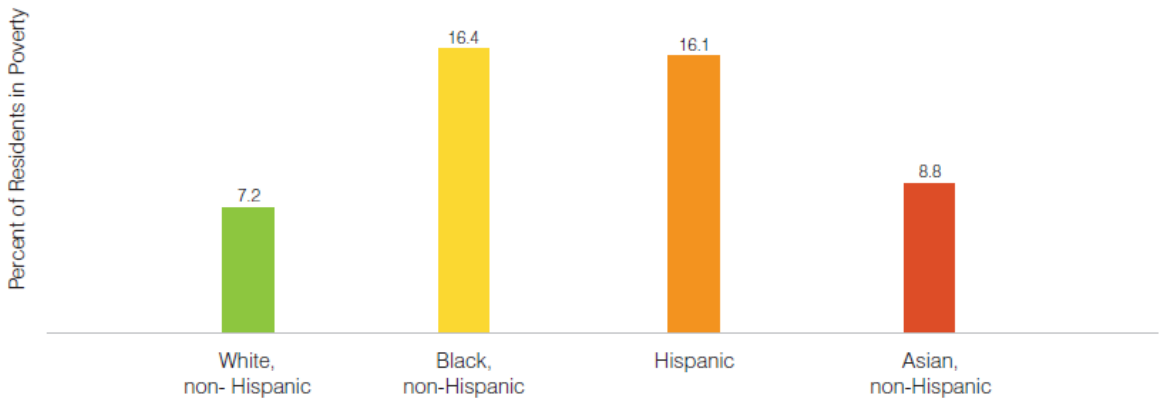
Figure 4. Median Household Income, Montgomery and Prince George's Counties, and all Maryland, by Race, 2009. Source: U.S. Census Bureau. (2011). American Community Survey 1-Year Estimates

Percentage of households with incomes below the federal poverty guidelines within the CBSA:

3.8%

Source: Nielsen Population Estimates: Current Year 2011

While Prince George's County has a higher proportion of residents living in poverty, Montgomery County experienced the greatest increase in poverty compared to neighboring Prince George's and Frederick Counties, with nearly a 40 percent rise between 2006 and 2009 (U.S. Census Bureau, 2011). Six percent of Montgomery County's population lives below the federal poverty level, and the majority of that percentage is comprised of minorities[5]. In 2010, across all counties in Maryland, as well as within Washington Adventist Hospital's CBISA area, more residents were living below the poverty level than in 2006. In 2006, eight percent of Maryland residents lived in poverty; by 2010, just over nine percent of people had income below the poverty line, representing a 15 percent increase (U.S. Census Bureau, 2011). In 2008, when the national recession first began, all residents of Prince George's County, which has a majority minority population, experienced a significant downturn in household income, while the household income of residents of Montgomery County was more stable (U.S. Census Bureau, 2011). Across the state of Maryland, nearly a quarter of black residents had incomes less than 100 percent of the federal poverty level (FPL) in 2010. Approximately 16 percent of both black and Hispanic residents were impoverished at this time, compared to seven percent of whites and nine percent of Asians (see Figure 5).



*In 2010, 100% of poverty for a family of four was $22,350.
Source: U.S. Census Bureau. (2011). Current Population Survey. http://www.bls.gov/cps/

Figure 5. Poverty Rate by Race, Maryland, 2010

[5] "Quantitative Needs Assessment: Social Determinants of Health Section." *Healthy Montgomery*. 2011. http://www.healthymontgomery.org/javascript/htmleditor/uploads/SDOH.pdf

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

Prince George's County: 14.8 %

Montgomery County: 12.5%

Source: U.S. Census Bureau, American Fact Finder: 2010 American Community Survey

AHRQ's 2010 National Healthcare Disparities Report defines access to healthcare as the efficient and timely use of personal health services to obtain the best health outcomes. The report states that racial and ethnic minority groups—as well as people with low incomes—have disproportionately high rates of uninsurance or coverage through public programs. Overall, minorities tend to have more limited access to healthcare services—and the care they do receive is often of poor quality—which results in a multitude of healthcare complications (Agency for Healthcare Research and Quality (2010).

In 2010, Hispanics in Maryland were uninsured at more than twice the rate of blacks and more than four times the rate of whites (see Figure 6). Asians are most likely to have health insurance coverage through an employer-based plan than any other racial or ethnic group.

Black and Hispanic individuals are more than two times as likely to be covered by Medicaid as whites across the state of Maryland (see Figure 6).

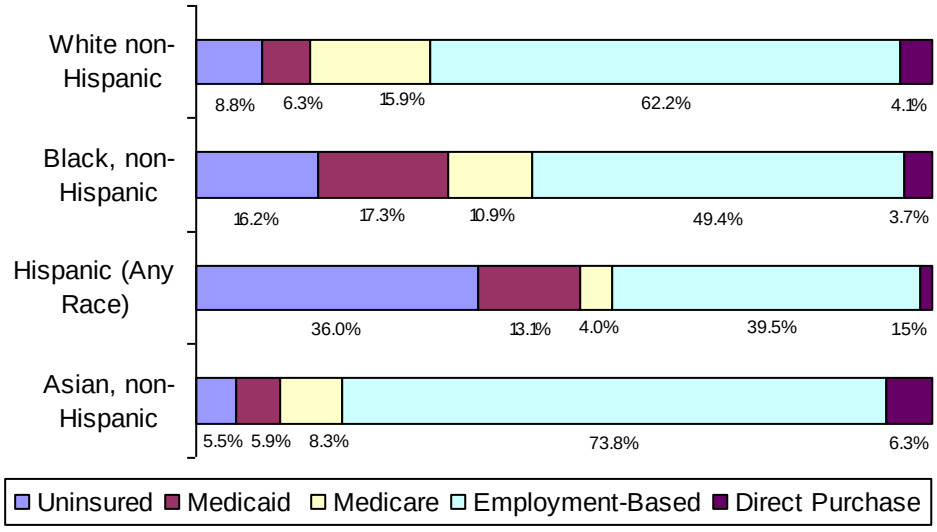


Figure 6. Health Insurance Coverage of Non-Elderly by Race/Ethnicity, Maryland, 2010. Source: Current Population Survey (2010). Health Insurance Coverage of Non-Elderly. http://www.bls.gov/cps/#data.

According to the U.S. Census Bureau, approximately 12.9 percent of all Maryland residents under the age of 65 were uninsured. Approximately 16.1 percent of Prince George's County residents and 12.5 percent of Montgomery County residents were uninsured in 2010 (U.S. Census Bureau, Fact Finder). Across the state, Hispanic males are more likely (37 percent) not to have health insurance coverage than white, non-Hispanic men (10 percent) and black, non-Hispanic men (17 percent). The trend is similar among females in Maryland: Hispanic women are uninsured at a rate of 30 percent, while almost 8 percent of white, non-Hispanic women and 12 percent of black, non-Hispanic women are uninsured.

In both Prince George's and Montgomery Counties, men are more likely to be uninsured than women. Nineteen percent of men in Prince George's County do not have health insurance, while 13 percent of women in the county are not covered; in contrast, rates of uninsurance among men and women in Montgomery County stand at almost 14 and 11 percent, respectively (U.S. Census Bureau, 2011). Despite Montgomery County's relative wealth with regard to income, education and support for public services, between 80,000 and 100,000 residents lack health insurance[6]. They usually are not homeless or unemployed, but rather low-income workers whose jobs no longer provide healthcare coverage, or self-employed individuals who cannot afford expensive premiums. Around 75 percent of the uninsured in Montgomery County are Hispanics/Latinos, while the rest are mostly Asian, West African, Haitian and African American.

Percentage of Medicaid recipients by County within the CBSA:

Prince George's County: 10.7%

Montgomery County: 13.1%

(Source: PCA Informatics-Maryland inpatient discharges, 2011)

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available):

Prince George's County (2009): Overall: 77.5 years (Source: http://dhmh.maryland.gov/ship/)

Male (Total) = 73.9 years

Male (Black) = 72 years; Male (White) = 76.7 years

Female (Total) = 79.5 years

Female (Black) = 78.3 years; Female (White) = 81.6 years

(Source: Institute for Health Metrics and Evaluation)

[6] "Montgomery Cares…For the Uninsured." *US Department of Health and Human Services Office of Minority Health.* http://minorityhealth.hhs.gov/templates/content.aspx?ID=4949&lvl=3&lvlID=313

Montgomery County (2009): Overall: 83.8 years (Source: http://dhmh.maryland.gov/ship/)

Male (Total) = 81.4 years

Male (Black) = 77.9 years; Male (White) = 82 years

Female (Total) = 85 years

Female (Black) = 82 years; Female (White =) = 85 years

(Source: Institute for Health Metrics and Evaluation)

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available):

Overall Mortality Rate, Montgomery County (2004-2006): 566.8 per 100,000

Overall Mortality Rate, Prince George's County (2004-2006): 822.4 per 100,000

Prince George's County performed worse than the state baseline on certain mortality measures, including rates of infant mortality and heart disease deaths (2007-2009):

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Infant Mortality Rate per 100,000 live births (VSA 2007-2009)	10.4	7.2	6.7	White/NH 0.6 Black 13.3 Asian 2.7 Hispanic 4.6	6.6	**-44.4**	**-55.2**

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
Rate of **heart disease deaths** per 100,000 population (age adjusted) (VSA 2007-2009)	**224.2**	194.0	173.4

(Source: http://dhmh.maryland.gov/ship/)

Montgomery County performed worse than the state baseline on the rate of deaths associated with falls (2007-2009):

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Rate of **deaths** associated with **falls** per 100,000 population (VSA 2007 – 2009)	7.7	7.3	7.0	6.9	**-5.1**	**-9.6**

(Source: http://dhmh.maryland.gov/ship/)

Although Montgomery County performed better than the state baseline on the rate of infant mortality overall, there are disparities among racial and ethnic groups. For example, the infant mortality rate among blacks is approximately double the county baseline:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Infant Mortality Rate per 100,000 births (VSA 2007-2009)	5.7	7.2	6.7	White/NH 4.9 Black 11.3 Asian 4.4 Hispanic 2.6	6.6	**20.8**	**14.9**

(Source: http://dhmh.maryland.gov/ship/)

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources):

EDUCATION:

Several studies have found that people with more education have longer life expectancies and lower disease rates than their less-educated counterparts. Because minority groups tend to complete fewer years of education than whites, they may be at particular risk for worse health. Those with lower educational attainment (i.e., completed high school or less) have been found to have higher mortality rates due to chronic conditions, such as heart disease and cancer.[7]

Prince George's County Education:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	73.3%	80.7%	84.7%

(Source: http://dhmh.maryland.gov/ship/)

High School Graduation Rates (Prince George's County, 2011):

- Overall: 85.17%
- American Indian – 86.36%
- Asian – 94.59%
- Black/African American – 86.01%
- HI/Pacific Islander – N/A
- Hispanic/Latino – 76.69%
- White – 86.17%
- Two or more races – 88.37%

Source: www.mdreportcard.org

[7] Meara, E. et al. The Gap Gets Bigger: Challenges in Mortality and Life Expectancy, by Education, 1981-2000. *Health Affairs*. March/April 2008.

The percentage of children who enter kindergarten ready to learn in Prince George's County is also lower than in the state of Maryland overall (MD DHMH, SHIP, 2011):

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)	79.0%	81.0%	N/A	N/A	85.0%	-2.5	N/A

Montgomery County Education:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	Maryland 2014 Target
Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	85.0%	80.7%	84.7%

High School Graduation Rates (Montgomery County, 2011):

- Overall: 86.8%
- American Indian – 69.6%
- Asian – 94.3%
- Black/African American – 81.3%
- HI/Pacific Islander – 90.9%
- Hispanic/Latino – 75.3%
- White – 93.9%
- Two or more races – 92.0%

Source: www.mdreportcard.org

People 25+ with a Bachelor's Degree or Higher (Montgomery County):

- Overall: 56.7%
- American Indian – 26.9%
- Asian – 64.1%
- Black/African American – 41.7 %
- HI/Pacific Islander – 0%
- Hispanic/Latino – 22.8%
- White – 67.5%
- Two or more races – 50.6%

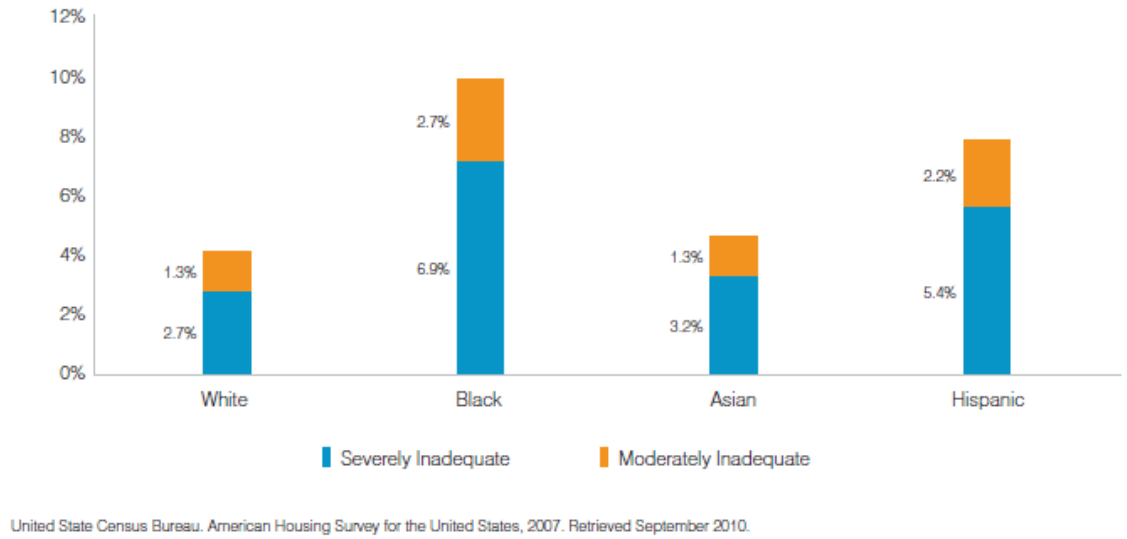
Source: http://factfinder2.census.gov

The percentage of children who enter kindergarten ready to learn in Montgomery County is lower than in the state of Maryland overall (MD DHMH, SHIP, 2011):

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)	74.0%	81.0%	N/A		85.0%	**-8.6**	N/A

HOUSING:

A person's living situation – the condition of their homes and neighborhoods – is a crucial determinant of health status. Low-quality housing may contain a range of environmental triggers that can cause or exacerbate health conditions, like asthma and allergies. Residential segregation has led certain neighborhoods – particularly minority neighborhoods – to face greater health risks due to living environments (see Figure 7).



United State Census Bureau. American Housing Survey for the United States, 2007. Retrieved September 2010.

Figure 7. Frequency of Housing Units with Physical Problems by Race (2007)

<u>Montgomery County Housing:</u>

- Renters spending 30.0% or more of household income on rent: 50.8%
- Homeowner vacancy rate: 1.2%

Source: U.S. Census, ACS, 2010

- Housing units: 375, 905
- Homeownership rate: 69.3%
- Housing units in multi-unit structures: 32.5%
- Median value of owner-occupied housing units: $482, 900
- Households: 353, 177
- Persons per household: 2.66

Source: U.S. Census, Quick Facts, 2010

Spotlight on Homelessness:

Perhaps the most extreme case of living situation having a negative impact on health is that of homelessness (see Figure 8). A study by the Urban Institute estimates that between 2.3 and 3.5 million people experience homelessness each year in this country.[8] In the area served by Washington Adventist Hospital, shelters, transitional housing, and motel placements in fiscal year 2008 served nearly 8,000 residents.[9] Homelessness amplifies the threat of various health conditions and introduces new risks, such as exposure to extreme temperatures.

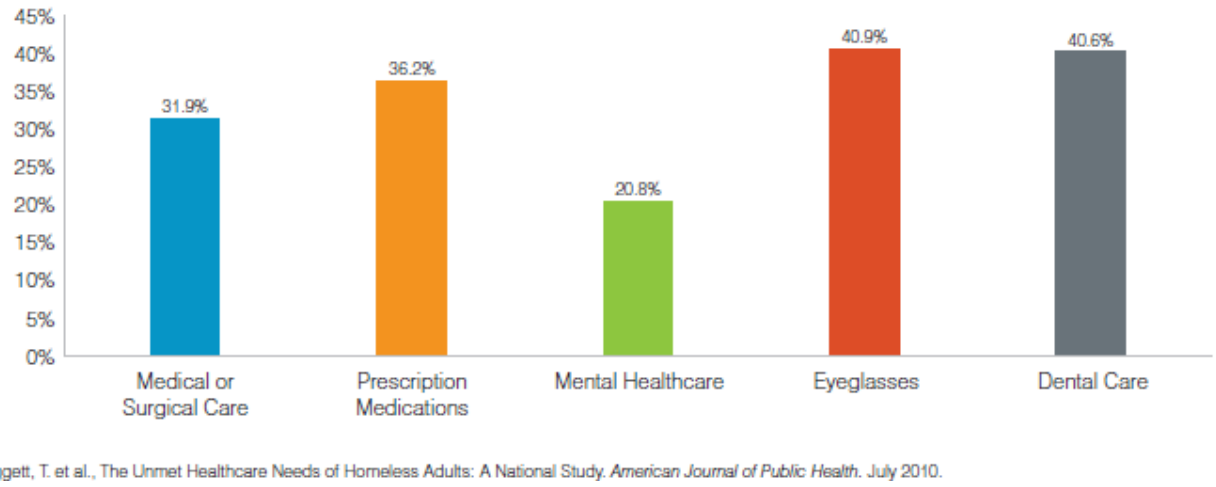


Figure 8. Prevalence of Unmet Healthcare Needs among Homeless Adults (2003)

Washington Adventist Hospital supports and partners with a non-profit organization in Montgomery County called Interfaith Works, which provides assistance to the county's homeless population. According to Interfaith Works, approximately 1,064 people are homeless on any given day in Montgomery County. Interfaith Works provides shelter to approximately 744 homeless men and women each night, and has served 135,000 meals through its Homeless Services programs.

Several efforts in Washington Adventist Hospital's CBISA area aim to improve the homeless population's living situation. One office within the Montgomery County Department of Health and Human Services helps homeless people in the county access medical care. Healthcare for the Homeless coordinates with providers to offer healthcare services for homeless individuals living in the county. This office trains local hospital staff to identify patients who are homeless in order to link them with discharge planning—including follow-up medical care, designated medical beds

[8] Burt, M. et al. *How many homeless people are there? Helping America's Homeless: Emergency Shelter or Affordable Housing?* June 2001.
[9] Maryland Department of Human Resources Office of Grants Management. Homeless Services in Maryland. Retrieved September 2010 from http://www.dhr.state.md.us/transit/pdf/ann2008.pdf.

in shelters, and access to prescriptions.

The Montgomery County Coalition for the Homeless has shelters and emergency housing as well as a program to provide permanent housing for families throughout the county. These permanent housing solutions also offer case management to help people succeed as tenants. The organization helps residents apply for Medicaid, food stamps, and other entitlement programs. It provides vocational assistance for their residents, including GED and ESL classes at Montgomery College. The Coalition provides bus tokens and other means for people to help them travel within the county. Each of these local programs attempts to overcome challenges to people's housing and living situations.

TRANSPORTATION:

Lack of reliable transportation is a common barrier to accessing healthcare. For low-income people, even those with insurance, problems accessing care remain when they do not have a dependable source of transportation. Unreliable or unavailable public transportation can prevent individuals from seeking care and cause them to miss scheduled appointments. There is a Ride On bus stop located right next to Washington Adventist Hospital (Carroll Avenue & Sligo Creek Parkway), and Ride On Bus 17 will drop off passengers directly at the main entrance to the hospital.

Mean travel time to work: 33.2 minutes (2006 – 2010); Montgomery County, Maryland ranks in the top 25% of the longest commute times among all counties in the U.S. (see Figure 9). Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel, which is both expensive for workers and damaging to the environment (U.S. Census, ACS, 2012).

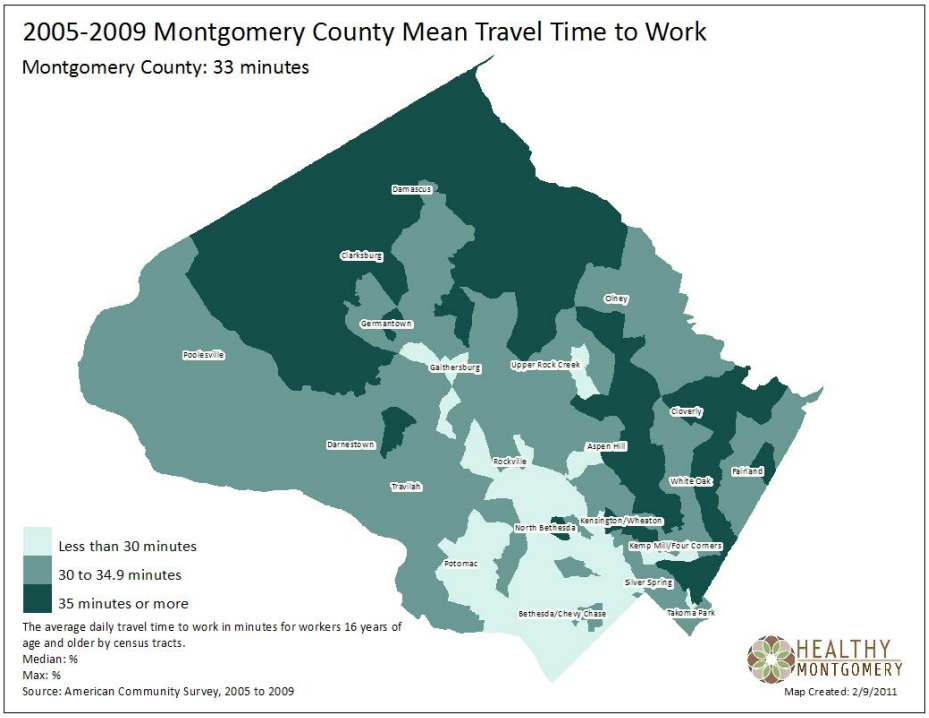


Figure 9. Mean Travel Time to Work, Montgomery County, 2005-2009

<u>Public Transportation Options in Montgomery County:</u>

Transit system: Ride On, Park and Ride, Metrobus, Metrorail, MetroAccess, Call 'N' Ride, AMTRAK, MARC, VRE, Taxis

- Ride On wheelchair accessible
- Available transportation options for seniors and persons with disabilities
- Free fare (during certain hours)
- Provide service for persons unable to use regular transit
- Provide subsidized tax trips for low-income persons with disabilities or senior citizens

Source: http://www6.montgomerycountymd.gov/tsvtmpl.asp?url=/content/dot/transit/index.asp

Percentage of people in Montgomery County (2009) who get to work by:

- Public transportation = 15.0%
- Single occupancy vehicle = 66.1%
- Active Transport (Biking, Walking) = 2.5%

Source: http://ideha.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/MontgomeryCounty_Final.pdf)

The rate of pedestrian injuries on public roads in Montgomery County is worse than both the state and national baselines:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Rate of pedestrian injuries (SHA 2007 – 2009)	44.2	39.0	22.6	29.7	**-13.3**	**-95.6**

Source: http://dhmh.maryland.gov/ship/ (2012)

Pedestrian Death Rate, Montgomery County: 1.4 deaths/100,000 population, compared to 1.8 deaths/100,000 in the state of Maryland. The Healthy People 2020 target is to reduce pedestrian deaths to 1.3 deaths/100,000 population.

Source: Healthy Communities Institute, Fatality Analysis Reporting System (2010)

Public Transportation Options in Prince George's County:

Transit system: Metrorail, Metrobus, TheBus, Call-A-Bus, MARC, Commuter Connection, Central Maryland Regional Transit, Call-A-Cab

- Senior citizens and disabled ride TheBus free during normal operational hours (6 a.m.-7 p.m.; Monday - Friday)
- Senior transportation service (STS) provides regular transportation throughout Prince Georges' County curb to curb
- STS provides transportation for a number of programs for senior citizens.

Percentage of people in Prince George's County (2008) who get to work by:

- Public transportation = 17.4%
- Single occupancy vehicle = 64.1%
- Active Transport (Biking, Walking) = 2.4%

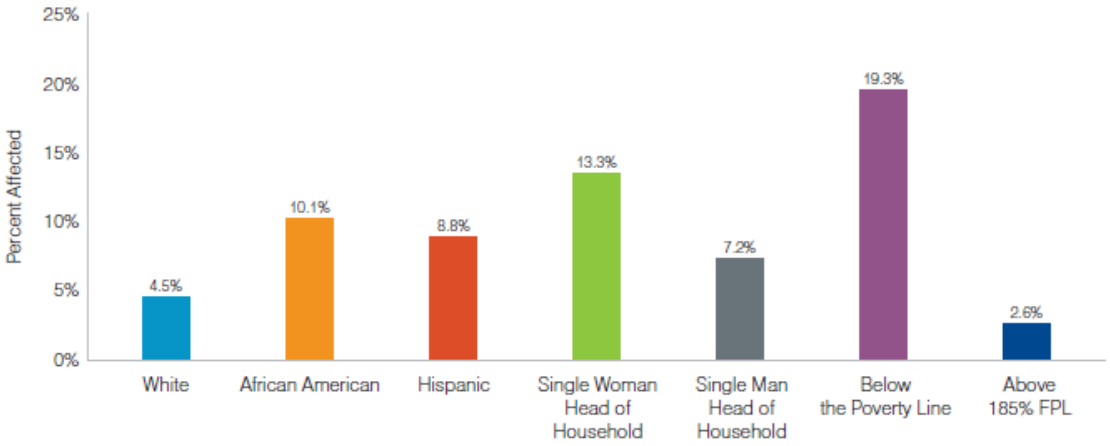
Source: http://ideha.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/PrinceGeorgesCounty_Final.pdf)

FOOD

Poverty often leads to food insecurity – the limited availability of nutritious food. As a result, low-income families are disproportionately overweight and undernourished. Such conditions are the precursors to a range of other health conditions, including diabetes, heart disease, and hypertension. Food insecurity is also tied to lower self-reported health status and depression.

The United States Department of Agriculture's (USDA) definition of food insecurity is the "limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways." Within communities where there is food insecurity, the problem is often not that there are too few calories to feed people in the community. It is more often that the calories available are nutritionally deficient. As a result, places with high food insecurity are often correlated with obesity. When households have limited money for food, families compromise the quality of their diets — eating more energy-dense foods that are lower in nutrients. Energy-dense foods (higher in fats and carbohydrates) cost less than nutrient-dense foods.

Food insecurity impacts populations differently. In an examination of its data for 2008, the USDA found that very low food security (a more intense level of insecurity) varied by race, ethnicity, income, and head of household (see Figure 10).



Nord, M. et al., Household Food Security in the United States, 2008. *Economic Research Service, United States Department of Agriculture*. November 2009.

Figure 10. Food Insecurity by Household Demographics (2008)

The effects of food insecurity are not limited to obesity. Food insecurity also can impact other aspects of physical and mental health.

Prince George's County performs worse than the state of Maryland and national baselines when it comes to accessing healthy food:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Percentage of census tracts with food deserts (USDA 2000)	13.6%	5.8%	10.0%	5.5%	**-134.5**	**-36.0**

- Percent of all restaurants that are fast-food establishments: 71% in Prince George's County; 59% in Maryland; 25% National benchmark

Source: www.countyhealthrankings.org (2012)

Montgomery County performs better than state and national baselines with regard to food deserts:

SHIP Measure (County Baseline Source)	County Baseline	Maryland Baseline	National Baseline	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Percentage of census tracts with food deserts (USDA 2000)	1.1%	5.8%	10.0%	5.5%	**81.0**	**89.0**

- Percent of all restaurants that are fast-food establishments: 55% in Montgomery County; 59% in Maryland; 25% National benchmark (2012)

Source: www.countyhealthrankings.org (2012)

- Percentage of adults who eat five or more servings of fruits and vegetables per day: 29.6% in Montgomery County, 2010 (compared with an average of 25.2% adult vegetable consumption in Maryland). There are disparities in fruit and vegetable consumption by gender and by racial/ethnic groups (see Figures 11 and 12).

Source: Maryland BRFSS; Accessed: HealthyMontgomery.org (2012)

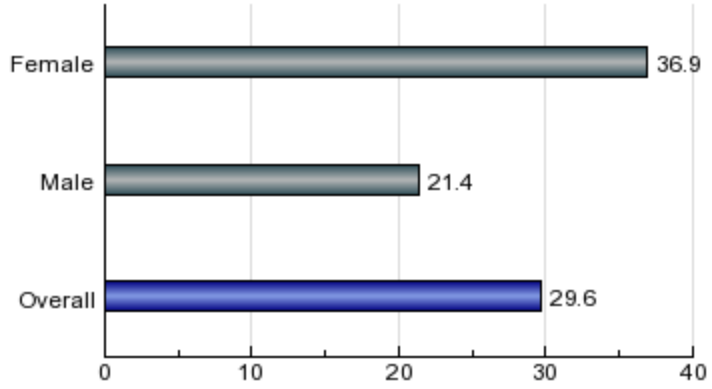


Figure 11. Adult Fruit and Vegetable Consumption by Gender

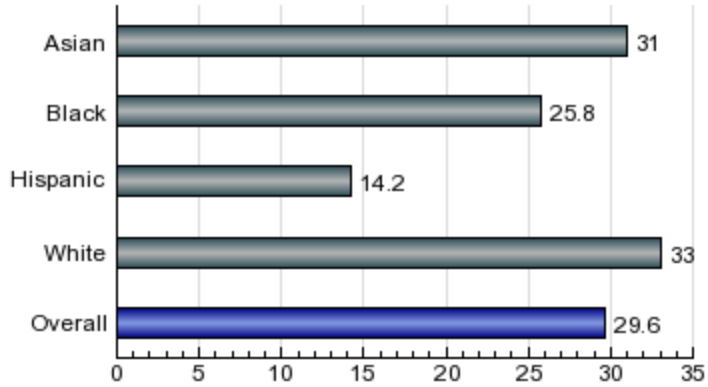


Figure 12. Adult Fruit and Vegetable Consumption by Race/Ethnicity

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

For the purposes of this report and as described in Health General 19-303(a)(4), a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

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

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

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

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

Approach/Methodology

Establishing Infrastructure and Selecting Priorities

Washington Adventist Hospital is a member of Adventist HealthCare, which formed a Community Benefit Council (CBC) to guide and lead its community benefit activities, including conducting the Community Health Needs Assessment. The council members include: Ismael Gama, Mission & Pastoral Care Services; Maria Chervenak, Center for Healthier Living; Parv Chotoo, Financial Services; Talya Frelick, Center on Health Disparities and Health & Wellness; Cindy Glass, Communications; Sue Heitmuller, Health Ministry; Judy Lichty, Health & Wellness; Peter Mbugua, Planning & Market Analysis; Marcos Pesquera, Center on Health Disparities; and Raquel Samuels, Financial Planning & Reimbursement.

As a starting point, the Community Benefit Council decided to research topics for the needs assessment in alignment with Montgomery County's Healthy Montgomery Focus Areas of: cancers, cardiovascular diseases, diabetes, maternal & infant health, behavioral health, and obesity. The Community Benefit Council also decided to research additional topics of interest to the hospital including: asthma, influenza, HIV/AIDS, senior health, income and poverty, access to care/health insurance coverage, food access, housing quality, education, and transportation. All of the topics included in this Community Health Needs Assessment were reviewed, discussed and approved by the Community Benefit Advisory Board.

We convened an Advisory Board in 2006 to help guide our efforts to reduce and eliminate health disparities, to identify community needs, and to help assess and direct our response to those needs. The Advisory Board is comprised of both internal and external (community) leaders. Members include clinicians, researchers, administrators and others from our hospitals, community-based organizations, local and state health departments, University of Maryland, the National Institutes of Health (specifically, the National Institute of Minority Health and Health Disparities), and other public health stakeholder organizations. After assessing the community's health needs, the board will review and discuss which priority areas to address through strategic planning and programming.

After completion of the Community Health Needs Assessment, the Advisory Board, along with input from internal resources, will meet to discuss and vote upon future initiatives. This active process began in November 2011 with a preliminary meeting.

Collecting and Analyzing Data

Washington Adventist Hospital identifies unmet health care needs in our community in a variety of ways. Adventist HealthCare's Center on Health Disparities, which supports Washington Adventist Hospital, developed and released its 2011 Annual Progress Report, *Partnering Toward a Healthier Future: Health Disparities in the Era of Reform Implementation*. This progress report offers an update on health disparities affecting communities in the tri-county region of

Maryland, including Montgomery County, Prince George's County, and Frederick County. Much of the information in the first chapter of the report fed into this community health needs assessment, as it details demographic trends and assesses disparities across a range of issues within three broad health topics affecting our community: maternal and infant health, heart disease and stroke, and cancer. The report incorporates descriptive findings from national, state and county-level databases on the racial and ethnic makeup of the population, the prevalence of disease across these groups, and the rates of receiving appropriate treatment. Information from Adventist HealthCare's Center on Health Disparities' 2010 Annual Progress Report, *Social Determinants of Health: Promoting Health Equity through Social Initiatives*, also helped to inform related sections in the Community Health Needs Assessment. This report summarized the evidence on social factors that influence health disparities among racial/ethnic groups in the tri-county area, and highlighted local efforts to eliminate them.

In addition to the research conducted for the annual Center on Health Disparities reports, we also analyzed the U.S. Census Bureau's American Community Survey and Profiles of General Population and Housing Characteristics to produce a broad demographic overview by county, race, and ethnicity. In Maryland, we produced descriptive tabulations based on data from the Maryland Behavioral Risk Factor Surveillance System, the Maryland Cancer Registry, the Maryland Vital Statistics Administration, the Maryland Health Care Commission, the Maryland Department of Health and Mental Hygiene's (MDHMH) Office on Minority Health & Health Disparities, and from MDHMH's State Health Improvement Process (SHIP). In addition to these data sources, we have also summarized findings from various national and state-level reports on insurance coverage, disease condition, and healthy behaviors released by the Agency for Healthcare Research and Quality, the Kaiser Family Foundation, and the MDHMH's Family Health Administration, Office of Chronic Disease Prevention.

Healthy Montgomery

Locally, we worked with Montgomery County's Health and Human Services, Community Health Improvement Process (CHIP), to review the State of Maryland's State Health Improvement Plan's (SHIP) 39 health indicators. Our Regional Director of Health and Wellness, Judy Lichty, MPH, serves on the Health Montgomery Steering Committee.

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

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

The Montgomery County Community Health Improvement Process launched in June 2009 with a comprehensive scan of all existing and past planning processes. Past assessment, planning, and evaluation processes were compiled that related to health and well-being focus and social determinants of health across a multitude of sectors, populations, and communities within Montgomery County. The group also developed the Healthy Montgomery website, http://www.healthymontgomery.org. This is a one-stop source of population-based data and information about community health. This website outlines thirty-three community indicators. The purpose of the Montgomery County Healthy Montgomery Community Health Improvement Process is to address the need of organizations to have valid, reliable, and user friendly data related to health and the social determinants of health and to coordinate efforts of public and private organizations to identify and address health issues in Montgomery County.

In its Priority-Setting Process in October 2011, the Steering Committee identified six priority areas:

- Behavioral Health;
- Cancers;
- Cardiovascular Health;
- Diabetes;
- Maternal and Infant Health; and
- Obesity

In addition to selecting these six broad priorities for action, the HMSC selected three overarching themes (lenses) that Healthy Montgomery should address in the health and well-being action plans for each of the six priority areas. The themes are:

- Lack of access;
- Health inequities; and
- Unhealthy behaviors.

The Steering Committee started to establish workgroups, composed of individuals who are experts in the respective priority areas in May 2012. Their task is to develop, execute, and evaluate specific action plans that are designed to improve the health and well-being of the residents of Montgomery County.

Washington Adventist Hospital gave $12,500 in grants to the Urban Institute in 2009 and in 2010 to provide support for the Healthy Montgomery work. In 2011 and in 2012 Washington

Adventist Hospital increased its funding to $25,000. This included coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Department of Health and Mental Hygiene) and needs assessments and improvement plans from organizations in Montgomery County, support of the effort to select the 100 indicators to include in the Healthy Montgomery Website, preparation of indicators and maps that show the social determinants of health for the County as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the Needs Assessment document.

Other Available Data

We also utilized data from needs assessments and reports conducted by other local organizations to identify unmet needs, particularly among minority communities. We used the following resources to add to our assessment of community health needs:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014.
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008.
- Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012.
- The Community Needs Index (CNI) (http://cni.chw-interactive.org/). This online tool identifies the severity of health disparity for every ZIP code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations (Dignity Health, 2012). For each ZIP code in the United States, The Community Needs Index accounts for the underlying economic and structural barriers that affect overall health, including those related to income, culture/language, education, insurance, and housing. The CNI averages the scores for each barrier condition to produce a final CNI score to represent the socio-economic barriers in each zip code. This score can then be used by hospitals to direct community benefit and outreach efforts toward the areas with the greatest need.

Partnerships

Washington Adventist Hospital, a member of Adventist HealthCare, has ongoing partnerships with several community-based organizations and health care clinics that provide valuable input on the health needs of community members. We partner with clinics that improve access to care by serving the low-income residents of Montgomery County and Prince George's County, many of whom are limited English proficient and/or racial and ethnic minorities. One of Washington Adventist Hospital's safety net clinic partners is Mary's Center for Maternal and Child Care. Another partner, Mobile Medical Care (MobileMed), operates three mobile healthcare vehicles and provides primary and preventative healthcare to the uninsured, low income, working poor and homeless in Montgomery County. In FY 2012 we supported these clinics with $ 395,439 in cash donations for general operating costs as well as for clinical services. We expanded our prenatal services in 2006 by partnering with the Montgomery County Department of Health and

Human Services in its Maternal Partnerships Program, a referral program that collaborates with hospitals to provide obstetric and gynecologic services for uninsured women in Montgomery County.

We also provide health services for women in the community with breast cancer through a partnership with the Komen Foundation. In addition, Adventist HealthCare and the Center on Health Disparities have ongoing collaborations with Sinai Hospital of Baltimore, the University of Maryland School of Public Health, and the Primary Care Coalition of Montgomery County. Public Health experts from these various partner organizations provide Washington Adventist Hospital with important input on the needs affecting the health of the communities we serve.

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

We convened an Advisory Board to help guide our efforts to reduce and eliminate health disparities, to identify community needs, and to help assess and direct our response to those needs. The Advisory Board is comprised of both internal and external/community leaders.

Adventist HealthCare Community Benefit Advisory Board Members:

Aisha Bivens, JD, BSN
Associate Vice President of Clinical Effectiveness
Washington Adventist Hospital

Perry Chan
Senior Program Coordinator, Asian American Health Initiative
Montgomery County Department of Health and Human Services

Irene Dankwa-Mullan, MD, MPH
Director, Office of Innovation and Program Coordination
National Institute on Minority Health and Health Disparities

Steve Galen, MS
President and CEO
Primary Care Coalition of Montgomery County

Carol W. Garvey, MD, MPH
Chair
Primary Care Coalition

Carlessia Hussein, DrPH, RN
Director, Office of Minority Health and Health Disparities
Maryland Department of Health and Mental Hygiene

Judy Lichty, MPH
Regional Director, Health and Wellness
Adventist HealthCare

Skip Margot, RN, MS
CNE and VP of Patient Care Services
Shady Grove Adventist Hospital

Sonia Mora, RN
Manager, Public Health Services/Latino Health Initiative
Montgomery County Department of Health and Human Services

Richard "Dick" Pavlin, MHCA
Executive Director
Mercy Health Clinic

Olivia Carter-Pokras, PhD
Associate Professor
University of Maryland College Park, School of Public Health

Howard Ross
Chief Learning Officer
Cook Ross, Inc.

Terrence P. Sheehan, MD
Chief Medical Officer
Adventist Rehabilitation Hospital of Maryland

Tom Sweeney, RN, MBA, FACHE
Vice President – Chief Nursing Officer
Washington Adventist Hospital

Lois A. Wessel, RN CFNP
Associate Director for Programs
Association of Clinicians for the Underserved

In addition to the formal advisory board, the staff of Adventist Health Care and Washington Adventist Hospital participates in various ways in the community. We actively participate in numerous committees, coalitions, and partnerships that provide information on the health needs in the community. The health professionals that provide programs in the community also provide valuable information and knowledge of community needs.

Primary Data Collection

The community's perspective was obtained through a Community Health Needs Assessment Survey offered to the public at health screening events, health fairs, community events, and meetings with community leaders. A 25-item survey, available either online through surveymonkey.com or in hard copy, asked community members and community leaders alike to identify their sociodemographic information, health needs, problems affecting the health of the community, barriers to accessing care, and strengths/resources in the community. The survey results will be analyzed and included in Washington Adventist Hospital's 2013 Community Health Needs Assessment.

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

   November 2011

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

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

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X_ Yes
___ No

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

i. ***Senior Leadership***

1. _X__CEO
2. __X_CFO
3. __C_Other (please specify) Associate Vice President for Mission Integration & Spiritual Care

ii. Clinical Leadership

1. _X__Physician (Chief Medical Officer)
2. _X__Nurse (CNE & VP of Patient Care Services)
3. _X__Social Worker (Director of Case Management
4. __X_Other (please specify) Allied health professionals

iii. Community Benefit Department/Team

1. _X__Individual (please specify FTE) 1 FTE Community Benefits Manager
2. __X_Committee (please list members) (Associate VP, Mission Integration & Spiritual Care; Executive Director Center on Health Care Disparities; Regional Director Health & Wellness; Communications Manager, Public Relations/Marketing; Senior Tax Accountant; Manager of Planning and Market Analysis, Manager for Center for Healthier Living, Project Manager, Finance; Manager, Community Benefits and Health Ministry.

3. ___Other (please describe)

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

Spreadsheet	___X__yes	_____no
Narrative	__X___yes	_____no

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

Spreadsheet	____x_yes	_____no
Narrative	___x__yes	_____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

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

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

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

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

Initiative 1: Help Stop The Flu

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Access to Care Influenza – persons most at risk include the elderly, the very young, and the immuno-compromised. According to Montgomery County's Community Health Needs Assessment, in the zip code where WAH is located, 20912, the age-adjusted ER rate due to immunization-preventable pneumonia and influenza is in the 'yellow' zone close to the 'red' zone, compared to other MD counties (20912 has 13.3 ER visits/ 10,000; green is <9.7 ER visits/ 10,000; red is >14.6 ER visits/10,000).	Help Stop The Flu	To provide flu vaccines for community members, regardless of the ability to pay, in various easily accessible locations including: senior centers, apartment complexes, schools, and faith communities, as well as the hospital. Provide over 200 free flu shots to community members who normally would not be able to receive a flu shot.	Multi-year from 2008 – present year	*Washington Adventist Hospital *WTOP 103.5 Radio Station *M & T Bank *CASA of Maryland, Other sites included senior centers, low-income housing complexes, Washington Adventist Hospital, and local congregations.	Evaluation completed at the end of each flu shot clinic	Provided 107 free flu shots at M&T Bank in Silver Spring. Free flu shots were also provided at First United Methodist church in Hyattsville, which serves an at-risk community. Provided a total of 679 flu shots for the community. An average of 30 to 35 shots were provided at each clinic.	The intention is to continue and expand this program.	Cost of the program is $22,000 Vaccination, supplies and administration: $14,000 Staff Salary: $8,000 M & T grant: $5,000

Although flu shots are widely available in Montgomery County there are still many at-risk people who are not getting vaccinated due to income, cultural barriers, and access to clinics.								

Initiative 2: "Reaching Out to Our Latino Neighbors"

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Access to Care In 2010 Hispanics in Maryland were uninsured at more than twice the rate of blacks and more than four times the rate of whites. About 75% of the uninsured in Montgomery County are Hispanics/Latinos. (Sources: U.S. Dept of Labor, Bureau of Labor Statistics, Current Population Survey, 2010; U.S. DHHS, OMH, 2007)	Bridging the Gap, Collaborating with our Latino Neighbors Initiative A: "Fiesta de las Madres"	Washington Adventist Hospital worked with two organizations to provide needed health education and health screenings in the Latino community. At the *Fiesta de Las Madres* (Celebration of Mothers) event in downtown Silver Spring, WAH focused on providing education for Latina women on breast feeding, breast cancer, diabetes/nutrition and alcohol awareness, and helped to connect residents to primary care physicians. We also provided the following health screenings: bone density test, body composition, grip strength test, derma scan test (facial skin analysis), and hand-washing activity.	This is an annual event that WAH sponsored in both 2011 and 2012 This was a	Washington Adventist Hospital and Telemundo (a local Latino TV station)	A process evaluation was conducted after the event.	Impact: 8,000 people attended the event; 25 participants received referrals to local partner safety net clinics and physicians. Process: A process evaluation was conducted after the event to determine what worked well and what changes to make for next year's event.	We have partnered with Telemundo to provide this event to the community and we plan to continue this partnership as well as look for additional opportunities to reach out to this community.	Cost of staff time: $2800.00

	Initiative B: "To Your Health – Neighbors Meeting Neighbors"	"To Your Health – Neighbors Meeting Neighbors" offered free screenings and physician consultation to the neighborhood surrounding CASA of Maryland. The goal was to decrease the barriers to obtaining health services for this community. Instead of the community coming to the hospital, the health services came to this specific community.	one time event in August 2011	Washington Adventist Hospital Health Ministry Dept., and Health & Wellness Dept., CASA of Maryland and Sligo Adventist Church	A process evaluation was conducted after the event.	Impact: The festive type venue attracted over 300 people from the neighborhood and volunteers from the congregation engaged residents. Process: A process evaluation was conducted after the event.		$3,000 donation for the event to cover cost of food and equipment Staff time: $150

Initiative 3: Navigate to Health: Rapid Referral Program (Mammography)

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Cancer Breast Cancer Screening for Low-Income Women According to the National Cancer Institute, the death rate for breast cancer in Prince George's County is 14% higher than the average in Maryland, and 23.5% higher than the national average. In both Montgomery and Prince George's Counties, the breast cancer mortality rate for black women (28.8% and 33.6%, respectively) is a great deal higher than for white women (19.9% and 25.3%, respectively).	Navigate to Health: Rapid Referral Program (Mammography)	The goal of Navigate to Health: Rapid Referral Program is to provide comprehensive breast care services to bridge the gap to medically under-served, low-income, minority women in Montgomery County. The focus is to expand and enhance breast care services while providing a rapid and continuous process between referral and screening and the diagnosis and treatment for all patients served.	Multi-year/ ongoing	* Washington Adventist Hospital * Primary Care Coalition * Mary's Center * Mobile Medical * Muslim Communi., Clinic * Spanish Catholic Center * Women's Cancer Control Program of Montgomery County * Komen Race for the Cure	Ongoing process evaluation & monthly quality improve-ment meetings	Impact: In 2011 Washington Adventist Hospital provided 670 free mammograms to low-income women. Wait time from referral to screening for those patients coming for the SafetyNet Clinics is under 32 days. Process: Ongoing process evaluations are conducted to determine the effectiveness of this program. Currently monthly quality improvement meetings take place with key partners on successes, challenges and discussions regarding what works with the collaboration and identification of program gaps.	The hospital's breast cancer screening program implemented in 1993 has grown and expanded since then.	The overall budget for the program is $195,905 per year. $114,625 is covered annually by a Komen Race for the Cure. The rest (salary & mammograms) by Washington Adventist Hospital and the Washington Adventist Hospital Foundation: $81,280.

According to Montgomery County's Community Health Needs Assessment, Montgomery County's breast cancer incidence rate is in the 'yellow' zone compared to other U.S. counties (M.C. has 128 cases/ 100,000; green is <116.7 cases/ 100,000). Although the age-adjusted death rate due to breast cancer is low in Montgomery County in general, great disparities exist (31.6/100,000 deaths for blacks compared to 19.9/100,000 deaths overall).								

Initiative 4: Cancer Screening Day

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Cancer WAH's top four cancers are Prostate, Breast, Colorectal, and Lung. Blacks are diagnosed with and die from prostate cancer nearly 30% more often than whites; the death rate due to prostate cancer for Prince George's County is 117% higher than that of Montgomery County, 46% higher than the Maryland state average, and 65% higher than the national average. The death rate for breast cancer in Prince George's County is 14% higher than the average in Maryland, and	Annual Cancer Screening Day March 2012	Provide free cancer screening for Prostate, Skin, Breast, Oral, Thyroid, Bladder and Colorectal Cancers to improve access to screenings for low income and disadvantaged populations. As a certified cancer center we need to provide a screening event each year but because of the need we do 6 screenings per year.	This annual program began in 1998 to give community members access to free cancer screenings	*Washington Adventist Hospital Health and Wellness Department and Cancer Committee, * Montgomery County Cancer Crusade * Washington Adventist Hospital's physicians Physicians volunteer their time for this initiative.	At time of screening and f/u with abnormal patients up to 6 months after screening. The evaluation of the overall program is conducted following this event to improve the program for the next year	Impact: The annual cancer screening day provided a total of 382 screenings with 197 normal screenings and 68 abnormal screenings. Process: The process evaluation of the overall program is conducted following this event to improve the program for the next year. Some participants return each year to receive these screenings and assistance is provided to ensure follow up with physicians or safety net clinics as needed.	Because of the positive response of this initiative, this program will continue as a free service to community members.	Overall cost of program is $8,000. This includes free laboratory tests and staff time to coordinate the event.

23.5% higher than the national average, and there are large disparities in breast cancer death rates among racial groups in both Montgomery and Prince George's Counties. Colorectal Cancer mortality rates were much higher for blacks than whites or other races in 2007. Lung Cancer is the leading cause of cancer-related death among men and women in Maryland. (Sources: MD DHMH Cancer Report, 2010; NCI State Cancer Profiles, 2012)								

2. ***Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.)***

Washington Adventist Hospital's mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing. Although we recognize that we cannot immediately address all identified health needs in the community, we will use a rigorous process to make decisions on which needs to address from those identified through our 2013 Community Health Needs Assessment. We currently strive to address community health needs that fulfill our mission and overlap with our clinical strengths. Based on data gathered for this Community Benefit Report as well as on informal evaluations that have been conducted this year, we are aware that there is a high rate of new HIV/AIDS (incident) cases in Prince George's County compared with the state of Maryland and with the United States. However, we do not have hospital programs to address that need at this time because we do not have the infrastructure needed to develop and implement programs that would improve this area. Although we cannot currently provide programs aimed at improving the percentage of new HIV infections in Prince George's County, Washington Adventist Hospital will continue to support and partner with other organizations in the community that are working to meet this need.

V. PHYSICIANS

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

Washington Adventist Hospital is committed to addressing access to care and has noted an increase in the number of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our service area. The 2012 County Health Rankings shows that the primary care physician to patient ratio in Prince George's County is 1,304:1 compared with the state average of 824:1 and the national benchmark of 631:1. Prince George's County has Healthcare Provider Shortage Areas (HPSA) in primary medical care, dental care, and mental health care, according to HRSA.gov. One of the HPSA's for primary medical care is in the Greenbelt/Langley Park/College Park area where there is a large Medicaid population; this is one of the primary service areas for Washington Adventist Hospital. Washington Adventist Hospital partners with local safety net clinics including Mobile Medical Care, Inc. and Mary's Center to narrow the gap in availability of specialist providers to serve the uninsured cared for by the hospital.

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

These categories, as defined by Community Benefit report, would not be able to meet patient demand if they did not receive a subsidy from Washington Adventist Hospital:

Hospital-based physicians with whom the hospital has an exclusive contract:

- Anesthesia
- Emergency Physicians
- Radiologists

Non-Resident house staff and hospitalists:

- OB-Gyn
- Internal Medicine
- Psychiatry

Coverage of Emergency Department On-Call:

- Gastrointestinal surgery
- ENT
- Interventional Cardiologists
- General Surgery
- Orthopedic Surgery
- Plastic Surgery
- Urology
- Thoracic and Vascular Surgery
- Psychiatry
- Neurology
- Neurosurgery
- Pediatric Ophthalmology

Physician recruitment to meet community need:

- Cardiac, Vascular and Thoracic Surgeons
- Ophthalmology
- Pediatrics
- Pediatric Ophthalmology
- Oncology
- Family Medicine
- Neurosurgery

Below is the summary of the subsidies to physicians that are provided by the hospital.

In FY 2012, Washington Adventist Hospital paid subsidies to physicians in the following service areas:

Physician Category	**Amount**
Emergency Department On-Call	$1,603,836.97
Non-Resident House Staff and Hospitalist	$7,679,388.66
Recruitment of Physicians to meet community need	$4,420,785.86

APPENDICES

<u>To Be Attached as Appendices</u>:

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

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

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

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

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

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

Appendix I

Financial Assistance Policy Description

Washington Adventist Hospital informs patients and persons of their eligibility for financial assistance according to the National CLAS standards and provides this information in both English and Spanish at several intervals and locations. The Hospital's Notice of Financial Assistance and Charity Care policy is clearly posted in the emergency department and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy (FAP) at either the time of admission or discharge, a copy of the document will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is informed that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid, a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines if the patient qualifies for Medicaid, an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistants may be available if they do not have the financial means to pay their bill. If patients request financial assistance, at that time, a copy of the Hospital's charity application will be sent to them.

The Hospital has an outside contractor experience in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

Charity Care Policy

Effective Date	01/08 (previously "Financial Assistance Policy")	Policy No:	AHC 3.19
Cross Referenced:	AHC 3.19.1 Public Disclosure	Origin:	PFS
Reviewed:	02/09, 06/15/10	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/11/11	Page:	1 of 15

SCOPE

This policy applies to all AHC-affiliated facilities, except for Hackettstown Regional Medical Center, which has its own Charity Care policy that is compliant with New Jersey regulations.

PURPOSE:

To provide a systematic and equitable way to ensure that patients who are uninsured or underinsured and lack adequate resources to pay for services have access to medically needed care at our institutions consistent with our mission and values while also complying with Maryland State regulations.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

OUR VALUES:
Respect: we recognize the infinite worth of each individual and care for the whole person.

POLICY:

All patients, regardless of race, creed, gender, age, national origin or financial status, may apply for Charity Care. Printed public notification regarding the program will be made annually.

Each application for Charity Care will be reviewed, and a determination made based upon an assessment of the patient's circumstances. Circumstances could include, but not limited to; the needs of the patient and/or family, available income and/or other financial resources. It is part of Adventist Healthcare's mission to provide necessary medical care to those who are unable to pay for that care. However, this policy encourages a patient or their representative to cooperate with, and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for the services related to the request for Charity Care.

Charity Care Policy

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SCOPE:

A. The Charity Care policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland. A patient may apply for Charity Care at anytime during or after medical care. Pre-approved charity for scheduled medical services is approved by the appropriate staff based on criteria established in this policy and on based on individual patient circumstances. Services not covered by the Charity Care policy include, but not limited to:

1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
2. Cosmetic, other elective procedures, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
3. Patients who are eligible for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Charity Care Program to the extent that services would be covered under those programs.
4. Patients where it has been proven by the electronic income estimator that the patient/household has the means to cover their medical services.

B. The patient would be required to fully complete an application for Charity Care and/or completion of the "Income" and "Family Size" portions of the State Medicaid Application could be considered as "an application for Charity Care." A final decision will be determined by using; an electronic income estimator, the state of Maryland poverty guidelines and the review of requested documents. An approved application for assistance will be valid for twelve (**12**) months from the date of service and may[1] be applied to any qualified services (see "A" above), rendered within the twelve (**12**) month period. The patient or Family Representative may reapply for Charity Care if their situation continues to merit assistance.

1. Once a patient qualifies for Charity Care under this policy the patient or any immediate family member of the patient living in the same household shall be eligible for Charity Care at the same level for medically necessary care when seeking subsequent care at the same hospital during the 12 month period from the initial date of service.

[1] Patient may be subjected to provide current financial documents within the twelve month approval period to support any new visits under Charity Care.

Charity Care Policy

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2. When the patient is a minor, an immediate family member is defined as; mother, father, unmarried minor natural or adopted siblings, natural or adopted children residing in the same household.
3. When the patient is not a minor, an immediate family member is defined as: spouse, minor natural or adopted siblings, natural or adopted children residing in the same household.

This program provides for care to be, either free or rendered at a reduced charge to those most in need, based on limited income and family size, (i.e., individuals who have income that is less than or equal to 500% of the federal poverty level), and the absence of other available financial resources. See attached Sliding Scale Chart.

C. Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Charity Care without having completed a formal application. This would occur after a determination that other family members have no legal obligation to provide Charity Care. After receiving a death certificate and appropriate authorization, the account balance will be adjusted via the appropriate adjustment codes 23001 – Account in active AR, 33001 – Account in Bad Debt.

D. Where a patient is from out of State with no means to pay, follow instructions for "B" above.

E. A Maryland Resident who has no assets or means to pay, follow instructions for "B" above.

F. A Patient who files for bankruptcy, and has no identifiable means to pay the claim, upon receipt of the discharge summary to include debt owed to AHC, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

G. Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

H. A Patient is denied Medicaid but is not determined to be "over resource" follow instructions for "B" above.

I. A Patient who qualifies for federal, state or local governmental programs whose income qualifications fall within AHC Charity Care Guidelines, automatically qualify for AHC Charity Care without the requirement to complete a charity application.

Charity Care Policy

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J. Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, charity will be processed without a completed application and current balances adjusted as instructed in "C" above.

K. If a patient experiences a material change in financial status, it is the responsibility of the patient to notify the hospital within ten days of the financial change.

PROCEDURE:

A. Financial Counselor(s), Registration, Collection and Patient Communication staff should be thoroughly familiar with the criteria and process for Charity Care.

B. An individual notice regarding the Hospital's Charity Care policy shall be provided at the time of preadmission or admission to each person who seeks services at the Hospital.

C. Patients being admitted should be prescreened for potential Charity Care qualification, using the questions found in the Registration- Charity Care Pathway and the electronic income estimator.

D. All inpatients without documented Insurance Coverage and no means to pay for Hospital services as Self Pay will be referred to the Government Services Vendor by the Admitting Office Staff to complete a Medicaid application.

E. All applications for Charity Care should be sent to the Patient Financial Services Office. The Application should include at minimum, information regarding the patient's family size and income level. **Manager of Collections and Customer Service (or designee) will take the following actions:**

1. Review application to ensure that all required information is complete and if necessary, contact patient/guarantor via mail or phone specifying what information is still needed.

2. Determine probable eligibility within two business days following the patient's request accompanied by a completed application.

3. If the patient/guarantor is deemed over scale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are over scaled per the Federal Poverty Guidelines.

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4. If the patient/guarantor qualifies according to their income, the Customer Service Manager (or designee) will query the patient accounting system to identify all of the patient or guarantor's accounts, looking for patient responsibility balances.

5. Accounts still outstanding with the patient/guarantor's insurance carrier or the Government Services Vendor for payment or Medicaid Eligibility will be held until the insurance either makes or denies payment, it will then be processed according to policy for Charity Care.

6. The Manager (or designee) will then complete an adjustment form, using the Charity Care adjustment code, 23001 or 33001 and note all accounts where a charity application has been received with the activity codes listed below.

Charity Care decisions are noted on a patient account with the following activity codes:

a. CHRP - Charity Care Appl. Rec'd/Processing
b. CHDN - Charity Care Appl. Denied - Final
c. CHIN - Charity Care Appl. Incomp/Need Info
d. CHLT - Charity Care Appl. approval sent to patient
e. CHWO - Charity Care write-off - Approved

7. The Manager (or designee) will notify any agencies that hold accounts for the patient/guarantor that they have been approved/denied Charity Care, providing details if there is any patient/guarantor responsibility.

8. The application will then be forwarded to imaging to be scanned into the patient folder.

AUTOMATED CHARITY PROCESS - Accounts sent to outsourced agencies:

Outsourced agencies are using software to determine a patient or guarantor's Payment Predictability Score (PPS). Where the PPS meets criteria for Charity Care, an adjustment will be made to the Patient's Account without a completed application by the patient, See "C" above. Adjustments will be processed electronically via an electronic report sent to the PFS Regional Director or designee for review and final approval. The approved accounts are automatically written off by PFS per the amount of Charity Care applied to each account. Supporting Documents for the write-offs are kept in Electronic Files on the PFS – "N" Drive, by Vendor.

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Charity Care Policy

Effective Date	01/08 (previously "Financial Assistance Policy")	Policy No:	AHC 3.19
Cross Referenced:	AHC 3.19.1 Public Disclosure	Origin:	PFS
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NOTICE TO BE POSTED IN THE ADMISSIONS OFFICE, BUSINESS OFFICE AND THE EMERGENCY DEPARTMENT

ADVENTIST HEALTHCARE
NOTICE OF AVAILIBILITY OF CHARITY CARE

Shady Grove Adventist, Adventist Behavioral Health, Washington Adventist Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Charity Care is available to patients whose family income does not exceed the limits designated by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than five time these amounts, you may qualify for Charity Care.

Size of Family Unit	Guideline
1	$10,890
2	$14,710
3	$18,530
4	$22,350
5	$26,170
6	$29,990
7	$33,810
8	$37,630

Note: The guidelines increase **$3,820** for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made two business days of the receipt of your completed application.

Revised March 2011

Charity Care Policy

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ADVENTIST HEALTHCARE

Patient Financial Services, 1801 Research Blvd, Suite 300, Rockville, MD 20850

☐ Washington Adventist Hospital ☐ Adventist Behavioral Hospital
☐ Shady Grove Adventist Hospital ☐ Adventist Rehabilitation Hospital of Maryland

CHARITY CARE APPLICATION- DEMOGRAPHICS

Date: _____Account Number(s)_____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____ Cell Phone: _____

Social Security #: _____ US Citizen: _____ No Residence: _____

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application_____

Dependents Listed on Tax Form:

Name: _____ Age: ____Relationship:_____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Employment: Patient employer **Spouse employer**

Name: _____ Name:_____

Address: _____ Address: _____

Telephone #: _____ Telephone #:_____

Social Security #: _____ Social Security #: _____

How long employed: _____ How long employed: _____

TOTAL FAMILY INCOME $_____

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months worth of pay-stubs, an official income verification letter from your employer and/or your current taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses. Any missing documents will result in a delay in processing your application or could cause your application to be denied.

Charity Care

Effective Date	01/08	Policy No:	AHC 3.19
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CHARITY CARE APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _____

Food _____

Transportation _____

Utilities _____

Health Insurance premiums _____

Medical expenses not covered by insurance _____

Doctor: _____

_____

_____

Hospital: _____

_____

TOTAL: _____

Has the applicant ever applied or is currently applying for Medical Assistance?

Please Circle the appropriate answer: **YES or NO**

If yes, please provide the status of your application below (caseworker name, DSS office location, etc.)

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Applicant Signature: _____ Date: _____

Return Application To: Adventist HealthCare

Patient Financial Services

Attn: Customer Service Manager

Charity Care

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1801 Research Blvd, Suite 300

Rockville, MD 20850

COMMUNITY CHARITY CARE APPLICATION- OFFICIAL DETERMINATION ONLY

This application was: **Denied /Approved /Need more information**

The reason for Denial:

What additional information is needed?:

Approval Details:

Patient approved for _____%
$_____ will be a Charity Care Adjustment
$_____ will be the patient's responsibility

Approval Letter was sent on _____

AUTHORIZED SIGNATURES:

_____
CS/COLLECTION MANAGER
UP TO $1500.00

_____
Sr. ASSISTANT DIRECTOR
UP TO $2500.00

_____
REGIONAL DIRECTOR
UP TO $25,000.00

_____
VP of Revenue Cycle or HOSPITAL CFO
OVER $25,000.00

Revised October 2008

Charity Care

Effective Date 01/08
Cross Referenced: Previously: Financial Assistance Policy
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2011 POVERTY GUIDELINES

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	$10,890	100%	0%
2	100%	$14,710	100%	0%
3	100%	$18,530	100%	0%
4	100%	$22,350	100%	0%
5	100%	$26,170	100%	0%
6	100%	$29,990	100%	0%
7	100%	$33,810	100%	0%
8	100%	$37,630	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	125%	$13,613	90%	10%
2	125%	$18,388	90%	10%
3	125%	$23,163	90%	10%
4	125%	$27,938	90%	10%
5	125%	$32,713	90%	10%
6	125%	$37,488	90%	10%
7	125%	$42,263	90%	10%
8	125%	$47,038	90%	10%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	150%	$16,335	80%	20%
2	150%	$22,065	80%	20%
3	150%	$27,795	80%	20%
4	150%	$33,525	80%	20%
5	150%	$39,255	80%	20%
6	150%	$44,985	80%	20%
7	150%	$50,715	80%	20%
8	150%	$56,445	80%	20%

Appendix II

Charity Care

Effective Date 01/08
Cross Referenced: Previously: Financial Assistance Policy
Reviewed: 02/09
Revised: 03/11

Policy No: AHC 3.19
Origin: PFS
Authority: EC

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	$19,058	70%	30%
2	175%	$25,743	70%	30%
3	175%	$32,428	70%	30%
4	175%	$39,113	70%	30%
5	175%	$45,798	70%	30%
6	175%	$52,483	70%	30%
7	175%	$59,168	70%	30%
8	175%	$65,853	70%	30%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	200%	$21,780	60%	40%
2	200%	$29,420	60%	40%
3	200%	$37,060	60%	40%
4	200%	$44,700	60%	40%
5	200%	$52,340	60%	40%
6	200%	$59,980	60%	40%
7	200%	$67,620	60%	40%
8	200%	$75,260	60%	40%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	225%	$24,503	50%	50%
2	225%	$33,098	50%	50%
3	225%	$41,693	50%	50%
4	225%	$50,288	50%	50%
5	225%	$58,883	50%	50%
6	225%	$67,478	50%	50%
7	225%	$76,073	50%	50%
8	225%	$84,668	50%	50%

Charity Care

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	$27,225	40%	60%
2	250%	$36,775	40%	60%
3	250%	$46,325	40%	60%
4	250%	$55,875	40%	60%
5	250%	$65,425	40%	60%
6	250%	$74,975	40%	60%
7	250%	$84,525	40%	60%
8	250%	$94,075	40%	60%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	275%	$29,948	30%	70%
2	275%	$40,453	30%	70%
3	275%	$50,958	30%	70%
4	275%	$61,463	30%	70%
5	275%	$71,968	30%	70%
6	275%	$82,473	30%	70%
7	275%	$92,978	30%	70%
8	275%	$103,483	30%	70%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	300%	$32,670	20%	80%
2	300%	$44,130	20%	80%
3	300%	$55,590	20%	80%
4	300%	$67,050	20%	80%
5	300%	$78,510	20%	80%
6	300%	$89,970	20%	80%
7	300%	$101,430	20%	80%
8	300%	$112,890	20%	80%

Charity Care

Effective Date 01/08
Cross Referenced: Previously: Financial Assistance Policy
Reviewed: 02/09
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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	350%	$38,115	15%	85%
2	350%	$51,485	15%	85%
3	350%	$64,855	15%	85%
4	350%	$78,225	15%	85%
5	350%	$91,595	15%	85%
6	350%	$104,965	15%	85%
7	350%	$118,335	15%	85%
8	350%	$131,705	15%	85%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	400%	$43,560	10%	90%
2	400%	$58,840	10%	90%
3	400%	$74,120	10%	90%
4	400%	$89,400	10%	90%
5	400%	$104,680	10%	90%
6	400%	$119,960	10%	90%
7	400%	$135,240	10%	90%
8	400%	$150,520	10%	90%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	450%	$49,005	5%	95%
2	450%	$66,195	5%	95%
3	450%	$83,385	5%	95%
4	450%	$100,575	5%	95%
5	450%	$117,765	5%	95%
6	450%	$134,955	5%	95%
7	450%	$152,145	5%	95%
8	450%	$169,335	5%	95%

Charity Care

Effective Date 01/08
Cross Referenced: Previously: Financial Assistance Policy
Reviewed: 02/09
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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	500%	$54,450	0%	100%
2	500%	$73,550	0%	100%
3	500%	$92,650	0%	100%
4	500%	$111,750	0%	100%
5	500%	$130,850	0%	100%
6	500%	$149,950	0%	100%
7	500%	$169,050	0%	100%
8	500%	$188,150	0%	100%

Charity Care

Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy	Origin:	PFS
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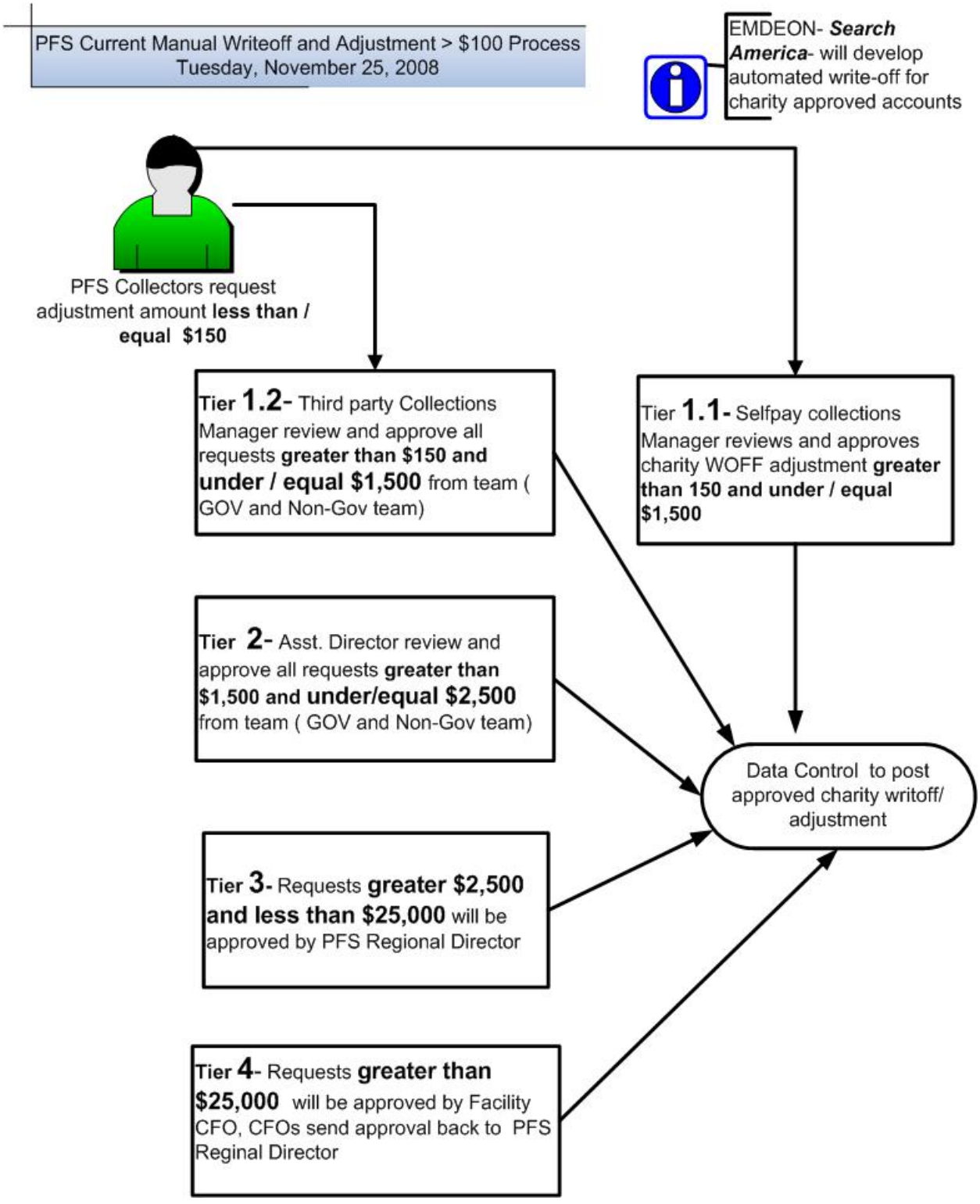

Washington Adventist Hospital

Appendix III

PUBLIC NOTICE OF FINANCIAL ASSISTANCE AND CHARITY CARE

Washington Adventist Hospital is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance at Washington Adventist Hospital. Each application for Financial Assistance (charity care) will be reviewed based upon an assessment of the patient's and/or family's need, income and financial resources.

It is part of Adventist Health Care's mission to provide necessary medical care to those who are unable to pay for that care. This policy requires patients to cooperate with and avail themselves of all available programs (including Medicaid, workers compensation and other state and local programs) that might provide coverage for medical services.

A determination of probable eligibility can be made immediately if medical care has already been provided or within two business days from the submission of a request that includes sufficient financial information.

For more information please call our Patient Access Department at (301) 891-6323, or you may call and speak directly to a Medicaid Eligibility worker located at Washington Adventist Hospital at (301) 891-5250.

You may also pick up an application for Financial Assistance at the hospital in the Patient Access Department on the first floor or the Emergency Registration Department on LL1.

AYUDA FINANCIERA

El Hospital de Washington Adventist esta comprometido a acomodar las necesidades de asistencia medica de su communidad atraves de un servicio de curacion fisica, mental y spiritual. Todos los pacientes, sin tener en cuenta su raza, religion, sexo, edad, origen nacional o estado financiero, pueden solicitar ayuda financiera al Hospital de Washington Adventist.

Cada aplicacion para la Ayuda Financiera sera basada sobre una evaluacion de necesidad del paciente y/o familia, ingresos o recursos financieros.

Esto es parte de la mission del Cuidado Medico Adventista de proporcionar la asistencia medica necesaria a aquellos que son incapaces de pagar por aquel cuidado. Este plan require que los pacientes cooperen y se sirvan ellos mismos de todos los programas disponibles (incluyendo ayuda medica, compensacion de trabajo y otros programas estatales y locales) que podrian proporcionar la cobertura para servicios medicos.

Una determinacion de elegibilidad puede ser hecha immediatamente si la asistencia medica ya ha sido proporcionada o dentro de dos dias laborales de la entrega de la solicitud donde esta incluida suficiente informacion financiera.

Para mas informacion por favor llamar a nuestra Unidad Departamento de Admision al (301) 891-6323, o usted puede llamar y hablar directamente con un trabajador de Eligibilidad de Ayuda Medica ubicado en el Hospital de Washington Adventist al (301) 591-5250.

Usted tambien puede recoger una aplicacion para la Ayuda Financiera en el hospital en el Departamento de Admision ubicado en el primer piso o el Departamento de Emergencia en el LL1.

Washington Adventist Hospital
A Member of Adventist HealthCare

Appendix IV

Mission & Values

Our Mission
Our mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing.

Our Vision
Our vision: Adventist HealthCare will be a high performance integrator of wellness, disease management and health care services, delivering superior health outcomes, extraordinary patient experience and exceptional value to those we serve.

Our Values
Washington Adventist Hospital's Mission, Vision, and Value statement was developed based on the following five concepts known as R.I.S.E.S.:

1. **Respect:** Recognize the infinite worth of each individual and care for each individual as a whole person.

2. **Integrity**: Be above reproach in all that we do.

3. **Service:** Provide compassionate and attentive care in a manner that inspires confidence.

4. **Excellence**: Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.

5. **Stewardship**: Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.