Dimensions Healthcare System

COMMUNITY BENEFITS REPORT FOR THE FISCAL YEAR JULY 1, 2010 – JUNE 30, 2011

Prince George's Hospital Center
3001 Hospital Drive
Cheverly, Maryland 20785
301-618-2000

INTRODUCTION AND BACKGROUND:

Prince George's Hospital Center (PGHC) has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 60 years, Prince George's Hospital Center has grown to become a major tertiary care center for the region and one of its largest employers. However, our greatest service to the community is that Prince George's Hospital Center is a private not-for-profit hospital with a tremendous public mission.

Prince George's Hospital Center was founded in 1944 and is an acute care teaching hospital and regional referral center located in Cheverly, Maryland. Prince George's Hospital Center is a member of the Dimensions Healthcare System.

Leadership: Chairman, Board of Directors – C. Phillip Nichols, Jr.
CEO – Neil J. Moore (Acting)
President – John A. O'Brien
Chief Nursing Officer – Ruby Anderson

Location: 3001 Hospital Drive, Cheverly, Maryland 20785

Facility type: Acute care teaching hospital and regional referral center

No. of licensed beds: 244 (plus 40 bassinets)

No. of inpatient admissions: 12,739

No. of Employees: 1,893

Specialty services:

A comprehensive range of inpatient and outpatient medical and surgical services including:

- Emergency and trauma services (designated Level II regional trauma center for southern Maryland)
- Critical care services
- Cardiac care services (comprehensive cardiac care – only program of its kind in the County)
    - Open-heart surgery
    - Two cardiac catheterization labs (diagnostic & therapeutic cardiac caths, cardiac stenting)
    - 10 bed CCU and 66 telemetry beds
    - Cardiac diagnostic evaluation center

    - Cardiac rehabilitation
- Laboratory and pathology testing
- Medical and surgical services (virtually all adult specialties performed)
- Maternal and child health
    - Labor and delivery postpartum units
    - Perinatal diagnostic center
    - Diabetes and pregnancy program
    - Neonatal intensive care unit (designated Level III, regional center for Prince George's County)
    - Inpatient pediatric unit
    - Chronic pediatric inpatient unit and outpatient program

Other specialty services:

- Ambulatory and outpatient services
    - Surgical short-stay center
    - Special procedures
    - Diabetes treatment center
    - Glenridge Medical Center (internal medicine, family practice, ob/gyn)
- Behavioral health services
    - Inpatient psychiatric unit for adults
    - Hospital-based sexual assault center
    - Partial hospitalization program
    - Emergency psychiatric services
- Graduate medical education, internal medicine residency programs

Facilities:

- The Surgical Services and Critical Care Center Pavilion houses a 24 bed intensive care unit, 10 operating suites, a 15 bay Post Anesthesia Care Unit, 11 private room Short Stay Center, two state-of-the-art cardiac catheterization labs with 10 Transcare bays and 2 endoscopy suites with 9 recovery bays.
- The PGHC Emergency Department includes 15 acute care rooms, 4 hall area beds, a 4 bed resuscitation area, 2 isolation rooms, 2 dedicated trauma rooms, an 8 bed ambulatory emergency area, with 2 minor trauma/suture rooms and a designated ENT room, point-of-care testing, and a blood bank.
- PGHC also has a licensed, freestanding emergency department, located on the Bowie Health Center campus, with a total of 15 beds, including two cardiac rooms, 2 suture rooms, a GYN room, an isolation room, a stat lab, and radiology services.

Ownership:

- Member of Dimensions Healthcare System, the largest not-for-profit provider of heath care services in Prince George's County.

Prince George's County Demographics:

PGHC's community benefit service area (CBSA) is Prince George's County, Maryland. According to the 2011 Prince George's County Health Rankings (CHR), Prince George's County has an estimated population of 834,560, making it the second most populous jurisdiction in Maryland. The County, immediately north, east, and south of Washington, D.C. has a population that is 66% African-Americans, 15% White and reported as 14% of Hispanic origin. Of all Maryland counties, this County has the largest percent of its population who belong to either a racial or ethnic minority group. In addition, approximately 25% of the population is under 18 years of age and persons age 65 years and older represent 10% of the population.

Statistics from the 2011 CHR revealed that the median household income for County residents was $71,696 – higher than the Maryland median household income of $70,482.

Community Challenges & Health Statistics:

Despite the higher than average median household income, educational attainment, and percentage of individuals in the work force represented by Prince Georgians on comparison with national figures, the County does contain several pockets of low socioeconomic status. The 2009 Community Health Status Report data reveal that medically vulnerable Prince Georgian's (uninsured and Medicaid enrolled individuals) number approximately 297,784 or 35.7% of the total population.

According to the CDC document Summary Health Statistics of the U.S. Population: National Health Interview Survey (2004) being poor and uninsured are two of the strongest determinants of whether a person "did not receive medical care", or whether they "delayed" seeking care.

As a result, issues such as diabetes mortality, heart disease, hypertension, stroke, deaths from breast, colorectal and prostate cancers, HIV and infant mortality all represent significant health challenges for community members. Furthermore, persistent disparities in mortality and health status for several health indices are seen in various racial and ethnic populations. Among Prince George's residents, relatively high rates of asthma, obesity, and homicide are additional areas of concern. These are certainly planning considerations in this majority minority community. Additionally, the racial and ethnic minorities are approximately 2/3 of Prince George's County Medicaid beneficiaries. County and Maryland State health statistics are similar to national trends regarding the status of minority health.

Identification of Community Needs:

A Prince George's County Health Profile Snapshot Report was completed by PGHC in June 2006. The Report was generated as a result of a collaborative effort of PGHC and the Prince George's County Health Department. The data referenced in the Report was acquired from U. S. Census data and from the Public Health Quick Stats for Prince George's County, Maryland and the most recent Maryland Vital Statistics Report.

PGHC management has also carefully reviewed the Prince George's County healthcare assessment report, Assessing Health and Health Care in Prince George's County, completed by the RAND Corporation (RAND) in February 2009 for the Prince George's County Council, to assess the status of community health needs. Some of the findings of the RAND report are as follows:

- ***The health behaviors and use of preventive care by adults within Prince George's varies widely*** – County residents who are poor and less educated are more likely to drink heavily, smoke, not exercise, and not use seatbelts. Preventive care use among uninsured residents of Prince George's is sharply lower than among insured residents.
- ***Prince George's residents are uninsured at relatively high rates*** – an estimated 80,000 County adult residents are uninsured, more than twice as many as neighboring Howard County and roughly one-third more than in Montgomery County.
- ***Prince George's County lacks a primary care safety net*** – the County's capacity to provide safety-net care, beyond hospital and emergency care, is limited. Relatively few primary care physicians practice in poorer areas of the County. Moreover, the County has only one federally qualified health center – Greater Baden Medical Services, Inc., which serves uninsured and low-income patients. PGHC and other charitable organizations also run clinics that provide care to the uninsured, but these clinics provide care for only a small portion of the total uninsured County residents.

The main findings of both the 2006 PG County Health Profile Snapshot Report and the 2009 RAND Report is that there are significant health disparities in Prince George's County and that the County lacks a robust health safety net. The mission of PGHC is to continue to provide high quality and efficient healthcare services to preserve, restore and improve health status in partnership with the community, and to continually seek to expand the health safety net available to the uninsured and vulnerable residents of the County. The two largest community benefit expenditures made by PGHC are the mission-driven, non-reimbursed subsidies paid to its physicians, and charity care expenditures -- expenditures that both guarantee the continuation of the PGHC safety net mission.

PGHC management has begun work on the formal community health needs assessment (CHNA) required by the Patient Protection and Affordable Care Act (ACA).

Decision Making:

In March 2008, the PGHC Board of Directors established a Community Health Task Force (CHTF) committee. The CHTF includes collaborations with such organizations as the Prince George's County Health Action Forum and the Prince George's County Health Department. The purpose of the CHTF is to assist management in the development of relationships and a plan to work with identified community-based health services and to make an optimal range of services more widely available to improve community health status. To date, the CHTF has focused attention on community health needs, provided improved health information, and is currently working the National Institute of Health – National Library of Medicine (NIH – NLM) to identify sustainable community health information delivery initiatives.

Given that PGHC's overall mission is to provide community benefit in the form of safety net health services, the Board of Directors of PGHC is involved in the high-level decision making process regarding community benefit. However, given the financial challenges the hospital has faced in recent years, PGHC has not devoted significant human or capital resources to the development of a detailed community benefit program. All PGHC department managers are aware of PGHC's community benefit mission and, therefore develop, oversee and report on department level programs.

Community Benefit Program Evaluation:

As stated above, the two largest community benefit expenditures made by PGHC is the mission-driven, non-reimbursed subsidies paid to its physicians and charity care expenditure that both guarantee the continuation of the PGHC safety net mission. As mentioned, the PGHC Board of Directors is continually involved in reviewing and evaluating the status of the Hospital's mission. All other community benefit services are evaluated at the department level.

Description of Physician Subsidies and the Gaps in the Availability of Specialist Providers to Serve the Uninsured:

PGHC's physician subsidies outlined in category C of the CB Inventory Sheet are primarily subsidies to cover the compensation of Hospital-based physicians with whom the Hospital has exclusive contracts. Although PGHC has one of the largest populations of uninsured patients in the State, PGHC's mission provides that all patients should receive the highest level of care regardless of economic standing.

This goal can only be achieved with experienced specialist physicians caring for all of PGHC patients even when so many of the patients cannot afford to pay. To overcome this obvious dilemma, physicians are paid to cover their bad debts so the "gap" exists in the hospital's profits but not in patient care. We get no funds from the regulated system to offset these physician payments but, in light of PGHC's safety net mission, we will always put the patients first.

APPENDIX 1

Description of the PGHC Financial Assistance Program:

- Dimensions Healthcare System provides compassionate care for all, regardless of an individual's ability to pay. We serve as the safety net for the uninsured and underinsured. It is our mission to help save lives and improve the quality of living.

- Dimensions Healthcare System through its health care services, provides financial assistance to those who need medical and health care services but do not have the resources to pay for that care, and it does so by preserving the dignity of the individual who needs assistance.

- In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs may be eligible for free or discounted healthcare services based on established criteria.

- Eligibility for the Dimensions Healthcare System Financial Assistance Program is based on income and family size. Should a patient be found eligible for financial assistance, the patient will receive a Financial Approval Letter indicating his/her eligibility amount. Any balance due after the financial assistance allowance has been applied, will become the responsibility of the patient. Physicians bill separately and their charges are not included in the financial assistance program.

APPENDIX 2

- See attached Financial Assistance Program Policy #200-41.

APPENDIX 3

Description of the PGHC Mission, Vision and Value Statements:

- The mission of PGHC is to provide comprehensive health care with the highest quality to residents, and others who use our services while strengthening our relationships with universities, research and health care organizations to ensure best in class patient care.

- The vision of PGHC is to be recognized as a premier regional health care system.

- The values of PGHC include respect, excellent service, personal accountability, quality, open communication, innovative environment, and safety.

APPENDIX 4

- See attached Mission, Vision, Values, and Service Priorities Policy #200-24.

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. Dimensions Healthcare System is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a

reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility in order to create awareness of the financial assistance program and the assistance available. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area in accordance with the state's Language Assistance Services Act.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

A. 1. *Assets:* Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:

a. Homestead property
b. $2,000 for the uninsured patient, or $3,000 for the uninsured patient and one dependent residing together.
c. $50 for each additional dependent residing in the same household.
d. Personal effects and household goods that have a total value of less than $2,000.
e. A wedding and engagement ring and items required due to medical or physical condition.
f. One automobile with fair market value of $4,500 or less.
g. Patient must have less than $10,000 in net assets.

2. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.

5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.

6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment I.

7. *Family:* The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

8. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

9. *Qualified Patient:*

   a. *Financially Needy*: A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.

   b. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

10. *Medically Necessary Service:* Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:

    a. Non-medical services such as social, educational, and vocational services.
    b. Cosmetic surgery.

B. **Financial Assistance Guidelines and Eligibility Criteria (see PFS Department for current form)**

a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 150 percent of the current Federal Poverty Guidelines. 150 percent (150%) of the Federal Poverty Guidelines represents an individual earning minimum wage.

b. Patients with household income that exceeds 150 percent (150%) but is less than 300 percent (300%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.

c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.

d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.

e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.

f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

PROCEDURE:

A. **Identification of Potentially Eligible Patients:**

Admitting 1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:

a) Routine and comprehensive demographic data.
b) Complete information regarding all existing third party coverage.

2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.

3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

Dir., PFS 4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. **Determination of Eligibility:**

PFS 1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.

2. Requests for financial assistance may be received from:

a. the patient or guarantor;
b. Church-sponsored programs;
c. physicians or other caregivers;
d. various intake department of the institutions;
e. administration;

f. other approved programs that provide for primary care of indigent patients.

3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.

4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.

5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.

Dir., PFS 6. Approval for financial assistance for amounts up to $50,000 should be approved by the Director of Patient Financial Services. Those greater than $50,000 should be approved by the CFO.

PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).

8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee's review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).

9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

C. **Notification of Eligibility Determination:**

PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

FAC 2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization's final and executive review.

3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.

Patient 5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance, or a change in their payment plan terms.

D. **Availability of Policy:**

PFS 1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. **Application Forms:**

PFS 1. Every hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient's eligibility for financial assistance.

F. **Monitoring and Reporting:**

PFS 1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

a. account number,
b. date of service,
c. application mailed (y/n),
d. application returned and complete (y/n),
e. total charges,
f. self-pay balances,
g. amount of financial assistance approved,
h. date financial assistance was approved.

2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

_____

G. T. Dunlop Ecker
President & Chief Executive Officer

Financial Assistance Program 200-41 (1/23/2008)

ATTACHMENT:

Application for Financial Assistance

APPLICATION FOR FINANCIAL ASSISTANCE

Information About You

Name _____
First Middle Last

Social Security Number ___-___-___ Marital Status: Single Married Separated

US Citizen: Yes No Permanent Resident: Yes No
Citizenship status does not affect your ability to qualify for financial assistance.

Home Address _____ Phone _____

_____ _____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip Code

Household Members:

Name	Age	Relationship

Services for Which You Are Requesting Financial Assistance

Dates of service _____
Total amount of bill _____
Amount of assistance requested _____

Have you applied for Medical Assistance Yes No
If yes, what was the determination? _____

Account number _____ Medical record number _____

Family Income

Please list the amount of your monthly income from the following possible sources and include copies of your federal tax return and other documents to show proof if income. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pensions benefits	_____
Social Security benefits	_____
Public Assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment	_____
Other income source	_____

Liquid Assets	Current Balance
Checking accounts	_____
Savings account	_____
Stocks, bonds, CD, money market, or other accounts	_____

Other Assets
If you own any of the following items, please list the type and approximate value.

Home			Approximate value	_____
Automobile	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Other property			Approximate value	_____

Monthly Expenses *Amount*

Rent or Mortgage _____
Utilities _____
Car payment(s) _____
Credit cards(s) _____
Car insurance _____
Health insurance _____
Other medical expenses _____

Other Expenses

Do you have any other unpaid medical bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the Hospital extend additional financial assistance, the Hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the Hospital of any changes to the information provided within ten days of the change.

_____ _____
Applicant Signature Date

MISSION, VISION AND VALUES STATEMENTS

MISSION

Within the Dimensions Healthcare System, it is our mission to provide comprehensive health care of the highest quality to residents, and others who use our services while strengthening our relationships with universities, research and health care organizations to ensure best in class patient care.

VISION

To be recognized as a premier regional health care system.

VALUES

Dimensions Healthcare System:

- ***Respects*** the dignity and privacy of each patient who seeks our service.
- Is committed to ***Excellent Service*** which exceeds the expectations of those we serve.
- Accepts and demands ***Personal Accountability*** for the services we provide.
- Consistently strives to provide the highest ***Quality*** work from individual performance.
- Promotes ***Open Communication*** to foster partnership and collaboration.
- Is committed to an ***Innovative Environment***; encouraging new ideas and creativity.
- Is committed to having its hospitals meet the highest standards of ***Safety***.

APPROVAL:

Kenneth E. Glover
President & Chief Executive Officer

Mission, Vision, Values and Service Priorities 200-24 (6/6/2006, 4/16/2009, 11/1/2010, 7/14/2011)

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2011 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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:
244 Beds + 40 Bassinets	12,739	20785 20743 20747 20784 20706 20774 20737 20710 20748 20745	Doctors Community Hospital	Prince George's: 20.5%	Prince George's: 15.5%

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.) CBSA – Prince George's County, MD

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)	Prince George's County: Population – 834,560 Sex M – 48% F – 52% White – 15% African-American – 66% Hispanic/Latino – 14% Asian – 4% % age < 18 years – 25% % age 65 and older – 10%
Median Household Income within the CBSA	$71,696
Percentage of households with incomes below the federal poverty guidelines within the CBSA	6.7%
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	20.5% (An estimated 80,000 PG County adult residents are uninsured, more than twice as many as neighboring Howard County and roughly one-third more than Montgomery County.)

Percentage of Medicaid recipients by County within the CBSA.	15.7%
Life Expectancy by County within the CBSA.	78.6 years
Mortality Rates by County within the CBSA.	767.8/100,000
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)	Risk factors for premature death in Prince George's County: -- No exercise 24.6% -- Few fruits/vegetables 72.1% -- Obesity 25.5% -- High blood pressure 26.2% -- Smoker 17.8% -- Has diabetes 8.3% -- HIV prevalence rate 755/100,000 -- % illiterate (> age 16) 21.9%
Other Vulnerable populations	Vulnerable populations in Prince George's County: -- No high school diploma 9.7% -- Are unemployed 6.9% -- Are severely work disabled 2.0% -- Are recent drug users 6.1%
Other Access to primary care	Ratio of population to primary care physicians – PG County – 1,077:1 Nat'l Benchmark – 631:1 (Prince George's County has substantially lower per capita numbers of primary care physicians when compared to neighboring jurisdictions.)

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.

   In 2008, the Prince George's County Council engaged the RAND Corporation to provide a report on the changing health care needs in the County. The report was finalized in 2009.

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

   The RAND Corporation

3. When was the most recent needs identification process or community health needs assessment completed?

   Provide date here. __/__ /__ (mm/dd/yy)

   A formal CHNA , per ACA guidelines, will be completed on or before June 30, 2013.

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

   ___Yes

   _X__No

   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. N/A

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?

___Yes

__X_No

Note: PGHC (Dimensions Healthcare System) has a corporate strategic plan that includes significant community benefit services; however, PGHC does not have a formal distinct community benefit plan at this time.

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. ___CEO
2. _X__CFO

3. __X_Other (please specify) General Counsel

Note: The PGHC CFO and General Counsel are participating on the corporate team that is working on the upcoming federally mandated CHNA.

ii. Clinical Leadership

1. ___Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. __X_Committee (please list members)
3. ___Other (please describe)

CFO, General Counsel, VP – Reimbursement, System Controller, Director – Finance, Director – Strategic Planning, Community-based Health Manager.

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

Spreadsheet	_____yes	__X___no
Narrative	_____yes	___X__no

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

Spreadsheet	_____yes	__X___no
Narrative	_____yes	___X__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.

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.

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)

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).

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

DIABETES EDUCATION AT GLENRIDGE MEDICAL CENTER

a. Identified Need:

Prince George's County is the second largest county in the state of Maryland (MD). The demographic characteristics of the county reflect a significant diversity among its residents: 66% are African- American; 15% are Caucasian; 14% are Latino; 4% are Asian; and the remainder represent persons of other races and cultures. Given the unique demographical composition of Prince George's County, the relationships between race/ethnicity, health status, and patterns of health care use are especially important (Lurie et al 2009). According to a 2006 report from the state department of Health and Mental Hygiene, more than 50,000 PG county residents have diabetes. African Americans in Prince George's County have the highest prevalence of diabetes, age adjusted hypertension and HIV. These findings are consistent with national and local data that show blacks as disproportionally impacted by diabetes, hypertension and HIV and AIDS. African Americans with diabetes in Prince George's County have a higher rate of hospitalization than whites and much higher mortality rates than surrounding areas (Giles, 2003). The 50,000 county diagnoses made up more than 16 percent of the state's diabetes cases from 2002 to 2006, raising concerns that the population is not receiving enough guidance on how to handle and prevent the condition of diabetes. Last year Prince George's Hospital Center had more than 3,000 discharges with diabetes.

Prince George's Hospital Center recognizes the major effects diabetes plays both on patients and the community. One of the cornerstone's of diabetes care is education. The Diabetes Center at PGHC was established to provide a comprehensive diabetes self-management program. The program has achieved American Association of Diabetes Educators (AADE) recognition for comprehensive, effective diabetes self-management education. The quality accreditation process increases the feasibility of expanding diabetes education services into diverse community settings in Prince George's County. Services are provided to those with or at risk for diabetes and are covered by most insurance. For those without insurance, a program was established at Glenridge Medical Center.

b. Name of initiative: Diabetes Education at Glenridge Medical Center

c. Primary Objective: The primary objective of the project was to provide diabetes education to patients without insurance/under-insurance, increase patient and staff knowledge of diabetes and prevent complications and hospitalizations.

For those without insurance or with high deductible plans, the Diabetes Center at PGHC worked with Glenridge Medical Center to develop and provide diabetes education services, which provided free diabetes education and follow-up. In addition, nurses and staff attended several education programs on key diabetes prevention and control topics

including diabetes overview, meal planning, carbohydrate counting, medications, complications and standards of care in order to provide "teachable moments" with patients to reinforce diabetes self-management.

A volunteer medical student was selected to set up and run the program. Initial training involved shading the diabetes educator at Prince George's Hospital Center and reviewing components for the Diabetes Center Outpatient Program. (Please refer to Pearl Samuel at Glenridge Medical Clinic) for data and outcomes.

d. The initiative was initially set up for 1 year period beginning in the Spring 2011. The plan moving forward is to use volunteer medical students to continue the services.

e. Key partners include: The Diabetes Center PGHC, Glenridge Medical Center and the PGHC Residency program.

f. Evaluation: The Center tracks each patients blood sugar levels over a 3 month period to evaluation improvement as a result of the education.

g. Outcome: More than 150 participants have been enrolled in the program.

h. Continuation: Yes, the program will be continued.