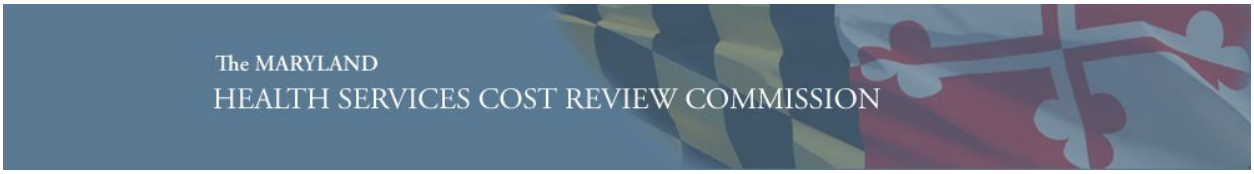

Doctors Community Hospital

FY 2018 Community Benefit Narrative Report

PART ONE: ORIGINAL NARRATIVE SUBMISSION

Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) 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 developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. 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 regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Doctors Community Hospital.	◉	○	
Your hospital's ID is: 210051	◉	○	
Your hospital is part of the hospital system called N/A.	◉	○	
Your hospital was licensed for 210 beds during FY 2018.	◉	○	
Your hospital's primary service area includes the following zip codes: 20706, 20715, 20721, 20737, 20743, 20747, 20770, 20774, 20784, 20785	◉	○	
Your hospital shares some or all of its primary service area with the following hospitals: Holy Cross Hospital, MedStar Southern Maryland Hospital Center, UM Laurel Regional Medical Center, UM Prince George's Hospital Center, Washington Adventist Hospital	◉	○	

Q3. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q4. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Q5. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q6. Please select the county or counties located in your hospital's CBSA.

- ☐ Allegany County
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Calvert County
- ☐ Caroline County
- ☐ Carroll County
- ☐ Cecil County
- ☐ Charles County
- ☐ Dorchester County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Harford County
- ☐ Howard County
- ☐ Kent County
- ☐ Montgomery County
- ☑ Prince George's County
- ☐ Queen Anne's County
- ☐ Somerset County
- ☐ St. Mary's County
- ☐ Talbot County
- ☐ Washington County
- ☐ Wicomico County
- ☐ Worcester County

Q7. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q8. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q9. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

☐ 20601	☐ 20712	☑ 20743	☐ 20772
☐ 20607	☐ 20715	☐ 20744	☑ 20774
☐ 20608	☐ 20716	☐ 20745	☐ 20781
☐ 20613	☑ 20720	☐ 20746	☐ 20782
☐ 20623	☑ 20721	☑ 20747	☐ 20783
☐ 20705	☐ 20722	☐ 20748	☑ 20784
☑ 20706	☐ 20735	☐ 20762	☑ 20785
☐ 20707	☑ 20737	☐ 20769	☐ 20904
☐ 20708	☐ 20740	☑ 20770	☐ 20912
☐ 20710	☐ 20742	☐ 20771	

Q24. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

  The CHNA was comprised of both quantitative health information and qualitative feedback from the community. This multi-faceted approach ensured a profile of the county's health that examined various perspectives and data sources. The three research components included secondary data, community surveys and focus group testing.
  With insight about the overall health status of Prince George's County, DCH can investigate strategies to address some of those concerns.

- [ ] Based on patterns of utilization. Please describe.

- [ ] Other. Please describe.

Q32. Provide a link to your hospital's mission statement.

https://www.dchweb.org/about-us/mission-vision-and-values

Q33. Is your hospital an academic medical center?

- (•) Yes
- ( ) No

Q34. (Optional) Is there any other information about your hospital that you would like to provide?

Q35. (Optional) Please upload any supplemental information that you would like to provide.

Q36.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (•) Yes
- ( ) No

Q37. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q38. When was your hospital's first-ever CHNA completed? (MM/DD/YYYY)

06/16/2016

Q39. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/16/2016

Q40. Please provide a link to your hospital's most recently completed CHNA.

https://www.dchweb.org/sites/doctors-community-hospital/files/Documents/Health_Wellness/2016%20PGCCHNA%20Report.pdf

Q41. Did you make your CHNA available in other formats, languages, or media?

- ( ) Yes
- (•) No

Q42. Please describe the other formats in which you made your CHNA available.

This question was not displayed to the respondent.

Q43. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q44. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: Southern Maryland Medical Center, Ft. Washinton Medical Center, Dimension Health System,	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Prince George's County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here:	☐	☐	☐	☐	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☐	☐	☐	☐	☐	☑	☐	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☐	☐	☐	☐	☐	☑	☐	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here:	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q45. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (•) Yes
- ( ) No

Q46. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/30/2016

Q47. Please provide a link to your hospital's CHNA implementation strategy.

https://www.dchweb.org/sites/doctors-community-hospital/files/Documents/Health_Wellness/Program%20Implementation%202016%20final.pdf

Q48. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q49. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- [x] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [x] Respiratory Diseases
- [ ] Sexually Transmitted Diseases

- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Hearing and Other Sensory or Communication Disorders
- [x] Heart Disease and Stroke
- [x] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal & Infant Health
- [x] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Sleep Health
- [x] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [x] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other (specify)

Q50. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

The finding were almost identical to the priorities identified in the CHNA conducted by the hospital in 2013.

Q51. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q52. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q53. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☑	☐	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☐	☐	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q54. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Prince George's County Health Department	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: Maryland Park and Planning Commission	☑	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here: Prince George's Community College	☐	☐	☐	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here: University of Maryland	☐	☐	☐	☐	☐	☐	☐	☑	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: African American Cancer Awareness Association, Casa de Maryland, Mary's Center, Community Clinic Clinca de Pueblo, Spanish Catholic Center, Pregnncy Aid Center, Greater Baden Medical Center	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Local Physicians	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q55. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☐ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor
- ☐ No

Q56. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q57. Please describe the community benefit narrative review process.

The report is reviewed by the Executive team members.

Q58. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ◉ Yes
- ○ No

Q59. Please explain:

This question was not displayed to the respondent.

Q60. Does the hospital's board review and approve the annual community benefit narrative report?

- (•) Yes
- ( ) No

Q61. Please explain:

This question was not displayed to the respondent.

Q62. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (•) Yes
- ( ) No

Q63. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

1) Growth of ambulatory services: Free mobile clinic & Free discharge clinic 2) Free TLC-MD care coordination services: Free medication reconciliation and Management, Free scales and glucose management. 3) Collaborations with underserved at LaClinica and Catholic Charities clinics

Q64. (Optional) If available, please provide a link to your hospital's strategic plan.

Q65. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q66. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q67. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q68. Initiative 1

Q69. Name of initiative.

Prevalence of Diabetes

Q70. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q71. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [ ] Cancer
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders
- [x] Nutrition and Weight Status

- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [x] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q72. When did this initiative begin?

07/01/2013

Q73. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ◉ The initiative will end when external grant money to support the initiative runs out. Please explain.

  It will end as it is formatted when the grant funds run out in FY18. IT will be re-evaluated and re-established with changes.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ○ Other. Please explain.

Q74. Enter the number of people in the population that this initiative targets.

102,000

Q75. Describe the characteristics of the target population.

12% of the population of Prince Georges County that are diabetic or have pre-diabetes

Q76. How many people did this initiative reach during the fiscal year?

937

Q77. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention

- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q78. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

Prince George's Health Department
Maryland Park and Planning Commission
LaClinica del Pueblo
Local Faith based organizations

- ( ) No.

Q79. Please describe the primary objective of the initiative.

1. To provide diabetes education to 250 residents and outreach and screening to 500 county residents 2. To increase diabetes self-management education and knowledge of participants and caregivers in the program both in English and Spanish. 3. To create a follow through plan for participants in the program with A1C levels that is above normal and abnormal. • Abnormal A1C results will be mailed to participants' and communicated to provider via fax for English classes • La Clinica staff will follow up with participants with abnormal A1C results and assist with link to care for Spanish classes 4. Develop and implement a comprehensive evaluation of program to assess and improve services by developing effective interventions, strategies and solutions to ensure healthier behaviors are being reinforced for long term management.

Q80. Please describe how the initiative is delivered.

A. On the Road Diabetes Program- The Joslin Center in collaboration with Prince George's County Health Department provide in-depth education and free A1c screening to county residents for Fiscal yr. 2017-18. B. Joslin Diabetes Center will offer Nutrition Seminars at Health Fairs. C. The Joslin Center added new collaboration with LaClinica de Pablo to provide in-depth education and free A1c screening to Spanish speaking county residents in 2017.

Q81. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [x] Biophysical health indicators A1c results
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q82. Please describe the outcome(s) of the initiative.

Aligned with Objectives 1) People Served: 187 Participated in Education Classes in FY17-18. Approximately over 750 people were provided information and screened in community outreach activities. 2) Education: (Pre-and Post test measures) - Pre-Test Questionnaire 4% scored less than 60% 54% scored 80% or higher. Post-Class Questionnaire: 100% scored 80% or higher 3) Clinical Outcomes: English Class • A1C screening done on 92 program participants • 46% with pre- diabetes • 34% with diabetes diagnosis • 20% without diabetes • 42% of diagnosed participants not at goal (less than 7%) • All participants were mailed A1C results. • Participants with abnormal A1C were called by diabetes educator for telephone counseling • 80% of results successfully sent to providers for patient follow-up (9% or above) Spanish Class • A1C screening done on 36 program participants • 27% of program participants needed navigation due to uncontrolled A1C (Between 7 - 8 (Follow-up with an endocrinologist) or 9 or above (Urgency)) • 60% of program participants with uncontrolled A1C provided contact information and were contacted by La Clinica Staff 50% of contacted program participants were linked to medical care Evaluation: Outside Evaluator completed 3-year review.

Q83. Please describe how the outcome(s) of the initiative addresses community health needs.

Need was identified by CHNA Process, HCI –Data, and Hospital Admissions -- Prevalence of Diabetes In Prince George's County – Reaffirmed in November 2016 Evaluation

Q84. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$70,876 no grants

Q85. (Optional) Supplemental information for this initiative.

Q86. Initiative 2

Q87. Name of initiative.

High Incidence of Breast Cancer

Q88. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q89. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q90. When did this initiative begin?

01/02/2012

Q91. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- (•) The initiative will end when external grant money to support the initiative runs out. Please explain.

Funded through FY 19, the program will be reformatted or continued at that time.

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

○ Other. Please explain.

Q92. Enter the number of people in the population that this initiative targets.

90,000 women

Q93. Describe the characteristics of the target population.

Total population targeted are approximately 90,000 women, with a focus on lower income and medically underserved population

Q94. How many people did this initiative reach during the fiscal year?

636

Q95. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☐ Chronic condition-based intervention: treatment intervention
- ☐ Chronic condition-based intervention: prevention intervention
- ☑ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☑ Condition-agnostic treatment intervention
- ☐ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q96. Did you work with other individuals, groups, or organizations to deliver this initiative?

● Yes. Please describe who was involved in this initiative.

1)Prince George's County Health Department
2) African Women's Cancer Awareness Assoc. Outreach activities are conducted at churches and health fairs
3) Casa de Maryland
4) Mary's Center
5) Community Clinic, Inc
6) Greater Baden Medical Services
7) Spanish Catholic Center
8) Pregnancy Aid Center
9) Clinica del Pueblo
10) Governor's Wellmobile
11) Dr. Luz Lopez Correa

○ No.

Q97. Please describe the primary objective of the initiative.

To enhance and sustain a community-based continuum that will increase utilization of breast screening by uninsured and underserved women. 1) Increase numbers of women receiving early screening and increase education and literacy about breast care and risks. And to re-screen women from the prior year ensuring annual mammogram. 2) Decrease fragmentation/length of time between abnormal screening and initiation of treatment including: 1) 100% of the women with abnormal findings will have been navigated by the Imaging Navigator; 2) Ensure a 75% adherence rate for cases requiring 3 and 6 month follow-up imaging. 3) Increase compliance rates to treatment plans. Ensure that 90% of women who are screened and have abnormal findings are navigated into diagnostic resolution within 60 days. At least 90% of women who have been diagnosed with breast cancer will be navigated into an oncology consult within 60 days of diagnosis. Ensure 80% of women diagnosed with breast cancer will adhere to initial treatment recommendations

Q98. Please describe how the initiative is delivered.

1) To reduce disparities in breast health care in Prince George's County residents. 2) To offer free screenings 3) To navigate those patients with abnormal findings 4) To assist residents in the screening process, up to an including medical or surgical treatment 5) To provide high quality outreach using existing community organizations. 6) To ensure early detection of breast disease and early treatment.

Q99. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q100. Please describe the outcome(s) of the initiative.

. By the end of the project, we will create a community-based continuum that will increase utilization of breast screening by uninsured and underserved women. Objective 1: Establish staffing and infrastructure to support the community-based continuum of breast care. -Examine % of staff positions filled with no vacancies. -Confirm navigator program launched. -Staffing/Infrastructure includes: 100% filled. 1) Program Coordinator 2) Treatment Navigator (In-kind) 3) The navigator program has been designed and launched. Recent purchase of an integrated navigation system that requires minimal manual input. 4) Screening navigator hired (50% in-kind) Objective 2: By the end of the first project year, a breast care navigation network will be established with the community providers. -Personnel (Treatment navigator)in place -Evaluate staff every six months -Track referrals -Memorandum's Of Understandings have been established with community partners to offer free screening mammograms and follow-up exams through outreach and transportations efforts. Conduct Outreach with partners in Latino Community The Community Clinic, Casa of Maryland, Franklin Park Clinic and St. Bernardita Church and retail stores in the Latino community. 8) First Baptist Church of Glenarden – Shabbach! Ministries This partnership provides transportation two times per month to and from the partner centers in Langley Park.

Q101. Please describe how the outcome(s) of the initiative addresses community health needs.

High Breast Cancer incident with low results in Breast Cancer Screening. Program affirmed from CHNA process and reaffirmed through a 2015 Study of African American women in Prince George's County.

Q102. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$474,950 Grant received $371,000

Q103. (Optional) Supplemental information for this initiative.

Q104. Initiative 3

Q105. Name of initiative.

Incidence of Colorectal and Other Cancers

Q106. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q107. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases

- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [x] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q108. When did this initiative begin?

07/01/2016

Q109. Does this initiative have an anticipated end date?

- ○ The initiative will end on a specific end date. Please specify the date.
- ○ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ◉ The initiative will end when external grant money to support the initiative runs out. Please explain.

  The initiative will be re-evaluated and redesigned to meet the need at that time.
- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ○ Other. Please explain.

Q110. Enter the number of people in the population that this initiative targets.

100,000

Q111. Describe the characteristics of the target population.

The demographic and health data for Prince George's County shows that 89% of African Americans are insured as compared to only 47% of Latino residents. African Americans have much higher mortality rates for colorectal cancer than Caucasians in Prince George's County (22.8 % vs.13.4%). Similarly, while the incident rate is low for the Latino population, cancers are discovered at later stages. Nationally, colorectal cancer is the second highest cause of cancer deaths of Latino men and the third highest in women -- with a combined rate of 10.2 per 100,000.

Q112. How many people did this initiative reach during the fiscal year?

244

Q113. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [ ] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q114. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

  Prince George's County Health Department
  FQHCs: Mary's Center, La Clínica del Pueblo, Greater
  Baden Medical Services, Elaine Ellis Center for Health a
  myriad of local primary care practices

- ( ) No.

Q115. Please describe the primary objective of the initiative.

Provide colorectal cancer education, screening and navigation services for low-income, uninsured residents in Prince George's County. Goal: serve 175 (target) men and women; 230 (stretch) in FY18 Outcomes were evaluated by the number of men and women who received colonoscopy 1) Provide at least 25 digital exams and PSA screening to residents. 2) Provide follow-up services as needed for those with abnormal findings.

Q116. Please describe how the initiative is delivered.

Provide Colorectal Cancer Prevention, Education, Screening and Treatment (CPEST) to residents of Prince George's County

Q117. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q118. Please describe the outcome(s) of the initiative.

1) CPEST Program -Number of people colonoscopies performed 244 Number of people with cancer findings undergoing treatment 3 2) DCH reached about 15,000 people relative to cancer education and outreach through mailings, health events and lectures, and online communications.

Q119. Please describe how the outcome(s) of the initiative addresses community health needs.

The Incidence of colorectal and other cancers was identified through CHNA process. Partnering with the Health Department and others to provide screening for early intervention. The demographic and health data for Prince George's County shows that 89% of African Americans are insured as compared to only 47% of Latino residents. African Americans have much higher mortality rates for colorectal cancer than Caucasians in Prince George's County (22.8 % vs.13.4%). Similarly, while the incident rate is low for the Latino population, cancers are discovered at later stages. Nationally, colorectal cancer is the second highest cause of cancer deaths of Latino men and the third highest in women -- with a combined rate of 10.2 per 100,000. Despite the purported affluence of the area, African-American and Latino women in the County are two to four times more likely to be affected adversely by health disparities than white men and women. As per the Prince George's County Health Improvement Plan, DCH through its health and cancer early detection programs is working to reduce disparities and mortality rates.

Q120. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$475,516 grant=$321,544

Q121. (Optional) Supplemental information for this initiative.

Q122. (Optional) Additional information about initiatives.

Q123. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q124. Were all the needs identified in your CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q125. Please check all of the needs that were NOT addressed by your community benefit initiatives.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☑ HIV
☐ Access to Health Services: Regular PCP Visits	☑ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☑ Injury Prevention
☑ Adolescent Health	☑ Lesbian, Gay, Bisexual, and Transgender Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☑ Maternal and Infant Health
☐ Blood Disorders and Blood Safety	☑ Mental Health and Mental Disorders
☐ Cancer	☐ Nutrition and Weight Status
☐ Chronic Kidney Disease	☐ Older Adults
☑ Community Unity	☑ Oral Health
☐ Dementias, Including Alzheimer's Disease	☐ Physical Activity
☐ Diabetes	☐ Preparedness
☐ Disability and Health	☐ Respiratory Diseases
☐ Educational and Community-Based Programs	☑ Sexually Transmitted Diseases
☐ Emergency Preparedness	☐ Sleep Health
☐ Environmental Health	☐ Social Determinants of Health
☑ Family Planning	☐ Substance Abuse
☑ Food Safety	☐ Telehealth
☑ Genomics	☐ Tobacco Use
☐ Global Health	☑ Violence Prevention
☑ Health Communication and Health Information Technology	☑ Vision
☐ Health-Related Quality of Life and Well-Being	☐ Wound Care
☑ Hearing and Other Sensory or Communication Disorders	☐ Other. Please specify.

Q126. How do the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? The State Health Improvement Process (SHIP) seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The SHIP measures represent what it means for Maryland to be healthy. Website: http://ship.md.networkofcare.org/ph/index.aspx. To the extent applicable, please explain how the hospital's community benefit activities align with the goal in each selected measure.

Enter details in the text box next to any SHIP goals that apply.

Reduce infant mortality	
Reduce rate of sudden unexpected infant deaths (SUIDs)	
Reduce the teen birth rate (ages 15-19)	
Increase the % of pregnancies starting care in the 1st trimester	
Increase the proportion of children who receive blood lead screenings	
Increase the % of students entering kindergarten ready to learn	
Increase the %of students who graduate high school	
Increase the % of adults who are physically active	Providing education about proper weight and nutritoin through our Diabetes and Bariatric Programs
Increase the % of adults who are at a healthy weight	Providing education about proper weight and nutritoin through our Diabetes and Bariatric Programs
Reduce the % of children who are considered obese (high school only)	
Reduce the % of adults who are current smokers	Co-sponsoring a Stop Smoking education program for smokers
Reduce the % of youths using any kind of tobacco product (high school only)	
Reduce HIV infection rate (per 100,000 population)	
Reduce Chlamydia infection rate	
Increase life expectancy	Providing education and materials about healthy living at Health Fairs and screenings
Reduce child maltreatment (per 1,000 population)	
Reduce suicide rate (per 100,000)	
Reduce domestic violence (per 100,000)	
Reduce the % of young children with high blood lead levels	
Decrease fall-related mortality (per 100,000)	Rehabiliation Servicesprovides education to vulnerable populations at health fairs
Reduce pedestrian injuries on public roads (per 100,000 population)	
Increase the % of affordable housing options	

Increase the % of adolescents receiving an annual wellness checkup	
Increase the % of adults with a usual primary care provider	Recruiting and supporting new physician practices in our community
Increase the % of children receiving dental care	
Reduce % uninsured ED visits	Providing promotion and education about proper use of the ED and informaiton about local clinics
Reduce heart disease mortality (per 100,000)	Providing cholesterol, blood Pressure and carotid artery screenings to the community
Reduce cancer mortality (per 100,000)	The CPEST Program provides screeenings
Reduce diabetes-related emergency department visit rate (per 100,000)	The Diabetes on the Road program provides screening, treatment referal and education about diabetes
Reduce hypertension-related emergency department visit rate (per 100,000)	Provide blood pressure screenings to the community throught health fairs, Mobile Clinic
Reduce drug induced mortality (per 100,000)	
Reduce mental health-related emergency department visit rate (per 100,000)	
Reduce addictions-related emergency department visit rate (per 100,000)	
Reduce Alzheimer's disease and other dementias-related hospitalizations (per 100,000)	
Reduce dental-related emergency department visit rate (per 100,000)	
Increase the % of children with recommended vaccinations	
Increase the % vaccinated annually for seasonal influenza	
Reduce asthma-related emergency department visit rate (per 10,000)	Provide support through group meetings about controlling breathing related disorders

Q127. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q128. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [ ] Primary care
- [x] Mental health
- [x] Substance abuse/detoxification
- [ ] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [ ] Neurosurgery/neurology
- [x] General surgery
- [x] Orthopedic specialties
- [ ] Obstetrics
- [ ] Otolaryngology
- [x] Other. Please specify. vascular, thoracic,

Q129. 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.

Hospital-Based Physicians	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q130. (Optional) Is there any other information about physician gaps that you would like to provide?

Q131. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q132. Upload a copy of your hospital's financial assistance policy.

copy of FAP.pdf
1.9MB
application/pdf

Q133. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Financial brochure.pdf
1.8MB
application/pdf

Q134. What is your hospital's household income threshold for medically necessary free care? Please respond with ranges as a percentage of the federal poverty level (FPL).

at or below 200 % of the Federal Poverty Guidelines

Q135. What is your hospital's household income threshold for medically necessary reduced cost care? Please respond with ranges as a percentage of the FPL.

25% above 200% of the Federal Poverty Guidelines

Q136. What are your hospital's criteria for reduced cost medically necessary care for cases of financial hardship? Please respond with ranges as a percentage of the FPL and household income. For example, household income between 301-500% of the FPL and a medical debt incurred over a 12-month period that exceeds 25 percent of household income.

c. Medical Hardship is available for patients whose gross family income is between 200 and 500 percent of the Federal Poverty Guidelines, when hospital debt exceeds 25% of the family gross income for the family unit. and such eligibility will remain active during a 12 month period beginning on the date which the reduced cost medically necessary care was initiated. All immediate family members within the family household who have medical debts at Doctors Community Hospital & Physician Affiliates will be considered. However, debts for other providers or account balances for patient deductible, coinsurance or copayments will be excluded under the Medical Hardship Program.

Q137. Provide a brief description of how your hospital's FAP has changed since the ACA Expansion became effective on January 1, 2014.

There were no changes to the policy, the Maryland Health Exchange was added to our Patient Financial Information Brochure

Q138. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q139. (Optional) Please attach any files containing further information about your hospital's FAP.

Q140. You have reached the end of the questions, but you are not quite finished. When you click the button below, you will see a page with all of your answers together. You will see a link to download a pdf document of your answers, near the top of the page. You can download your answers to share with your leadership, board, or others as required by your internal processes. Your report will not be submitted to HSCRC until you have clicked the button at the bottom of the next page, the one with all your answers.

Location Data

Location: (38.967498779297, -76.855102539062)

Source: GeoIP Estimation

PART TWO: ATTACHMENTS

TO: Camille Bash, Vice President Finance

FROM: Stella Reed, Director Patient Financial Services

DATE: October 20, 2014

SUBJECT: HSCRC Annual Filing 2014

Attached, please find the following data:

PDF File	Letter dated May 30, 2014, stating Policies and Procedures have been reviewed by the Hospital Board of Directors.
PDF File	Credit and Collection Policy
PDF File	Financial Assistance Policy with Exhibits A- D
PDF File	Accounts Receivable Clearing House Agreement dated 7/13/2010
PDF File	Accounts Receivable Clearing House W-9 Form
PDF File	Accounts Receivable Outsourcing Agreement dated 1/31/2016
PDF File	Debt Collection Financial Assistance Report FYE 2014
PDF File	English and Spanish Brochure page for Financial Assistance

DOCTORS COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596
301-552-8118

DATE: May 30, 2014

TO: Camille Bash, Vice President, Finance
Stella Reed, Director, Patient Financial Services

FROM: Heidi Riedlbauer, Secretary, Board of Directors

SUBJECT: Policies and Procedures for Patient Financial Services

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This memorandum certifies that the Annual Collections Policy was reviewed and approved by the Hospital's Board of Directors at the May 29, 2014 Board of Directors Meeting.

Heidi L. Riedlbauer
Secretary, Board of Directors

Doctors Community Hospital
Hospital Policy

Subject: Credit and Collection Policy | Policy Number: 030

Date: October 1, 1995
Last Revised Date: November 2010 | Page 1 of 4

Philip B. Down, President
Approved by:

PURPOSE:
The purpose of this policy is to establish an organization that consolidates the financial management activities of the hospital so that controls meet accounting standards, ensures optimal cash flow, meets all compliance standards and minimizes bad debt. It is the goal of the hospital to enhance relations among the hospital, the patient, the physicians and the community by performing all activities in a professional, courteous and timely manner.

GENERAL POLICY: The Director of Patient Financial Services is responsible to ensure that subordinate staff seeks collection of hospital debt at the earliest possible opportunity, unless patients have applied for financial assistance. (See Financial Assistance Policy Number 050)

Patient's Request for Estimate of Charges:
The patient may make a request for an estimate of charges for all services excluding emergency services, to the Hospital's Business Office during normal working hours of Monday through Friday from 8:00 a.m. to 4:30 p.m. The hospital's business office will provide the patient an estimate of charges in writing by one of the following written methods, US mail, e-mail, or fax.

Insurance
Insurance benefits are verified and authorizations are sought at time of patient scheduling for elective procedures or within 24 hours of an unplanned admission. Hospital staff bill insurance accounts on an electronic billing system and perform billing follow-up of accounts. Insurance follow-up is consistently completed until the claim is paid or acknowledged by the insurance. Denied claims are analyzed to determine if appeal should be initiated. Claims are appealed when there is evidence that technical denials or medical necessity denials should be challenged.

Self-Pay Collection
Collection efforts are made during the registration process seeking payment for self-pay accounts and or co-payments. The hospital sends an initial summary bill to all patients, which lists major service categories. Attached to summary bills is a Patient Financial Services Brochure, which provides information on billing and how to apply for Patient Financial Assistance (See Financial Assistance Policy 050).

Self-pay and residual self-pay balances are outsourced to a contracted agent who sends statements and letters seeking collection of hospital debt. The billing agent is directed to seek full payment at the earliest possible date and can accept monthly payment arrangements until the account is paid in full. The

billing/collection agent's collection activity to include statements and letters has been reviewed and approved by the hospital's Director of Patient Financial Services.

Sale of Debts: Neither the hospital nor its billing/collection agent will sell patient debts to businesses for the purpose of hospital profit for patient debt collection.

Credit Bureau Reporting
Credit bureau reporting is done in the name of the hospital's collection agent who analyses the account to ensure the balance due is the patient's liability and not due from an insurance company. All accounts placed with the Credit Bureau are sent to the Director of Patient Financial Services of the Hospital prior to placement reporting to review the data and respond to the hospital's collection agent, with approval or denial to report. Accounts are not reported until collection efforts were made with the patient by sending letters or making collection calls through the call center process for debt collection, which normally takes 6 months from placement date. The collection agent does not report accounts to the credit bureau when legal placement is made in order to ensure that the same debt is not reported twice to the credit bureau.

When patient debts are paid in full, the hospital's collection agent will notify the credit bureau, within 60 days that the debt has been satisfied and paid.
If a patient was reported to a credit bureau and it is determined that the patient qualified under a presumptive mean-test or qualifies for financial assistance, the hospital would report the debt as closed.

Bad Debt
The hospital classifies accounts as bad debt beyond 120 days from discharge date regardless of patient/guarantor payment activity since collection action is completed through the hospital billing/collection agent. The billing/collector agent, based upon payment history of the patient, may not have classified the debt as a bad debt in their system at the same time as the hospital. However, classification of the debt as a bad debt will not occur until the contracted billing/collection agent has exhausted collection efforts and the account is older than 120 days from discharge date, There could be circumstances when the debt would be placed earlier if return mail has been received and skip tracing is not successful. (See Bad Debt policy number 090).

Court Action
When collection efforts are not successful or the patient fails to meet payment commitments, legal action may be filed with the court. Prior to court filing, accounts are reviewed by the hospital's Patient Services Team Leader who oversees credit and collection duties.

Judgments and Liens:
The hospital will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital will maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

Vacate Judgment
If it is determined that the patient qualifies for Financial Assistance for the period of time for the debt, the hospital will refund to the patient any payment amounts exceeding $25.00 within a 2 year period from the date of service was found to be eligible for Financial Assistance. (See Financial Assistance Policy 050). An exception will be if the patient did not cooperate in providing the data for the financial assistance application and in such cases the refund period will be limited to 30 days from the patient's request for Financial Assistance.

Interest
Neither the hospital nor its billing/collection agent charges pre-judgment interest to patients.

Patient Complaints:

All patient complaints received by hospital staff or the hospital's billing/collection agent are referred to the Director of Patient Financial Services. The Director of Patient Financial Services will refer any clinical complaints to the hospital's Risk Manager and place a bill hold on the account until resolution is determined. Other billing complaints are reviewed and response is sent to the patient as instructed by the Director of Patient Financial Services.

Discounts

Patients who pay the full amount at time of service are given a 2% discount, which is applied against total charges. The hospital does not provide any special discounts to payers, or contractual allowances outside the designated allowance as determined by the Health Services Cost Review Commission.

Doctors Community Hospital

Financial Assistance Policy

SUBJECT: Financial Assistance Policy **Policy Number 050**

Prepared by: Patient Financial Services **Date: May 5, 2003**

Revised: December 17, 2007
January 2008, May 2009,
Oct 2009, Feb 2010,
April 2010, May 2010, Aug 2010,
Nov 2010, June 2013, Mar 2014

Philip B. Down, President
Page 1 of 3

Approved by

PURPOSE

To provide general information and guidelines to identify indigent persons who have no means of paying for medical services or treatments.

POLICY

General Statement:

The Patient Financial Services Department of the hospital is responsible for determining the eligibility for Financial Assistance patients. Referral for Financial Assistance is made by Registration, Billing, and Financial Counseling Staff within the department or by other departments such as, Nursing, Quality Assurance, Social Services, Physician Offices or the patient or a patient's family member with legal authority to act on behalf of the patient. Referral for Financial Assistance is also made by Medicaid Advocates and Collection Agents. The hospital will consider all medical debts for services provided within the hospital excluding purely cosmetic services.

1. Patient Education

Doctors Community Hospital recognizes its charitable mission to provide reasonable care to those patients who cannot afford Healthcare and has provided the following methods to communicate the Financial Assistance Program.

a. **Published notices of available Financial Assistance are printed in local newspapers annually,**
b. **Signs are posted at emergency registration, outpatient registration and the hospital's business office in patient waiting areas,**

c. Financial policy brochures written in English and Spanish, specifying who to call for Financial Assistance, medical assistance and billing questions, is available in patient lobby waiting areas of the hospital,
d. Financial policy brochures are provided to every inpatient at time of admission. The information is a hand-out as part of the Hospital's admission package,
e. Financial policy is provided to every patient with their initial summary bill,
f. Financial policy is provided to every patient upon patient request by the business office,
g. An overview of Financial Assistance is provided to all hospital employees as part of the annual employee orientation in order to provide direction or assistance to patients.

2. Eligibility Criteria

Patients will be considered for Financial Assistance regardless of race, sex, national origin or creed. To qualify for Financial Assistance, the following areas of eligibility must apply:

a. Free Care will be given to patients whose gross income is at or below 200 percent of the Federal Poverty Guidelines when considering number of family members in the household.

b. Reduced Cost Program is available with a 25% balance bill reduction when the family unit income is between 200 to 300 percent of the Federal Poverty Guidelines. Reduced cost program includes patient liability after third party payment such as deductible, coinsurance and co-payment amounts.

c. Medical Hardship is available for patients whose gross family income is between 200 and 500 percent of the Federal Poverty Guidelines, when hospital debt exceeds 25% of the family gross income for the family unit. and such eligibility will remain active during a 12 month period beginning on the date which the reduced cost medically necessary care was initiated. All immediate family members within the family household who have medical debts at Doctors Community Hospital will be considered. However, debts for other providers or account balances for patient deductible, coinsurance or co-payments will be excluded under the Medical Hardship Program.

3. Other Eligibility Consideration:

a. Self-pay patients enrolled in certain means-tested programs will qualify as presumptive Financial Assistance eligibility for free care by submitting proof of enrollment in a social service program within 30 days of request for free care. If the patient fails to summit the means-tested documentation within 30 days, upon patient request an additional 30 days will be granted for documentation. Programs that should be considered for presumptive assistance are as follows:

   i. Household with children in the free or reduced lunch program,
   ii. Supplemental Nutritional Assistance Program (SNAP),
   iii. Low income household energy assistance program,
   iv. Primary Adult Care Program,
   v. Women's, Infants and Children program (WIC),

b. In addition to programs listed in means-test for presumptive charity, the hospital will consider all accounts as free care without patient application or further proof when such patients' insurance eligibility through the hospital eligibility verification system indicate that the patient qualifies for a program such as pharmacy only or physician only coverage. Other state programs not mentioned where the patient is eligibility for assistance programs where there is no medical insurance coverage will also be considered.

c. Patients who qualify against credit bureau Propensity to Pay scoring when considering income estimates, household size and up to 200 % of federal poverty levels will have patient liability written off in full to presumptive charity.

d. The hospital may apply discretion and approve patients beyond the 12 month medical bill period when the patient's health status is severe or other financial circumstances prevent payment from the patient.

4. Ineligible Patients

The following is a list of situations where patients will not qualify for Financial Assistance.

a. Patients who have health insurance and services are payable by other third-party insurance,
b. Patients who refuse to complete the hospital's Financial Screening Application, when presumptive free care is not warranted,
c. A non U S citizen who traveled to the US primarily for the purpose of receiving medical services at no cost,
d. Patients whose credit bureau report validates the patient's application was false or misleading,
e. Patients who fail to provide supporting information to validate information contained on the Financial Assistance Application,
f. Patients whose monetary assets exceed $10,000 excluding up to $150,000 in a primary residence and retirement benefits where the IRS has granted preferential treatment.

5. Application Requests

Self pay patients, who do not meet the presumption means-test, are requested to complete an application when they apply for Financial Assistance. A Financial Screening Application (see Exhibit A) is given to the patient when one of the following situations occurs:

a. Patient requests Financial Assistance,
b. Patients or family member expresses inability to pay for medical debts,
c. Other hospital departments staff request Financial Assistance for the patient,
d. Medicaid Advocates or Collection Agents request Financial Assistance Application.

6. Application Process

Applicants are requested to complete the Financial Screening form and a cover letter listing documents to support program eligibility will be attached (see Exhibit B). Listed below is the required information, which must be received and verified prior to consideration for Financial Assistance, when presumptive meant test programs do not apply

a. All gross income for all family members of the household unit,
b. Other income such as, Alimony, Child support and stipends,
c. Assets as listed in Section Item 4, "Ineligible Patients" under section F of this document,
d. Monthly expenses for immediate family members of the household,
e. List of outstanding debtors,
f. List of medical debts owed or paid for the past 12 months for services at Doctors Community Hospital.

7. Approval Process

Excluding presumption programs, prior to approving patient applications, information is reviewed and additional verification of eligibility may be made by obtaining a credit bureau application. The patient generally is notified by letter, (see Exhibit C) unless the patient calls the office or makes a visit to the business office to determine eligibility. Patients are advised of the amount of eligibility and if there is any patient liability and who to call to make payment arrangements. Approval for write-off for Financial Services is made by the Director of Patient Financial Services with additional approval of the Vice President of Finance for account balances greater than $5,000.

8. Denial Process

Upon final review of the application and patient income and expense documents, patient's who do not qualify for the program are notified by letter indicating the reason for denial and how to request reconsideration if the patient disagrees with the hospital decision (see Exhibit D).

Exhibit A (1)

DOCTORS COMMUNITY HOSPITAL
"Slow for caring."

DOCTOR'S COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3596

Financial Screening Form

Please Print Legibly

Patient Name _____ SS # ___-___-___

Patient Address _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

Spouse Name *(if applicable)* _____ SS # ___-___-___

Spouse Address *(if different from Patient)* _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

Child's Name _____ Birth Date ___/___/___

RESPONSIBLE PARTY INFORMATION *(Do NOT Complete if Patient is Responsible Party)*

Responsible Party Name _____ SS # ___-___-___

Address _____

City _____ State _____ Zip Code _____

Birth Date ___/___/___ Home Phone No. ( ) ___-___ Work Phone No. ( ) ___-___

EMPLOYMENT INFORMATION

Place of Employment _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. ( ) ___-___ Extension _____ Supervisor Name _____

INSURANCE INFORMATION

Do you have health insurance? ..... ☐ Yes ☐ No

If YES, Name of Company _____ Policy # _____

Have you ever applied to a State Medical Assistance Program? ..... ☐ Yes ☐ No

If YES, Name of State _____ Birth Date ___/___/___

Do you receive assistance from the state? ..... ☐ Yes ☐ No

Exhibit A (2)

Please provide proof of income and expenses with this application:

Such as: Last 2 pay stubs, W-2 Forms, Bank Statements, Utility Bills, Mortgage Statements

MONTHLY INCOME

	GROSS	NET
Patient Salary		
Spouse / Other		
Soc. Sec. Income		
Disab. Income		
Pension Income		
Interest Income		
Unemployment		
TOTAL		

OTHER MONEY RECEIVED

Alimony		
Child Support		
Other		
TOTAL		

OTHER ASSETS

Name of Bank (Checking) _____

Account # _____

Name of Bank (Savings) _____

Account # _____

Name of Bank (Checking) _____

Account # _____

Name of Credit Union _____

Account # _____

Other Bank Account(s) _____

_____

Do you own stocks? ..... ☐ Yes ☐ No

Do you own bonds? ..... ☐ Yes ☐ No

Do you own property? ..... ☐ Yes ☐ No

I have answered the questions in this application correctly to the best of my recollection and based on my records. I understand that the Account Review Committee of Doctors Community Hospital may request additional information from credit reporting agencies, employers and other third parties.

Applicant Signature _____

Date of Application _____

MONTHLY EXPENSES

Rent / Mortgage _____

To Whom Paid _____

Telephone No. ( ) ____ - _____ Ext. _____

Auto Payment _____

Year _____ Make _____ Model _____

Financed By _____

Phone No. ( ) ____ - _____ Ext. _____

Electricity _____

Gas Utility _____

Telephone _____

Alimony _____

Child Support _____

Credit Cards *(See Below)* _____

Medical / Dental *(See Below)* _____

TOTAL _____

DOCUMENT CREDIT CARDS & MEDICAL / DENTAL

List Credit Cards

Account # _____

Account # _____

Account # _____

List Medical / Dental

_____ _____

_____ _____

_____ _____

Other Expenses

_____

_____

_____

_____

_____

_____

_____

_____

Exhibit B

Dear Patient:

It is believed that you may qualify for the hospital's Financial Assistance Program. Hospital Financial Assistance is only considered when there are no other financial assistance programs, which pay medical debts or insurance coverage.

Financial Assistance help is limited to medical expenses for services at Doctors Community Hospital. The program does not cover services elsewhere or physician bills. If you qualify for the program, all or part of your medical expenses may be considered.

If you quality for one of the following programs, please complete the attached application form and only provide with your application proof of eligibility in any one of the social service programs such as;

Children with reduced or free lunch program,
Supplemental Nutritional Assistance Program (SNAP),
Low-income household energy assistance program,
Primary Adult Care Program (PAC),
Women, Infants and Children (WIC).

If you do not qualify for one of the social service programs as listed above, you must complete the attached application screening form and provide with your application sufficient documents to prove your total income and expenses. In addition, the hospital may perform a credit check at the hospital's expense, validating your eligibility for the program. Documents required to be considered for Financial Assistance are as follows:

Wage statements for all household members such as pay stubs,
Other income such as, alimony, child support and stipends,
Your W-2 forms for current and prior year,
Bank statements, which show income and expenses,
Statement of any other income received in your household,
Copies of monthly statements and expenses paid to creditors,
List of outstanding medical expenses, owed or paid to Doctors Community Hospital for the past 12 months.

Please provide documents supporting assets excluding retirement programs where benefits are listed as exclusions under the IRS.

If you are unemployed and receive help or other support for daily living, you may provide a letter from another source indicating what kind of help you are receiving such as free room and board, utilities payments etc.

Failure to provide information to support your need for Financial Assistance may disqualify your eligibility. Please send all information within 30 days of this letter to:

Leslie Meade, Lead Patient Accounts Coordinator
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706-3596
(301) 552-8186

MNEMONIC: CHARITY1 ACTIVE: Y NAME: FINANCIAL APPLICATION APPROVED
PAGE SIZE: 66 LINE LENGTH: 75 LEFT MARGIN: 20
AUTO SPOOL: AUTO SORT:

Exhibit C

DOCTORS COMMUNITY HOSPITAL
8118 GOODLUCK ROAD
LANHAM, MARYLAND 20706

[DATE]

[GUARANTOR NAME]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY,STATE ZIP]

RE: [ACCOUNT #]
[PATIENT NAME]

Dear [GUARANTOR NAME]:

Your application has been approved for financial assistance for the following account(s):

ACCOUNT #	AMOUNT APPROVED	REMAINING BALANCE PAYABLE BY PATIENT

If there is a remaining balance on your account(s), please call the hospital's Business Office at 301-552-8092 to establish a payment plan.

Yours truly,

Leslie Meade
Collections Team Leader

Exhibit D

Dear Patient:

We regret to inform you that your application for financial assistance has been denied for the following reason (s).

_____ Your application was missing sufficient documentation to prove income and expenses,

_____ Your income exceeds eligibility criteria under the Federal Poverty Guidelines. Please contact our office at (301) 552-8092 to establish a payment plan,

_____ There is a conflict in the Credit Report and data reported with your application,

_____ Our records indicate that you have third-party insurance or you may qualify for a state program for Medical Assistance.

_____ Other reason (s) _____

_____

_____

_____

If you disagree with this decision, please provide missing information or contact me to provide reasons why your debts should be reconsidered for Financial Assistance by calling (301) 552-8186 within the next fifteen day (15) from the date of this letter to reopen your case.

Thank you,

Leslie Meade, Team Leader
Patient Accounts Coordinator

ARCH
ACCOUNTS RECEIVABLE CLEARING HOUSE

ADDENDUM TO MANAGEMENT SERVICES AGREEMENT

July 13, 2010

Ms. Stella Reed
Director, Patient Financial Services
Doctors Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706

Dear Stella,

This shall serve as an Addendum to the Accounts Receivable Outsourcing Agreement dated January 31, 2006, by and between Doctors Community Hospital (DCH) and Accounts Clearing House, LLC (ACH).

- All Early-Out Services will be proved by Accounts Receivable Clearing House, LLC and all bad debt collections services will be under the auspices of Accounts Clearing House, LLC.

All other terms and conditions as set forth in the Accounts Receivable Outsourcing Agreement shall remain in force and are not affected by this Addendum.

If you are in agreement with these changes and clarifications, please sign where indicated below.

Doctors Community Hospital

By: Stella Reed
Stella Reed
Director, Patient Financial Services

Date: 7-14-2010

Accounts Clearing House, LLC/Accounts

By: RWatkins
Ronald Watkins
President

Date: 7-13-10

DOCTORS COMMUNITY HOSPITAL BUSINESS ASSOCIATES AGREEMENT

Specific definitions:

a. Business Associate. "Business Associate" shall mean Accounts Recievable Clearing House, LLC.
b. Covered Entity. "Covered Entity" shall mean Doctors Community Hospital.
c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.
g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.
b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. [This provision may be included if it is appropriate for the Covered Entity to pass on its duty to mitigate damages to a Business Associate.]
d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, and in the time (in less than 45 days after receiving written request) and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. [Not necessary if business associate does not have protected health information in a designated record set.]

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner [Insert negotiated terms]. [Not necessary if business associate does not have protected health information in a designated record set.]

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available [to the Covered Entity, or] to the Secretary, in a time and manner [Insert negotiated terms] or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner [Insert negotiated terms], information collected in accordance with Section [Insert Section Number in Contract Where Provision (i) Appears] of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

k. The Covered Entity and Business Associate agree to negotiate to amend the Agreement as necessary to comply with any amendment to any provision of HIPAA or its implementing regulations set forth at 45 C.F.R. parts 160 and 164, including but not limited to, the Privacy Regulation, which materially alters either Party or both Parties' obligations under the Agreement. Both Parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to the Agreement to give effect to such revised obligations. If the Parties are unable to agree to mutually acceptable amendment(s) within 30 days of the relevant change in law or regulations, either Party may terminate the Agreement consistent with its terms.

l. In the event that any provision of this Agreement violates any applicable statute, ordinance or rule of law in any jurisdiction that governs this Agreement, such provision shall be ineffective to the extent of such violation without invalidating any other provision of this Agreement.

m. Business Associate agrees to indemnify, defend and hold harmless the Covered Entity, its directors, officers, agents, shareholders, and employees against all claims, demands, or causes of action that may arise from Business Associate's employees, agents, or independent contractors improper disclosure of the protected health information and from any intentional or negligent acts or omissions.

n. The Agreement shall be governed by the laws of the State of Maryland and shall be construed in accordance therewith.

Permitted Uses and Disclosures by Business Associate

a. Specify purposes:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity: Purposes: CAP SURVEY

Specific Use and Disclosure Provisions [only necessary if parties wish to allow Business Associate to engage in such activities]

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions [provisions dependent on business arrangement]

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. [Include an exception if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate].

Term and Termination

a. Term. The Term of this Agreement shall be effective as of November 13, 2008, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section. [Term may differ.]
b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement.
    2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy (in a manner that protects the confidentiality and privacy of the material) all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
c. Survival. The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Steven R Reed 7-14-2010 7-13-10

Hospital Representative Date Business Associate Date

BUSNASSOC3/05/03

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2

Name (as shown on your income tax return)
ACCOUNTS RECEIVABLE CLEARING HOUSE, LLC

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☑ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
PO BOX 2373

Requester's name and address (optional)

City, state, and ZIP code
GLEN BURNIE, MD 21060-2373

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number
26 2238344

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | Signature of U.S. person ▶ [signature] | Date ▶ 7-13-10

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

ACCOUNTS RECEIVABLE OUTSOURCING AGREEMENT

THIS AGREEMENT is made by and between Doctor's Community Hospital, with its principal offices at 8118 Good Luck Road, Lanham, Maryland 20706 ("Client") and Accounts Clearing House, LLC, a Maryland corporation with its principle offices at 300 Hospital Drive, Suite 30, Glen Burnie, Maryland, 21061 (ACH) as of the date of execution by a duly authorized representative of ACH. The effective date of this Agreement shall be _____.

In consideration of the mutual promises, covenants and agreements contained in this Agreement, the parties agree as follows:

1. SERVICES.

1.1 Accounts Receivable Outsourcing. ACH will seek to obtain reimbursement for Client's charges for *"Accounts"* (see Exhibit 1) placed with ACH through the follow-up, rebilling and collection activities relating to such Accounts (the "Accounts Receivable Outsourcing"). All activities undertaken on behalf of Client shall be done in the name of the Client. During the term of this Agreement, ACH will be the sole provider of Accounts Receivable Outsourcing services to the Client for the *Accounts*. As part of ACH's Accounts Receivable Outsourcing Services, ACH will:

(a) provide follow-up, tracking, re-billing and collection efforts and related activities for the *Accounts*;
(b) staff and manage an off-site receivables management center to handle the re-billing, follow-up, tracking and collection activities for the *Accounts* to include providing an off-site manager for the supervision of the management of the *Accounts* and other personnel as deemed necessary by ACH to perform the Accounts Receivable Outsourcing Services required by this Agreement;
(c) if necessary, provide on-site staff support at no additional cost to Client;
(d) prepare and send to Client, ACH's standard monthly management reports;
(e) develop work flows and follow-up letters for collection of the *Accounts*, with said work flows and letters to be mutually agreed upon as to process, content and format;
(f) direct all payments on the *Accounts* to Client. Any payments received by ACH will be logged and forwarded to Client within two (2) business days;
(g) establish a mutually agreed upon procedure for handling unpaid *Accounts* and for the request, use, maintenance and return of Client's patient files. ACH will prepare monthly and send to Client a hard copy of all returned *Accounts*.

All *Accounts* placed with ACH must be placed for a minimum of 120 days. ACH reserves the right to establish and amend its follow-up and collection efforts and activities as ACH, in its opinion, subject to Client approval, deems to be appropriate for the management of the *Accounts*. All follow-up and collection efforts and activities shall be in accordance with patient relation's policies and procedures consistent with those employed by Client. ACH and Client will establish a mutually agreed upon procedure for handling unreimbursed Accounts and for the request, use, maintenance, and return of Client's patient files.

1.2 Third-Party Agreements. Client acknowledges that in order for ACH to perform the Accounts Receivable Outsourcing Services, ACH will be required to enter into agreements with third-party payers and fiscal intermediaries regarding the provision of electronic claims submission, eligibility verification, claims statusing and other similar services (the "Third-Party Agreements"). Client agrees to indemnify and hold ACH harmless from and against any and all claims, actions, suits, proceedings, costs, expenses, damages, and liabilities incurred by ACH, including court costs and attorney's fees, related to any claim by any other party to a Third-Party Agreement, arising out of or relating to Client's provision of inaccurate or incomplete information to ACH or Client's negligence or willful misconduct.

2. CLIENT RESPONSIBLITIES AND OBLIGATIONS.

2.1 General. Client will cooperate and cause its employees to cooperate with ACH in every reasonable respect as mutually agreed by Client and ACH to allow ACH to perform its duties under the Agreement.

2.2 Provision of Account Information. Client will furnish ACH with all appropriate information necessary to enable ACH to perform the Accounts Receivable Outsourcing Services under this Agreement. As part of said responsibility Client will provide ACH:

(a) All patient and billing information mutually deemed appropriate and necessary by ACH and Client regarding the *Accounts*;

(b) Access to requested patient files, UB92 and /or HCFA 1500 forms, face sheets, itemized bills and other relevant *Account* documentation; and

(c) Cash receipt and application information.

Client is responsible for providing the information identified above relating to the accounts to ACH in the required format as agreed upon by Client and ACH. ACH will have no responsibility for the accuracy of the information received or problems arising out of erroneous or incomplete information received from Client. Further Client warrants that all *Accounts* are valid and legally recoverable debts.

2.3 Installation of Telephone Lines. At ACH' request and cost, Client will make available within 10 days following the Effective Date, a private dedicated "voice grade" telephone line to be used for the transmission of Account information to ACH. In the event that this Agreement is terminated within twelve (12) months from its inception, all installation and monthly charges for this telephone line shall be the sole responsibility of Client.

2.4 Special Instructions. Client will notify ACH in advance of any special instructions to be used by ACH in providing Accounts Receivable Outsourcing Services (such as listing of specific patients who are to be excluded from follow-up and collection activities due to their "VIP" status or for any other reasons).

3. FEES

3.1 Monthly Fee. The fees payable to ACH for providing Accounts Receivable Outsourcing Services to Client will be based on terms as specified in Exhibit I.

3.2 Payment Terms. Client will pay to ACH, within forty-five (45) days from the date an invoice is delivered to Client, all payments due under this Agreement. Any amount payable under this Agreement and not paid within forty-five (45) days will be delinquent and shall bear interest at the lesser of one and one-half percent (1 ½%) per month or the maximum monthly rate allowed by the applicable state.

3.3 Fee Change. ACH shall have the right to adjust the monthly fee in the event that Client fails to disclose to ACH at or prior to this Agreement is executed, accurate and complete information relating to Client's accounts receivable profile, which information, if disclosed, would have led ACH to propose a higher or lower Monthly Fee. In the event that ACH increases or decreases the Monthly Fee, ACH will provide Client with ninety- (90) day's prior written notice of this change. If any proposed fee increase is unacceptable to Client, Client may terminate this Agreement upon ninety (90) day's prior written notice to ACH.

3.4 Statement. ACH each month will render to Client a written statement setting forth all payments on the *Accounts* made to ACH directly and all deductions.

3.5 Taxes. All taxes and other levies in the nature of sales, use or excise taxes as they apply to the State of Maryland resulting from the services provided to the Client by ACH hereunder shall be the responsibility of the Client and shall be paid by the Client directly.

4. INITIAL TERM, RENEWALS AND TERMINATION.

The initial term of this Agreement will be two (2) years commencing as of the executed date of the Agreement. This Agreement shall be self-renewing for additional one (1) year terms unless wither party delivers to the other, written notice of termination at least thirty (30) days prior to the expiration of the then current term. This Agreement may be terminated by either party, for any reason, upon thirty (30) days prior written notice to the other without penalty from the date of inception of signed Agreement unless otherwise specified in the Agreement. Upon any termination of this Agreement, (a) ACH will continue its efforts with respect to the Accounts assigned prior to and existing as of the date of termination for a period of ninety (90) days; (b) ACH will continue its efforts with respect to all *Accounts* where payment arrangements are being met according to agreed upon terms, until conclusion of the payment arrangements; and (c) Client will pay ACH the Monthly Fee with respect to the collections referenced in (a) and (b) above regardless of when collections are received and whether received by Client or ACH.

5. CONFIDENTIALITY

5.1 Confidentiality of ACH Information. Client acknowledges that the System employed by ACH in providing Accounts Receivable Outsourcing Services is confidential and the sole property of ACH. Client agrees not to disclose to any persons or entities other than ACH, any information it receives concerning ACH business practices or other secrets deemed to be confidential by ACH.

5.2 Confidentiality of Client Information. ACH agrees not to disclose to any persons or entities not affiliated with ACH, any information about Client or any of Client's patients received by ACH in the course of providing the Accounts Receivable Outsourcing Services except as required to provide the Accounts Receivable Outsourcing Services or as otherwise legally required. Notwithstanding the preceding sentence, Client agrees that ACH may use Client information for statistical compilation purposes so long as Client and patient identifying information is kept confidential in accordance with applicable laws, rules and regulations.(See Exhibit II)

5.3 Confidentiality of Contract Terms. Without ACH' prior written consent, Client will not in any manner or form, disclose, provide or otherwise make available to any third parties, in whole or in part, this Agreement or any terms hereof.

6. DISCLAIMER OF WARRANTIES

Client acknowledges that ACH has the incentive to perform Accounts Receivable Outsourcing Services in a timely and efficient manner. Client acknowledges however, that the timing and amounts of collections generated through the Live Treat Services are subject to numerous variables beyond ACH' control. **THEREFORE, EXCEPT FOR THE EXPRESS REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS AGREEMENT, ACH DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES, EXPRESS, IMPLIED, OR STAUTORY, PERTAINING TO THE PERFORMANCE OF THE ACCOUNTS RECEIVABLE OUTSOURCING SERVICES HEREUNDER.**

7. LIMITATION OF LIABILITY

In no event will ACH be liable for lost profits or be responsible for the uncollectibility of any *Account*.

8. INDEMNIFICATION

Each party agrees to indemnify, defend and hold harmless the other party, their directors, officers, employees and agents from and against any claim, liability, loss or expense (including without limitation attorney's fees) arising directly or indirectly out of an act by a party or its directors, officers, employees or agents in connection with either party's duties or performance under this Agreement.

9. NON-INDUCEMENT

During the term of this Agreement and for a period of one (1) year thereafter, neither ACH nor Client will, without the prior written consent of the other, either directly or indirectly, on its own behalf or in the service of others, solicit, divert, or hire away, or attempt to solicit, divert, or hire away, any person employed by the other, whether or not such employee is a full-time, part-time, or temporary employee and whether or not such employee is pursuant to a written agreement, is for a determined period, or is at-will without the prior written consent of the parties.

10. ACCESS TO BOOKS, DOCUMENTS, AND RECORDS

The provisions of this Section 9 are included in this Agreement because of possible application to Section 1861(v)(1)(I) of the Social Security Act. If such section is not applicable to this Agreement, whether now or in the future, then this Section 9 will be deemed not part of this Agreement and will, or will thereafter, be considered null and void. If such provision is applicable to this Agreement, ACH agrees with the Client that until the expiration of four (4) years after furnishing the Accounts Receivable Outsourcing Services under this Agreement, ACH will make available to the Secretary of the United States Department of Health and Human Services (the "Secretary"), and the United States Comptroller General, and their duly authorized representatives, this contract and all books, documents and records necessary to certify the nature and extent of the costs of these services. If ACH carries out the duties of this Agreement through a subcontract worth $10,000 or more over a 12 month period with a related organization, the subcontract will also contain and access clause to permit access by the Secretary, the United States Comptroller General and their representatives to the related organization's books and records.

11. MISCELLANEOUS

11.1 Entire Agreement. This Agreement and the Exhibits referenced herein describe the entire agreement between the parties and will be binding upon and inure to the benefit of their successors and permitted assigns only with the express written consent of Client. This Agreement supercedes all prior written and oral agreements and understandings between ACH and Client pertaining to Accounts Receivable Outsourcing Services and can only be changed in writing executed by the parties against whom such change is sought to be enforced.

11.2 Notices. Any notice to be given under this Agreement will be in writing and will be effective on date of receipt if sent or delivered to:

If to ACH:	If to Client:
Boyce Reitterer President Accounts Clearing House, LLC 300 Hospital Drive, Suite 30 Glen Burnie, Maryland 21061	Dennis Scanlon Vice President, Finance Doctor's Community Hospital 8118 Good Luck Road Lanham, Maryland 20706

or in either case to such other address or individual as the party to be notified, by proper notice hereunder have directed.

11.3 Severability. If any provision of this Agreement, or portion thereof, is declared invalid, the remaining provisions will remain in full force and effect.

11.4 Assignment. This Agreement is binding upon and inures to the benefit of and is enforceable by ACH, Client and their respective legal representatives, permitted assigns and successors of interest. This Agreement will not be assigned or transferred, in whole or in part, by Client and may only be assigned by ACH with the express written consent of Client.

11.5 Governing Law. This Agreement is made and entered into and will be construed and interpreted in accordance with the laws of the State of Maryland.

11.6 Authority to Sign. ACH and Client acknowledge that they are duly authorized by appropriate corporate action to enter into this Agreement and that the Agreement is being signed by duly authorized agents authorized to act for their respective parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date executed by the duly authorized representative of ACH.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By:	By:
Title: Vice President, Finance	Title: President
Date: 1/31/06	Date: 1/31/06

EXHIBIT I

ACCOUNTS:

Phase I Accounts-

Those pr tient accounts and balances that are identified by financial class as Self Pay, Commercial, HMO, MCO, Worker's Compensation or any other Insurance accounts identified by Client.

Client represents that monthly Self Pay accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days	3,700	$1,100,000	N/A
31-60 days			
61-90 days			
91-120 days			
121-150 days			
151-180 days			
181 + days			

Client represents that monthly Commercial accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days			
31-60 days			
61-90 days			
91-120 days	300	$250,000	N/A
121-150 days			
151-180 days			
181 + days			

Client represents that monthly Secondary accounts are profiled as of 12/15/05 as follows:

Aging:	# of Accounts	Gross Assignments	Contractuals/Writeoff %
0-30 days			
31-60 days	TBD	TBD	
61-90 days			
91-120 days			
121-150 days			
151-180 days			
181 + days			

The above-referenced amounts are an estimate and represent an accumulated backlog of insurance accounts. Client may, at its discretion make additional placements at time intervals to be determined.

FEE SCHEDULE:

Self Pay Accounts. Client agrees to assign to ACH, for a minimum of at least the first six months from the effective date of the Agreement, 100 % of all Self Pay Accounts. Client agrees to pay ACH a monthly fee of nine and one-quarter percent (9.25%) of all monies collected from the accounts identified as Self Pay. After the first six months, should Client only assign to ACH fifty-percent of the Self Pay Accounts, the fee shall the be nine and one-half (9.5 %) of all monies collected from the accounts identified as Self Pay. It is further agreed that the determination for changing the assignment percentage from 100% to 50% shall be predicated on a mutually agreed upon performance baseline as agreed upon by Client and ACH. Any payments received within five calendar days from the date of placement shall not be subject to any fee.

Commercial Accounts. Client agrees to pay ACH a monthly fee of six percent (6%) of all monies collected from the accounts identified as Commercial Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

Secondary Accounts. Client agrees to pay ACH a monthly fee of five percent (5%) of all monies collected from the accounts identified as Secondary Accounts. Any payments received within seven calendar days from the date of placement shall not be subject to any fee.

ADDITIONAL SERVICES

ACH will provide for the licensed use of the AegisEDI remit management and follow-up systems (ARIS) as described in attached AegisEDI Subscription Agreement.

Upon termination client shall reserve the right to continue use of ARIS. Fees for use will be the same as described in attached AegisEDI Subscription Agreement.

Should client decide to enforce the fifty percent assignment protocol on Self Pay Accounts as described in the Fee Schedule referenced above, ACH agrees to allow Client to retain the ARIS system at no charge. The only event that shall occur that will allow AegisEDI to implement the Fee Schedule in the Aegis EDI Subscription Agreement will be the termination of the Accounts Receivable Outsourcing Agreement or an assignment level on Self Pay Accounts lower than fifty percent of the total Self Pay Accounts.

ACH agrees to assume the ARIS Setup Costs as described in Exhibit A of the AegisEDI Subscription Agreement.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By:	By:
Title: VP Finance	Title: President
Date: 1/3/06	Date: 1/31/06

EXHIBIT H

INDEPENDENT CERTIFICATION AND AGREEMENT OF COMPLIANCE

I hereby certify that I am a duly authorized officer of the independent contractor named below ("Contractor). On behalf of Contractor and its officers, directors, employees, and agents, I certify that I have received and read the "Compliance Program Policy Manual" dated _____ of *Doctor's Community Hospital* and fully understand the requirements set forth in that document. I certify that Contractor shall act in full accordance with all rules and policies of *Doctor's Community Hospital*. These rules and policies include *Doctor's Community Hospital's* commitment to comply with all applicable federal and state laws, and *Doctor's Community Hospital's* commitment to conduct its business in compliance with the highest ethical standards.

To this end, Contractor expressly agrees that the *Doctor's Community Hospital* "Compliance Program Policy Manual" shall be incorporated within and made a part of the Contractor's Agreement with *Doctor's Community Hospital* and shall survive termination of this Agreement for any reason. Any failure of Contractor to comply with the rules and policies set forth in *Doctor's Community Hospital* "Compliance Program Policy Manual" or to report violations of these rules and policies may result in immediate termination by *Doctor's Community Hospital* of its Agreement with Contractor.

CLIENT: DOCTOR'S COMMUNITY HOSPITAL	ACCOUNTS CLEARING HOUSE, LLC
By: _____	By: _____
Title: VP Finance	Title: President
Date: 1/31/06	Date: 1/31/06

Debt Collection/financial Assistance Report

FYE 2014

Hospital Name: Doctors Commuity Hospital

Hospital Numb: 210051

1. Collection Agency Name

a. Accounts Receivable Clearing House
b.
c.
d.
e.
f.
g.
h.

2. Number of liens

i. 0

3. Number of extended payment plans

j. 1,823

FINANCIAL ASSISTANCE

4. Number of applications for financial assistanc received

k. 231

5. Number of applications for financial assistance approved

218

Note: represents number of applications not number of accounts

attach: DCH Policies and Procedures for assigning a debt to a collection agent for collection and for compensating such a collection agent for services rendered. (PDF format)

HSCRC

General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
Seabrook, MD 20706
301-552-8093

While you are still at the hospital, you may pose your questions to the following:

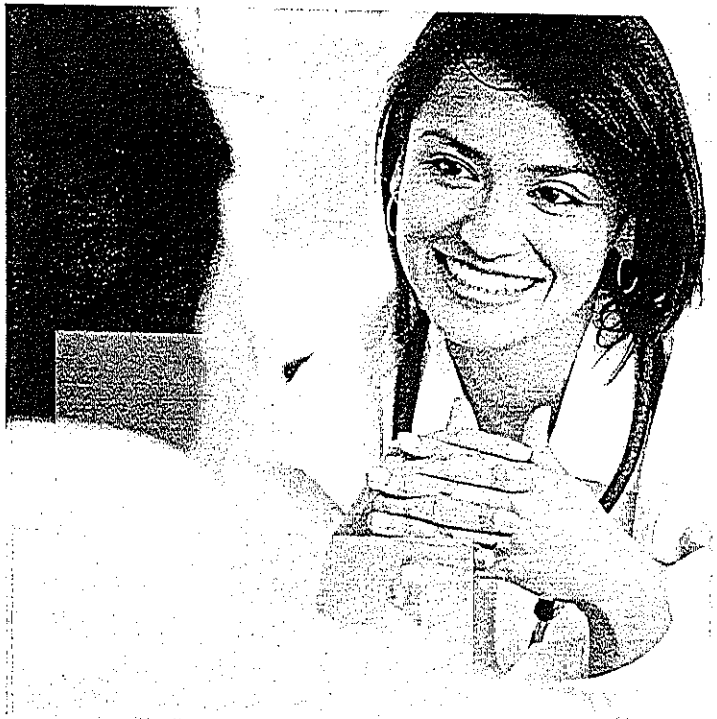
- **Outpatient Registration Department**
  Main Hospital, 2nd Floor
  Monday to Friday, 8:00 a.m. to 4:30 p.m.
- **Emergency Department Registration Office**
  Main Hospital, 1st Floor
  24 hours a day

Patient Obligation

- Pay your bills timely
- Provide your correct insurance information
- Notify the Business Office if your financial status changes and will impact your ability to pay the bill

Patient Rights

- Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria
- Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter



How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

Applications for financial assistance may be obtained at emergency registration or outpatient registration at the hospital. **You can also call the Business Office at 301-552-8186 to have an application mailed to you.**

Mail the completed application as well as proof of family income and expenses to the following:

Doctors Community Hospital
Patient Financial Services
8118 Good Luck Road
Lanham, MD 20706

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients who received inpatient or emergency outpatient care with Maryland Medical Assistance applications. Patients who received inpatient care, and do not have insurance, may contact one of the telephone numbers listed below.

LAST NAME BEGINNING WITH:		
A-J	DECO	301-552-8116
K-Z	MEDLAW	301-552-8682

Additional Assistance

Emergency Outpatient Services

- **Contact DECO at 301-552-8116**

Medical Medicaid Applications for Other Outpatient Services

- **Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434**

Servicios no facturados por Doctors Community Hospital

Es posible que su tratamiento en Doctors Community Hospital requiera los servicios de proveedores que facturan por separado. Estos proveedores le facturarán a su proveedor de seguros. Sin-embargo, si por algún motivo la compañía de seguros no paga por los servicios, es posible que usted reciba una factura. Si tiene preguntas respecto de las facturas de estos proveedores, comuníquese directamente con ellos. A continuación, se proporciona la información de contacto de algunos de los proveedores.

Para servicios profesionales:

- Clinical Laboratory Associates
- Diagnostic Imaging Associates
- Doctors Emergency Physicians
- Elliott & Wargotz Pathology
- Matrix House Physicians

Contacto:

- **Meridian Financial Management**
  301-498-2922

Para servicios profesionales:

- Joslin Diabetes Center
- The Center for Wound Healing

Contacto:

Asistencia financiera

Se encuentra disponible asistencia financiera para los pacientes que reciben atención para servicios de urgencias o emergencias. Se proporciona atención gratuita para los pacientes cuyo ingreso bruto familiar sea del 200% de las Pautas federales de pobreza, o menos.

Las solicitudes de Asistencia financiera pueden obtenerse en el Departamento de registro de emergencias o en el Departamento de registro de pacientes ambulatorios, o llamando a la Oficina comercial al *301-552-8186*.

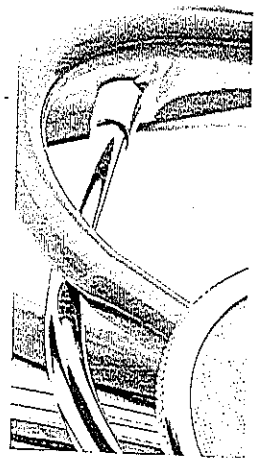
Si se solicita, se enviará al paciente una solicitud por correo. A fin de reunir los requisitos, el solicitante también debe presentar comprobantes del ingreso y de los gastos familiares.

Asistencia médica de Maryland

Para los pacientes que han recibido atención para pacientes hospitalizados o atención ambulatoria de emergencia, Doctors Community Hospital ofrece trabajadores de casos que ayudan a estos pacientes con las solicitudes de Asistencia médica de Maryland. Los pacientes que hayan recibido atención para pacientes hospitalizados y no cuenten con un seguro pueden llamar a uno de los siguientes números de teléfono:

Si su apellido comienza con:

	Contacto	Núm. de teléfono
A-J	DECO	*301-552-8116*
K-Z	MEDI AW	301-552-8682



Paying Your Bill

Bills for services rendered are to be paid upon receipt. **Co-payments are set by your insurance provider and are due at the time of service.**

Services Not Billed by Doctors Community Hospital

Your treatment at Doctors Community Hospital may require services of healthcare professionals who will bill your insurance provider separately. However, if for some reason the insurance company does not pay for the services, you may receive the bill. If you have questions about such bills, contact those professionals directly. Below is the contact information for some of these services.

Professional Services

- Clinical Laboratory Associates
- Diagnostic Imaging Associates
- Doctors Emergency Physicians
- Elliott & Wargotz Pathology

Contact Meridian Financial Management at 301-498-2922

- Joslin Diabetes Center
- Center for Wound Healing and Hyperbaric Medicine

Contact Universal Health Network at 888-846-5527

- Southern Maryland Anesthesia & Associates, LLC

Contact Southern Maryland Anesthesia & Associates at 800-583-1360

Your private physician may also bill you. Please contact him/her directly to discuss those bills.

What If My Visit Is Due To A Motor Vehicle Accident?

We will ask for your automobile and health insurance information. Your automobile insurance will be billed first. If your automobile insurance does not pay the bill, your medical insurance will be billed next. We will bill you for any non-covered balances.

What If I Am Injured On The Job?

We will bill the workers' compensation insurance provider of your employer. If payment is not received from this provider, you are responsible for the bill.

What Does Medicare Cover?

Medicare Part A covers inpatient charges, and Medicare Part B covers outpatient charges that are considered "medically necessary."

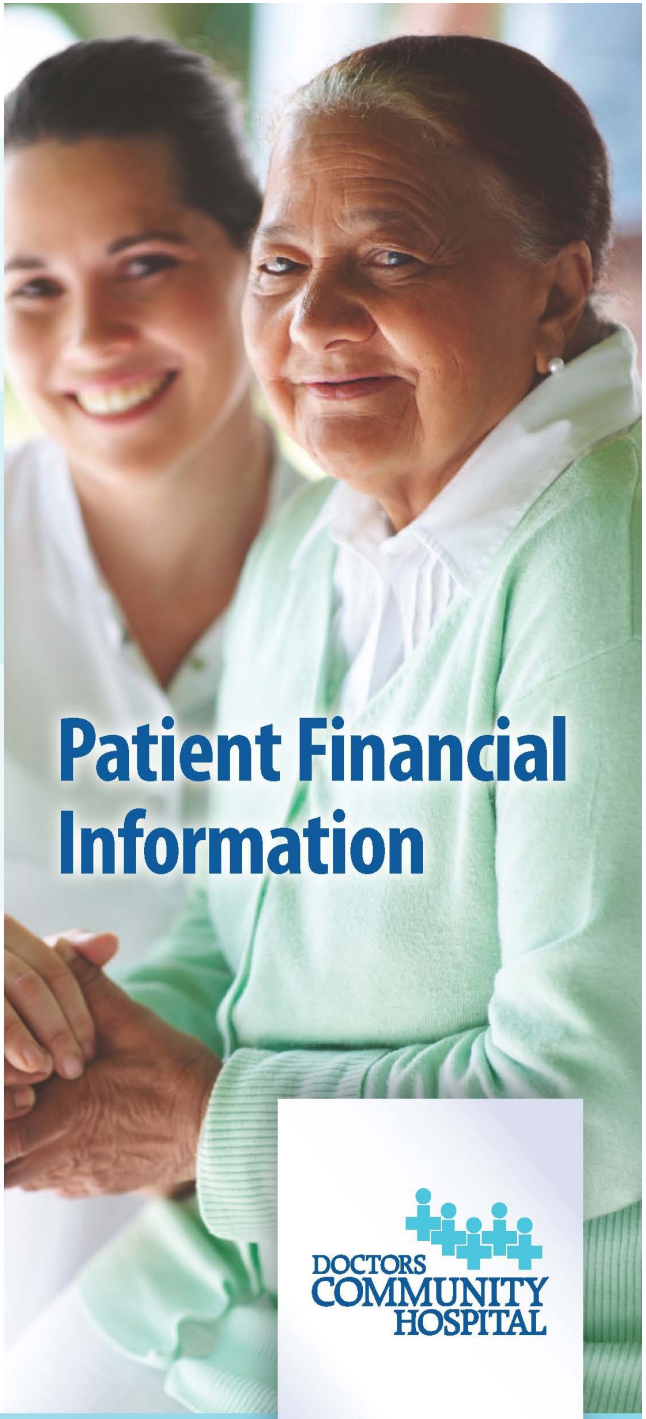
If your doctor orders a service that is not considered "medically necessary" by Medicare, you will be asked to sign an Advance Beneficiary Notice (ABN). The ABN is Medicare's way of informing you of the possibility that it might not pay for the service ordered. By signing the ABN, you agree to accept responsibility for payment if Medicare does not pay.

You can sign the ABN and agree to pay for service, or you can refuse the service. If you refuse, we encourage you to talk with your doctor about alternative options that would be covered by Medicare.

DOCTORS COMMUNITY HOSPITAL

8118 Good Luck Road
Lanham, Maryland 20706

PHONE 301-552-8118



Patient Financial Information

DOCTORS COMMUNITY HOSPITAL

General Billing Information

About four days after receiving medical services, you will receive a Summary Bill in the mail. To request an itemized bill or if you have any questions, contact the Business Office:

7404 Executive Place, Suite 300 A
Seabrook, MD 20706
301-552-8093

While you are still at the hospital, you may pose your questions to the following:

+ **Outpatient Registration Department**
  Main hospital, 2nd floor
  Monday to Friday, 8:00 a.m. to 4:30 p.m.
+ **Emergency Department Registration Office**
  Main hospital, 1st floor
  24 hours a day

Patient Obligation

+ Pay your bills timely
+ Provide your correct insurance information
+ Notify the Business Office if your financial status changes and will impact your ability to pay the bill

Patient Rights

+ Doctors Community Hospital or Medicaid may provide assistance to patients who meet the financial assistance criteria.
+ Patients who believe they were wrongly referred to a collections agency have the right to contact the Business Office to discuss this matter.

How Does Health Insurance Billing Work?

After receiving services, we will bill your health insurance. To ensure that the claim was properly submitted, we will make a copy of your current identification and insurance cards.

Insurance companies require that we supply them with complete information on the person who carries the coverage. This information includes name, address, telephone number, date of birth, employment and social security number.

Incomplete information could cause a denial by your insurance provider, and you could be responsible for the balance.

If you are unable to provide complete insurance and subscriber information, we will not be able to bill your insurance.

Financial Assistance

Financial assistance is available for patients who receive services at Doctors Community Hospital. Patients may qualify for free care or partial care based on their family's gross income as applied to the Federal Poverty Guideline.

Applications for financial assistance may be obtained at emergency or outpatient registrations at the hospital. **You can also call the Business Office at 301-552-8186 to have an application mailed to you.**

Mail the completed application as well as proof of family income and expenses to the following:

Doctors Community Hospital
Patient Financial Services
8118 Good Luck Road
Lanham, MD 20706

Maryland Medical Assistance

Doctors Community Hospital provides case workers to assist patients who received inpatient or emergency outpatient care with Maryland Medical Assistance applications. Patients who received inpatient care, and do not have insurance, may contact one of the below telephone numbers.

LAST NAME BEGINNING WITH:		
A-J	**DECO**	**301-552-8116**
K-Z	**MEDLAW**	**301-552-8682**

Additional Assistance

Emergency Outpatient Services
Contact DECO at 301-552-8116

Medical Medicaid Applications for Other Outpatient Services
Contact the Maryland Department of Social Services at 800-332-6347, TTY 800-925-4434