COMMUNITY BENEFIT NARRATIVE REPORTING ATLANTIC GENERAL

Effective for FY2011 Community Benefit Reporting

Health Services Cost Review Commission
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BACKGROUND

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

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
62	4011 Emergency Room visits 36981	21811 21842 21863 21813 21841	Peninsula Regional Medical Center Beebe Medical Center Nanticoke Memorial Hospital McCready Hospital	Worcester County 21%	Worcester County 13%

Table I

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

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

Worcester County is our primary service area. Our Community Benefit Service Area reaches into the lower portion of Sussex County Delaware. Both areas are rural in population and services.

Worcester County is the easternmost county located in the U.S. State of Maryland. The county contains the entire length on the state's Atlantic coastline. It is the home to the popular vacation resort area of Ocean City. The county is approximately 60 miles long. According to the U.S. Census Bureau the county has a total area of 695 square miles which 468.28 square miles of it is land and 221 square miles is water.

According to the 2010 census the population is 51,454 residents. The median income is $47,829. The per capita income for the county is $31, 626. About 12% of the population is below the poverty line. The median age is 43 years and the mix of male and female is almost even. Nearly one fourth of Worcester County residents are over 65. Our major payer of health care claims is Medicare (more than 55%). It is estimated that Worcester County will grow more than 6% between 2010 and 2015.

The Regional Community Health Assessment data reports that 70% of residents are "overweight" or of an "unhealthy weight"/ Nearly one third are "obese". Our rate of diabetes in the county at 11.6%, though slightly lower than in the previous report, continues to be higher than the national average. According to the latest state results the leading causes of death in the county include heart disease, cancer and stroke. At least 2 out of three of these leading causes may be secondary to diabetes.

The largest concentration of the population is in the northern part of the county where the Ocean City resort area is located along with the Berlin/Ocean Pines area. This is a Mecca for retirees, many who divide their time between Maryland and Florida. The population of the resort of Ocean City increases by about 200,000 during the tourist season. Even though there is this area of higher population the entire county is considered rural and is determined to an "underserved" area for healthcare. The needs in the county vary greatly in the southern end from the northern end. Because the largest concentration of the population is in the north that is where the majority of the services are located and public transportation throughout the county is less than adequate.

Sussex County, DE, the other county in our CBSA is also a rural area. According to the most recent census the population of all of Sussex County is 197,145. We only service a small portion of the county. The population mix is 79% white, 12.7% black and 8.6% Latino/Hispanic and 8.3% report being non-English speaking at home. The population greater than 65 years of age is 20.8%. The per capita income is

$26,689 and the median income is $50, 024 with 12.2% of the people living below the poverty level. Again, like in Worcester County , Sussex County is a rural, underserved area. There are many migrant workers in the area for at least a portion of the year. Because of the migratory habits the consistency of health care is poor and makes follow up care very difficult for that population. Public transportation is a problem in Sussex County as well

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

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

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	Worcester County and lower, eastern Sussex County in Delaware. Target sex is both male and female since they are both about even in our CBSA. By statistics one fourth of our population is greater than 65 years of age throughout our CBSA and 55% of our healthcare claims for payment are to Medicare. The uninsured and underinsured tend to be in the 30 and 40 age category. Again the majority of the population in the CBSA Is white but the needs tend to be in the black and Latino populations.
Median Household Income within the CBSA	Worcester County - $47,829 Sussex County - $50,024
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Worcester County – 12% Lower Sussex County – 12.2%
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:	Worcester County – 14% Lower Sussex County – 8%

http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	
Percentage of Medicaid recipients by County within the CBSA.	Worcester county – 17% Lower Sussex County – 10%
Life Expectancy by County within the CBSA.	Worcester County – 77.4 Sussex County – 77.
Mortality Rates by County within the CBSA.	210.3 age adjusted death rate in Worcester County 224.3 age adjusted death rate in Sussex County
Access to healthy food, quality of housing, and transportation by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	In Worcester County it is estimated that 16.7% of the population does not have access to healthy foods and 26% live in inadequate housing.
Other Specific health conditions of concern in out CBSA.	Health conditions that are higher in CBSA than in the US include: Diabetes 11.6% Skin Cancer 10.7% Lung Disease 11.4% Heart Disease 8.4% Cancer (other than skin) 7.9% High Cholesterol 35.5% Overweight (62% and obesity (24%) slightly lower than in the US but still a significant concern.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the

community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

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

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

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

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

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

The hospital is currently working under the Strategic Initiatives which were developed for planning through 2015. Each year, within this framework the hospital makes plans for the upcoming year using the SWOT/GAP analysis model. Using this model the Leadership Team meets with the Medical Staff to look at strengths, weaknesses, opportunities and threats to plan for the coming fiscal year. This information then goes to the board to, along with senior leadership, finalizes the strategic initiatives for the coming year. Using this information the Community Benefits Committee and the Visions for Total Health Advisory Board determine the goals for the coming year.

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

The documents used by the hospital to determine community needs are:

The Health assessment publication from the health department, local agencies and 3 hospitals,

Worcester County Local Health Plan, FY2008

Tri-county Adolescents Association

State of Maryland Caner Registry

Latest Census update

Feedback from area physicians and community members

Questionnaires and evaluations from our community events

NCR Picker patient evaluations and feedback

Hospital Perception Survey 2010

Leadership members from the hospital sit on the boards of many community organization including: Public Safety Net Council

Child Advocacy Board

Worcester County School Board

YMCA

Tri County Diabetes

Chambers of Commerce of towns throughout the region

Many Health Department Councils

MHA committees

State health department boards

We also have a "Visions for Total Health Advisory Board" comprised of community providers of health related services including traditional as well as integrative health services. Through this committee we can keep our finger on the pulse of the area in which we serve. This committee gives us great feedback on services and programs that are needed those that are working and those that aren't/ It is through this committee that put on a major health conference each year which provides health education as well as screenings. In FY11 the committee decided to take health conference "on the road" and to hold it in different towns in our service area each year. Having held it in the northern end of the county since its inception it was held in the southern most town in the county in November 2010.We met with great success and according to the evaluations were able to provide services to people who otherwise would not have gotten them.

Our auxiliary volunteers are another great resource we use for keeping our pulse on the community. We have over 400 auxillians. They are active on many committees within the hospital and also represent the hospital on community boards.

3. When was the most recent needs identification process or community health needs assessment completed?
   Provide date here. 10/31/2009

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

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

III. COMMUNITY BENEFIT ADMINISTRATION

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

   a. Does your hospital have a CB strategic plan?

      _X_ Yes
      ___No

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

i. Senior Leadership

1. _X_CEO
2. _X_CFO
3. _X_Other (please specify) VP, Community Relations and Marketing
   VP, Medical Staff Services
   VP, Quality
   VP, Planning and operations
   VP, Professional Services
   VP, Information Services

ii. Clinical Leadership

1. _X_Physician
2. _X_Nurse
3. _X_Social Worker
4. _X_Other (please specify) Information Technology

iii. Community Benefit Department/Team

1. _2_Individual (please specify FTE)
2. _20Committee (please list members) A member from each department in the hospital
3. ___Other (please describe)

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

Spreadsheet	_X___yes	_____no
Narrative	_X___yes	_____no

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

Spreadsheet	__X__yes	__ __no
Narrative	__X__yes	__ __no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

   b. Name of Initiative: insert name of initiative.

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

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

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

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

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

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

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

V. PHYSICIANS

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

Because of the rural area we serve and because of the demographics of our population we are considered an underserved area and there are physician gaps in all specialty areas. We are always in the recruitment mode for specialties; some which are more more of a priority than others because of demonstrated need.

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Diabetes	Decrease the incidence of Diabetes and the chronic conditions associated with it.	Our ADA approved Diabetes Education department holds regular classes on treatment of and how to live with Diabetes.	Multi year	AGH, Tri-County diabetes Alliance, local healthcare providers, Worcester County health department	January each year	The incidence of diabetes in our county, though still higher than nationally, it has decreased slightly more than 2% since the previous health assessment.	The education will continue
		Two diabetes support groups in the county which provide education and support. They are held in two locations because of the diversity of the populations.	Multi year		January each year		
		Free diabetes clinic for those who are noninsured or under insured. This provides free lab testing and education and monitor training through a HRSA grant.	HRSA grant continues through FY12	County health departments	April each year		
		Education in schools and the community through our speakers bureau.	Multi year	Local schools	January each year		
		Attend health fairs and events in the “at risk” and “underserved” neighborhoods.	Multi year	Local police, churches, schools.	January each year		
		Offering the Chronic Disease Self Management workshops in the community.	Multi year	Local libraries, retirement communities	June each year		

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Heart Disease	To decrease the incidence of heart disease by teaching prevention and management of risk factors	Eight hypertension clinics offered in the local pharmacies each month	Multi year	Local pharmacies, community healthcare providers	June each year	We have lessened the load on our local physician offices on monitoring blood pressures of their patients and it has fostered good collaboration with them.	The initiative will continue as long as heart disease continues to be a risk factor in our community.
		Tri-county Go Red Event	Multi year	Local health departments and Peninsula Regional Medical Center	February each year	We reach about 150 women each year with the heart healthy message and health screenings at the event.	
		Visions for Total Health Conference – event with education, screenings (including lipid and glucose lab draws) and physical activity.	Multi year	Community providers, health department, providers of health related services	November each year	We reach about 250 community people with the health message at this event. It was held in Pocomoke, an underserved area of our county. Our keynote speaker was on healthy eating.	
		AARP Health Fair – fair targeted to the senior population. Provide free screenings (including lipid and glucose lab draws) and health information.	Multi year	AARP chapter, city council, community providers, health department, providers of health related services	Spring each year	We reach about 450 people at this event, most being senior citizens (at risk for heart disease).	

Heart Disease cont'd		Living Well Chronic Disease Self Management Class	Multi year	Local libraries, retirement communities	June each year	We offered this workshop 3 times in FY reaching about 45 people. It teaches people how to improve their lifestyle despite their chronic conditions.	

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Caner	To decrease the risk of cancer through education and treatment.	Hire a medical oncologist FY11. Open cancer infusion center in FY11. Continue to grow the Cancer Center.	Multi year	Peninsula Regional Medical Center, Radiation oncologists, community healthcare providers, American Cancer Society, Komen MD, Women Supporting Women local breast cancer support community.	June each year	Have opened the Outpatient Infusion Center allowing people who need cancer treatment to stay close to home. Have exceeded our projected patient visits.	The initiative will continue especially since the cancer rates in our county are higher than the national average.
		Provide education to the community on cancer prevention through the speaker bureau and health fairs.	Multi year	Civic organizations, churches, faith based partnerships, Community centers	June each year	Have educated the public on cancer risks of all types, especially breast cancer through our women's diagnostic Center.	

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Obesity	Decrease the epidemic of obesity in our community. Decrease the health risks secondary to obesity.	Begin the education about healthy eating in the elementary schools. Offered Food Play Productions in 6 area elementary schools. This is a production team that teaches children how to eat healthy and exercise.	Multi year	School board, community, partners, Food Play production team, private schools in the area, students and parents of the students.	June 2011	Students were receptive to the message. They were given materials to take home to the parents so the parents were educated through the program. The teachers were given follow up materials which they can use as curriculum to reinforce the healthy eating message.	The initiative will continue in our schools and in the community.
		Through the speakers bureau talks on obesity and nutritious eating.	Multi year	Civic organizations, faith based partnership group, churches, health department.	June each year	Increased awareness of obesity, it's health risk and healthy lifestyle choices.	
		Bariatric surgical services	Multi year	Community healthcare providers, surgeons, exercise physiologists, local gyms.	December each year	Increase in people using LAP Band to manage their weight and a decrease in co-morbidities on obesity.	
		Exercise programs for hospital associates and the community	Multi year	Local fitness providers, Visions for	January each year	Increase in the number of people in the community exercising and decreasing their stress through	

				Total Health committee, community healthcare providers, TOPS groups, Associate wellness program at AGH, local community centers, health department.		exercise.	
		Partnering with a local gym to offer a community weight loss program.	Single year plan	Local gym, TOPS group	January 2011	All participants in the program began an exercise program and healthy eating program and they all lost weight during the contest.	

Initiative 5.

Transportation is an identified as a barrier to healthcare in our CBSA.	Provide healthcare services convenient and throughout CBSA	Place primary care providers in local communities. Provide specialists in underserved areas. Increase services in the outlying areas of CBSA. Decrease ED visits and make care more convenient in the outlying areas. Hold the annual health fair in various locations targeting the underserved population.	Multi year	Atlantic General Health System, Rite Aid pharmacies. Health department, community providers, providers of health related services, churches, local businesses.	June	Primary care providers in 7 locations in our CBSA. Specialists divide their time in multiple offices in order to serve the more rural and underserved areas. Provide lab draws in primary care offices instead of just at the hospital. Established immediate care center in three Rite Aid pharmacies. One in the southern end, one in the northern end and one in the middle of our CBSA. Visions Health Fair held in Pocomoke the lower region of our CBSA. Provided services to the underinsured and uninsured. Was able to provide free screenings and health information.	Will continue and adjust as the need is identified.

Initiative 6

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Pulmonary Services	To treat and prevent lung disease	Pulmonary screening at health fairs and factories.	Multi year	Churches, local businesses	June	Provide education and screenings to the general population to determine those who need referrals to a provider for further care.	Will continue
		Educate through our faith based partnership sin their local places of worship.		Churches	June	Provide education about lung disease to their congregations. 150 people joined the getting healthy program promoted by the group.	Will continue
		Educate through our speakers bureau on lung health.		Civic organization and places of worship	June	Provide education on lung health including smoking, environmental hazards and asthma.	Will continue
		Stop smoking programs offered at the hospital.		Health department	annually	Community members and AGH associates have attended the class and taken steps to stop smoking.	Will continue

Initiative 7

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Women's Health Services	Increase services and make them more available to the community	One of the physicians providers of GYN services see patients in one of our primary care offices in the southern portion of our CBSA. This allows better access for the people when transportation is an issue.	Multi year	AGH health system	Annually	GYN service is more accessible to the underserved region.	
		Bone density screenings at health fairs and businesses		County offices, Health department, local businesses	June	IN FY11 620 people were screened for bone density and out of those 194 were found to be a probable risk osteopenia and 18 found to be a probable risk for osteoporosis. Each were referred for further follow up.	
		Education on breast health and bone health through health fairs and speakers bureau.		Local businesses and community centers, civic groups and churches.		Education provided for at risk populations by going to where they are in the community.	

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. Problems that could be handled appropriately on an outpatient mental health basis end up becoming physical problems resulting in emergency room visits and hospital admissions or social problems resulting in arrests or incarcerations. We have recently recruited a new psychiatrist and support team which will provide mental health services through our Atlantic Health Center location; this is a collaborative venture with the Health Department.

Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is 11.6%, more than the national rate. In this area, not even in this county, there is one endocrinologist. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go out of the eastern shore area for diabetic care and many go untreated or minimally managed. Through a grant AGH is able to provide treatment clinic for diabetes patients to educate and test for diabetes. This is offered twice a month free of charge. No income restrictions apply to the participants in this program.

In the northern part of the county the hospital has a walk-in site that treats patients and charges on a sliding fee schedule. In the next county to the southwest there is a similar medical service clinic (not run by AGH). This does somewhat serve the southern part of the county but because of the rural nature of our area and the lack of comprehensive public transportation there is still a need for more such services. In addition AGH opened open access care facilities in 3 Rite Aid Pharmacies in our service area. Through these we are able to offer drastically reduced priced athletic physicals to the youth in our service area.

This year we also lost our designated breast surgeon; she accepted a position in another state. This has left a large gap in the continuity of service that we can provide patients who have breast cancer. Recruitment for a general surgeon has been initiated.

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

Our Physician Subsidies listed in Category C are for Hospital-based physicians with whom the hospital has an exclusive contract. We also spent $48.485 on physician recruitment which we also include in the Community Benefit report.

VI. APPENDICES

To Be Attached as Appendices:

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

Dedicated financial counselors help those who are uninsured or underinsured, with few resources on which to rely, navigate the options that may be available to them, including the available Maryland Medicaid programs. If no other financial avenues are available to a patient, he or she may apply for financial assistance for those services deemed medically necessary. We base our financial assistance on 200 percent of the poverty level guidelines set by the federal government. Financial Assistance is available to all patients who qualify. This year, Atlantic General Hospital and Health System dedicated $1,475,240 to this program.

The Charity Care information is in a brochure which can be found in all public waiting areas of the hospital and health system sites. We also run articles in our newsletters that are distributed in the homes of all residents in the county and service areas. Through the Case Management and Patient Financial Services Departments those in need are determined and guided through the process as described above.

For ***example***, state whether the hospital:

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

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

Appendix 2

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

Appendix 2

TITLE:	**FINANCIAL ASSISTANCE POLICY**
DEPARTMENT:	**ADMINISTRATION/FINANCE**

POLICY:

It is the policy of Atlantic General Hospital/Health System to provide services without charge to all eligible persons who are unable to pay according to the Hospital's guidelines. Atlantic General's Financial Assistance program is granted after all other avenues have been explored, including payment arrangements or government financial assistance. A distinction is made between financial assistance and bad debts. Financial Assistance is amounts due the Hospital from patients not having the income or resources necessary to meet their responsibility to pay for their health care services within an appropriate length of time. Bad debts are amounts due from patients who are able, but unwilling to pay.

Financial Assistance will be available to all patients without discrimination on the grounds of race, color, national origin, creed.

A patient must have a valid social security number in order to be eligible for Financial Assistance.

1. AGH bases Financial Assistance on 200% of the Federal poverty guidelines (Exhibit A). Only income and family size will be considered in approving applications for Financial Assistance unless the amount requested is greater than $30,000, the tax return shows a significant amount of interest income, or the patient states they have been living off their savings accounts. If one of the above three scenarios are applicable in the application, liquid assets will be considered including checking and saving accounts, stocks, bonds, CD's, money market or any other accounts for past three months along with the past year's tax return and a credit report may be reviewed.
2. Financial Assistance can be applied to all active outstanding balances at the time of approval. Only in extraordinary circumstances will Financial Assistance be applied to a balance transferred to an agency.
3. A patient can be eligible for Financial Assistance in a catastrophic medical situation when medical liabilities are greater than 40% of the annual income or claims totally over $30,000.
4. Approvals can remain active for one year from date of application provided all information is reaffirmed. If information has changed at time of reaffirmation a new application must be submitted for approval. Medicare deductibles can be included on a previous application if service is within the same benefit year. All information must be reaffirmed. In special circumstances the committee may only grant financial assistance for accounts on the current application and not extend the financial assistance for one year.
5. Patients are not eligible for Financial Assistance if the account is for workers compensation, litigation, or the balance is pending an estate settlement.
6. If a patient is approved for Medicaid with a spend down, financial assistance can be applied to the spend down without completing the application process. A valid 216 or a screen print of the condition/occurrence code screen must be attached indicating the amount of the

   spend down. (Note: this does not grant financial assistance for a year, this automatic

   financial assistance only applies to the spend down.

7. If patients have paid any amount towards their bill prior to approval, the payment will not be refunded.
8. If patients do no comply with insurance requirements which results in a denial by the

   insurance company, they will not be eligible for Patient Financial Assistance.

9. If patients do not agree with the decision, they can file a written appeal to the Director of Patient Financial Services, who will review the documentation and make a recommendation to the Patient Financial Services Committee for a decision.

Patient Financial Services Procedures

1. Self pay patients or balances after insurance.
   a) It is the responsibility of the PFS (Patient Financial Services) Associate to determine that all available resources (Medical Assistance, private funding, family members, credit cards and /or payment arrangements) have been exhausted and noted on account.

b) PFS will have the patient or representative of the patient complete a Financial Assistance Application. (Exhibit B) Applications may be accepted from the patient by telephone. PFS documents on the signature line the application was verbal.
c) PFS updates the account to payer code PCHA (pending charity), plan code PCHA when application is completed by the patient or completed verbally over the phone with the patient/representative. The application **MUST BE COMPLETED** before using payer code PCHA. If patient/representative does not complete the application, payer is SELF. The completed original applications must be sent to the Collection Specialist in Patient Accounting via interoffice mail. A copy of the application (stamped COPY), along with the instruction letter should be provided to the patient/representative or mailed if completed over the phone.
d) PFS must put a REGS note type, and note code **PCAC** (Patient Charity Application Completed) with date, time, and initials on all pending financial assistance accounts.
e) If patient applies for Medical Assistance and completes our Financial Assistance application at the same time, use payer code PEND for primary and PCHA for secondary.
f) If patient has applied for Medical Assistance and approved, our Financial Assistance should be removed from payer except in the case of PAC, then CHAR stays as primary payer.
g) If patients are not eligible based on income, but an extenuating circumstance applies, an application with all supporting documentation can be referred to the Committee for review and a recommendation to the Director of Patient Financial Services to forward to senior leadership.

Procedures for Pending Applications

1. The Collection Specialist must follow guidelines below on the applications received:
    a. Accounts Balances of $0-$500 no reminder call to patient
    b. Account Balances of $500-$1000 1 reminder call to patient
    c. Account Balances of $1000-$3000 2 reminder calls to patient
    d. Account Balances > $3000 3 reminder calls to patient
2. The patient receives statements based on the schedule below if documentation is not received accounts will automatically transfer to collection agency.
    a. 2 days Summary Bill
    b. 4 days Statement 1
    c. 20 days from Statement 1 (24 days) Statement 2
    d. 20 days from Statement 2 (44 days) Statement 3 **FINAL NOTICE**
    e. **10 days from Statement 3 the system will pre-list (Bad Debt pre-list) the account.**
    f. **7 days from pre-list the system will transfer the account to Collection Agency.**
3. If patient is uncooperative or cannot be located and does not return supporting documentation within 30 days, Collection Specialist may forward account to collection agency prior to completion of the statement cycle for non-compliance. Collection Specialist places account in F/C BMAN and changes payer over ride flag to Y.
4. Messages generated on the statements:

   a. **Statements 1 and 2 message** – Thank you for utilizing the services of Atlantic General Hospital. Please return all required documentation for your Financial Assistance application or remit payment today. If information is not returned you will be ineligible.
   b. **Statement 3 message** – This is your final notice. Your account is past due and full payment is required. If payment is not received within 10 days your account may be referred to a collection agency.
5. Accounts may be put on bad debt hold at the discretion of the Collection Specialist if he/she believes the patient/representative needs additional time to send documentation. Accounts are placed on bad debt hold by:
   a. Entering Collection Status Code BDHD on an account.

Application Requirements

1. Family size – a family unit is defined as all exemptions filed on the income tax return filed for the individual filing the application whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household must be submitted
2. Income – Income is to be determined for the **entire family unit**. It should be supplied for the twelve months preceding the request or for the three months preceding the request. If 3 months is used, multiply the 3 month annual income by four to calculate the annual income. Income must be verified through a recent pay stub **and** the previous years' tax return. The annual income or the annualized income will be compared to 200% of the Federal Poverty Guidelines (Exhibit A) to determine eligibility. If anyone in the family unit owns a business, the net income from the business will be used for the calculation. If anyone in the family unit owns a business, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year tax return 1040 and Schedule C must be submitted.
3. For each family member receiving unearned income the following must be submitted with the application.
   1) Proof of Social Security Benefits
   2) Proof of Disability Benefits
   3) Proof of Retirement/Pension Benefits
   4) Proof of Veterans Benefits
   5) Proof of Child Support.
4. If anyone in the family unit is not working or has unreported income a signed notarized statement must be provided by the individual or a letter from a Government Agency that is providing financial information indicating the amount of the unreported income and/or the employment status.

5. The amount requested is greater than $30,000, interest income is significant, or the patients state they are living off their savings, bank statements, copies of CD's, and bonds must be provided.

6. If the tax return shows IRA or annuity distributions, the amount will be included in the income calculation unless the patient can prove the funds have been eliminated.

7. After the application is received the Collection Specialist reviews the application and if eligible completes the Approval of Financial Assistance Form. (Exhibit D) If the **patient** is eligible the Collection Specialist forwards the application for approval. Prior to sending the application for approval the Collection Specialist will EVS to insure the patient does not have Medicaid.

8. A decision will be rendered within 15 working days of receipt of a completed application.

9. The Collection Specialist notifies the patient of the decision for Financial Assistance in writing (Exhibit E or F).

Approval

a) The Collection Specialist completes the Approval of Financial Assistance Form (Exhibit D) and refers the form for the following authorized signatures:

Less than $2,000	Director of Patient Financial Services
$2,000 - $5,000	CFO/Vice President of Finance
Over $5,000	CEO/President
Over $30,000	Committee Chair and senior leadership

b) If the amount requested is greater than $30,000 the application and supporting documentation will be forwarded to the Patient Financial Assistance Committee for recommendation to senior leadership. All recommendations and decisions will be made on a case by case basis based on the documentation provided.

c) After the Financial Assistance Application has been approved, the Collection Specialist allowances off the appropriate amount to procedure code: 1031098

d) The Collection Specialist documents the system and indicates the patient was approved for Financial Assistance and the date of approval.

e) The Collection Specialist updates all accounts with payer code CHAR (Financial Assistance), plan code CHAR, and enters the effective and termination date of the Financial Assistance on the payer screen. Collection Specialist must be sure the history account has the payer code CHAR listed.

f) The Collection Specialist monitors accounts using a worklist identifying all accounts where CHAR is secondary and the primary insurance has paid.
g) Financial Assistance approvals and supporting documentation will be filed by month and maintained for a period of ten years.
h) Once applications are approved the Collection Specialists forward the applications with supporting documentation to the General Clerk for storage and retention.
i) The General Clerk balances the Financial Assistance Allowances to the monthly TRANSMTH01 report and provides the report to the Manager for review. The General Clerk files the TRANSMTH01 report showing transaction code 1031098 with the monthly Financial Assistance approvals.

Reaffirmation

a) If the patient presents for any additional services during the year approval period, the Registrar pulls forward the payer information and payer code CHAR will be present. Registrar verifies the approval dates are within the range of the approval period. The registrar affirms whether or not the patient's information has remained the same. If the information is the same then the registrar will answer "Y" to the reaffirmation question on the payer screen. If information has changed or date of service is outside the approval period, the patient must reapply for Patient Financial Assistance.
b) If patient returns within the year approval period for inpatient stay or surgical service, patient must be re-evaluated for Medical Assistance and notes posted on account. If the patient was previously approved and has an account greater then $30,000 within the one year eligibility, a recalculation must be done with liquid assets.
c) Once the CHAR payer code is on the account the system will automatically write off the balance at time of billing to code 1031098.The Collection Specialist reviews daily the automatic contractual write off report (PBRP110-001) to insure that the reaffirmation questionnaire is completed on the payer screen, and the account date of service is within the effective/termination dates of the 180 day approval period. If the questionnaire has not been answered the Collection Specialist must contact the patient. If CHAR is secondary on the account the Collection Specialist reverses the automatic write off pending outcome of primary payer.
d) To complete the reaffirmation, Section 4 must be followed and the Reaffirmation form (Exhibit C) must be completed for all accounts greater than $2000. For accounts less than $2000 the Collection Specialist must complete the Patient Financial Assistance confirmation (Exhibit G) indicating all information has been confirmed and forward to the Director of Patient Financial Services for approval.

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

Appendix 3

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE: **MISSION STATEMENT, STATEMENT OF VALUES, AND** ETHICAL COMMITMENT

DEPARTMENT: **ADMINISTRATION**

POLICY:

It is the policy of Atlantic General Hospital/Health System to maintain a Mission Statement, Statement of Values, and Ethical Commitment for the organization. This will be reviewed annually by the leadership and Board of Directors with approved changes made and communicated. The Mission Statement will be posted prominently throughout the organization.

Atlantic General Hospital and Health System

VISION

To be the leader in promoting access to healthcare services for the residents and visitors of Worcester County and the surrounding region.

MISSION

To provide quality care, personalized service and education to improve individual and community health.

VALUES

These values serve as the foundation for achieving our mission.

- *Dedication to patient safety*
- *Respect and kindness*
- *Community commitment*
- *Honesty, integrity, and trust*
- *Personalized attention*
- *Partnership and teamwork*
- *Financial accountability*
- *Continued learning and improvement*

These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers.

Ethical Commitment

To conduct ourselves in an ethical manner that emphasizes a basic community service orientation and justifies the public trust.