COMMUNITY BENEFIT NARRATIVE REPORT

FISCAL YEAR 2013

Holy Cross Hospital
1500 Forest Glen Rd
Silver Spring, MD 20910

Submitted December 13, 2013

BACKGROUND

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

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

FY13 Bed Designation:	442		
FY13 Inpatient Admissions:	31,981		
FY12 Primary Service Area ZIP Codes:	20705 20706 20707 20708 20774 20783 20852	20853 20874 20877 20878 20895 20901 20902	20903 20904 20906 20910 20912
All other Maryland Hospitals Sharing FY12 Primary Service Area:	Doctor's Community Hospital - 20706, 20774 Howard County Hospital - 20707 Johns Hopkins Hospital - 20707, 20874, 20878, 20902, 20904 Laurel Regional Hospital - 20705, 20706, 20707, 20708, 20904		

	MedStar Montgomery Medical Center - 20853, 20902, 20904, 20906 Prince George's Hospital Center - 20706, 20774 Shady Grove Adventist Hospital - 20852, 20874, 20877, 20878 Suburban Hospital - 20852, 20853, 20878, 20895, 20902, 20906 Washington Adventist Hospital - 20705, 20706, 20783, 20901, 20902, 20903, 20904, 20906, 20910, 20912
Percentage of Uninsured Patients, by county (Most recent 12 months – April 2012 to March 2013)	Montgomery County: 5.9% Prince George's County: 6.8%
Percentage of Patients who are Medicaid Recipients, by county (Most recent 12 months – April 2012 to March 2013)	Montgomery County: 19.4% Prince George's County: 24.2%

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.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

The Community We Serve (excerpt from Holy Cross Hospital's CHNA, Fiscal Year 2012)

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents. An estimated 1.5 million people make up our four market area, of which 62 percent are minorities. Our 12 ZIP code core market includes 339,489 people, of which 61 percent are minorities (see Figure 1).

Race	Four Market Area (1.5 Million)	Core Market (339,489)
White-Non-Hispanic	586,451 (38.4%)	131,225 (38.7%)
Black Non-Hispanic	502,823 (32.9%)	84,163 (24.8%)
Asian/Pacific Islander	151,230 (9.9%)	41,308 (12.2%)
Hispanic	241,125 (15.8%)	71,004 (20.9%)
All Others	45,893 (3.0%)	11,789 (3.5%)

Figure 1. Demographic breakdown of HCH market area by race

We draw 83 percent of our discharges from a defined market area with four sub-areas within Montgomery and Prince George's Counties (see Figure 2). Seventeen percent of our discharges come from outside this four-market area. Our core market is defined as 12 contiguous ZIP Codes in Montgomery County from which we draw 42 percent of our discharges. We draw 69 percent of our inpatient and outpatients from Montgomery County.

Figure 2. HCH Four market area

HCH Percent Distribution of Patient Discharges

- **Core (42%)**
- **Northern Prince George's (14%)**
- **Prince George's Referral (11%)**
- **Montgomery Referral (16%)**

The community we serve is one of the most culturally and ethnically diverse in the nation, having experienced a demographic shift and a pace of change that comes with being a "gateway suburb." Montgomery County is one of only 336 "majority-minority" counties in the country. During the last two decades, the county's foreign-born population increased from 12 percent in 1980 to more than 30 percent.[1] Immigrants from all over the world bring a great vitality to our community; at the same time, they challenge the hospital and other local community service providers to understand and meet their varied needs.

Montgomery County, Maryland's most populous jurisdiction, with a population of 971,777, has a median household income of $94,420 compared to the statewide median household income of $69,272. The county's income level is positively correlated to its level of education; more than half of the county's residents (56.3%) hold a bachelor's degree or higher compared to 35.7% statewide (U.S. Census Bureau, 2009 American Community Survey).

Due to the large number of federal agencies and contractors, the area generally enjoys low unemployment. However, relatively greater rates of unemployment are experienced among the African American and Latino American populations. During the last two decades, minorities have become the majority – today 49 percent of the county's residents are non-Hispanic whites, down from 60 percent in 2000 and 72 percent a decade before that (Morella & Keating, 2011). Despite its relative wealth in terms of income, education and support for public services, more than 123,000 adults are uninsured (SAHIE, 2007).

Fluency in English is very important when navigating the health care system as well as finding employment. In Montgomery County, the highest rates of linguistic isolation are among Latino Americans and Asian Americans. Forty-six percent of those who are foreign-born speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2007).

Prince George's County also experienced a large influx of foreign-born residents during the last two decades. The county's foreign-born population as a percent of total population gain from 2000-2007 was the highest in the state at 199.9 percent compared to a state average of 70.7 percent. More than 18 percent of the county's residents are foreign-born, of which 42 percent speak English less than "very well" (Maryland Department of Planning, Planning Data Services, 2009).

Prince George's County, like Montgomery County, is one of the states most populous jurisdictions with a population of more than 863,420 residents and a median household income of $69,947, slightly higher than the state average (see figure 3). Less than one third (29.2 percent) of the county's residents hold a bachelor's degree or higher (U.S. Census Bureau, 2009 American Community Survey) and over 149,000 individuals are uninsured (SAHIE, 2007).

Despite the relative affluence of our local community, disparities exist. For example, in Montgomery County, key minority populations average lower median income than the income level determined for self-sufficiency. In Prince George's County, relatively high income levels do not help lower the African American infant mortality rate.

[1] Neal Peirce, "Outreach to immigrants: A suburb's exciting new way," *The Washington Post* May 17, 2009, from http://www.postwritersgroup.com/archives/peir090517.htm.

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf)

Table II

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

	CBSA Area
2012 Total Population	1,585,117
Total Male Population	768,507
Total Female Population	816,610
Females, Child Bearing Age (15-44)	331,301

RACE/ETHNICITY

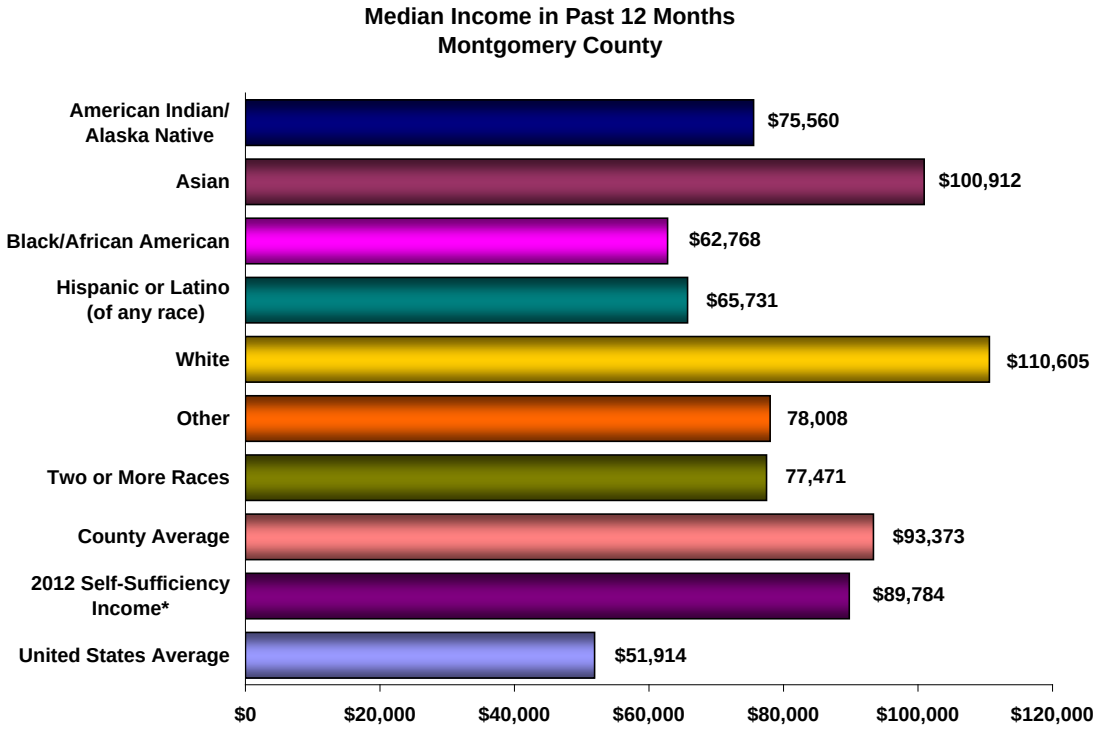
	Race/Ethnicity Distribution		
Race/Ethnicity	**2012 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	531,642	33.5%	62.8%
Black Non-Hispanic	550,596	34.7%	12.3%
Hispanic	296,816	18.7%	17.0%
Asian & Pacific Is. Non-Hispanic	159,504	10.1%	5.0%
All Others	46,559	2.9%	2.9%
Total	**1,585,117**	**100.0%**	**100.0%**

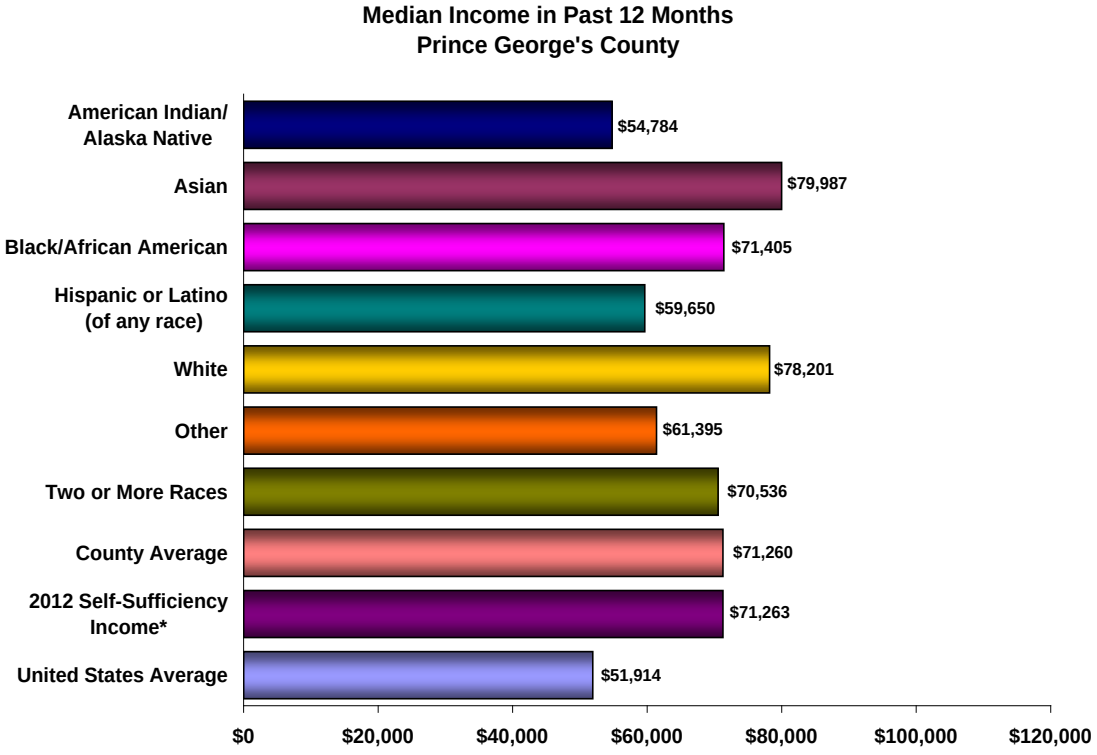
POPULATION DISTRIBUTION

	Age Distribution		
Age Group	**2011 Pop**	**% of Total**	**USA 2011 % of Total**
0-14	325,007	20.5%	337,355
15-17	70,856	4.5%	66,967
18-24	144,596	9.1%	148,446
25-34	212,717	13.4%	204,824
35-54	478,718	30.2%	460,510
55-64	179,649	11.3%	210,250
65+	173,574	11.0%	207,989
Total	**1,585,117**	**100.0%**	**1,636,341**

Median Household Income within the CBSA :

AVERAGE HOUSEHOLD INCOME	
CBSA Area	**USA**
$103,023	$67,315





Household Incomes by race for Montgomery and Prince George's County. Source: U.S. Census Bureau, 2011 American Community Survey
*Income for two adults, one preschool and one school age child. Source: The Self-Sufficiency Standard for Maryland 2012; Maryland Community Action Partnership

Percentage of households with incomes below the federal poverty guidelines within the CBSA: >25K = 10.4%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2011 Household Income	HH Count	% of Total	USA % of Total
<$15K	32,219	5.6%	13.0%
$15-25K	27,725	4.8%	10.8%
$25-50K	105,380	18.4%	26.7%
$50-75K	109,012	19.1%	19.5%
$75-100K	87,113	15.2%	11.9%
Over $100K	210,516	36.8%	18.2%
Total	**571,965**	**100.0%**	**100.0%**

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

Uninsured by County

Race/Ethnicity	Montgomery County	Prince George's County	Maryland	USA
Average, All Races	**11.7%**	**15.0%**	**10.4%**	**15.1%**
American Indian/Alaska Native	11.4%	25.9%*	20.0%	27.6%
Asian	10.4%	10.4%*	12.8%	15.4%
Black/African American	15.2%	10.4%	11.3%	17.7%
Hispanic/Latino (of any race)	29.8%	40.9%	31.4%	29.8%
White Alone (not Hispanic/Latino)	7.9%	16.8%	8.1%	13.4%
Two or more races	7.1%	12.9%*	10.0%	14.4%
Other	38.4%	48.4%	39.9%	33.6%

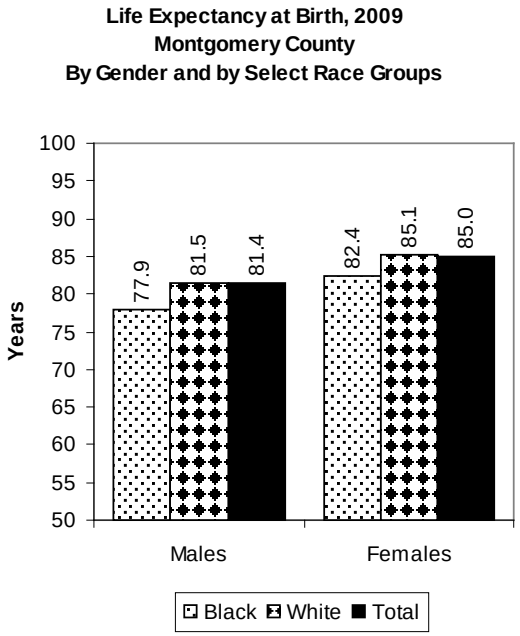
Source: U.S. Census Bureau, 2011 American Community Survey; *U.S. Census Bureau, 2009 American Community Survey

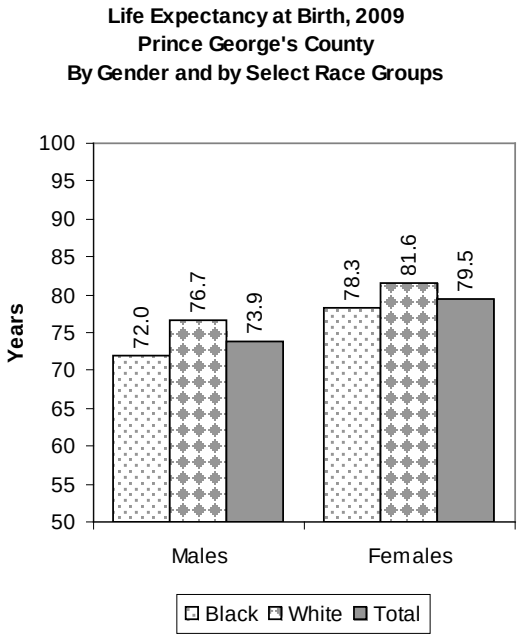
Percentage of Medicaid recipients by county within the CBSA:

Montgomery County: 10.1% (98,590 recipients)
Prince George's County: 15.4% (132,778 recipients)

Source: Maryland Medicaid eHealth Statistics, Maryland Department of Health and Mental Hygiene, 2013; Population Data from U.S. Census Bureau, 2010 Demographic Profile

Life expectancy by county within the CBSA: Montgomery County = 83.8 years; Prince George's County = 77.5 years
Source: State Health Improvement Process (SHIP), Maryland Department of Health and Mental Hygiene, VSA 2009





Source: Institute for Health Metrics and Evaluation (IHME). United States Adult Life Expectancy by State and County 1987-2009. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2012

Mortality Rates/100,000 by county within the CBSA (including by race and ethnicity where data are available:

Montgomery County

All Cause Death Rate: 530.4

Males: All races, ethnicities, and ages combined

Cause	Rank	Rate
Diseases of the Heart	1	154.9
Malignant Neoplasms	2	152.0
Major Non-Cardiac Vascular Diseases	3	44.7
Accidents	4	24.4
Influenza and Pneumonia	5	20.6

Females: All races, ethnicities, and ages combined

Cause	Rank	Rate
Malignant Neoplasms	1	119.6
Diseases of the Heart	2	107.5
Major Non-Cardiac Vascular Diseases	3	38.0
Chronic Lower Respiratory Disease	4	16.3
Alzheimer's Disease	5	16.3

Prince George's County

All Cause Death Rate: 760.3

Males: All races, ethnicities, and ages combined

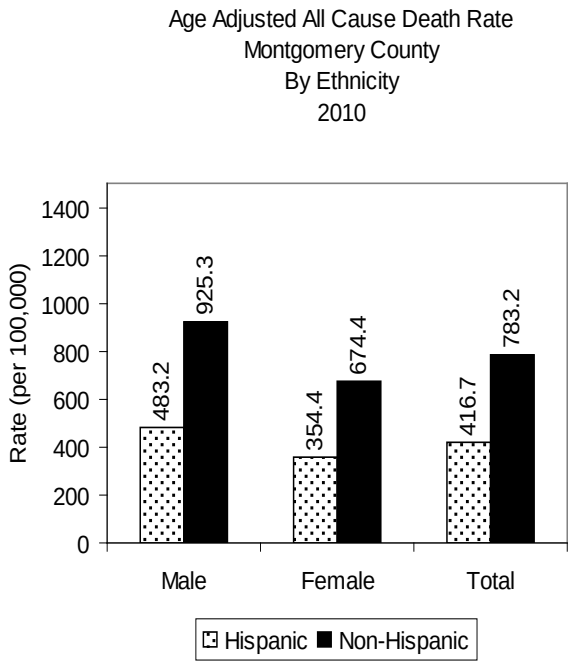
Cause	Rank	Rate
Diseases of the Heart	1	249.3
Malignant Neoplasms	2	218.2
Major Non-Cardiac Vascular Diseases	3	52.9
Accidents	4	33.9
Chronic Lower Respiratory Disease	5	33.9

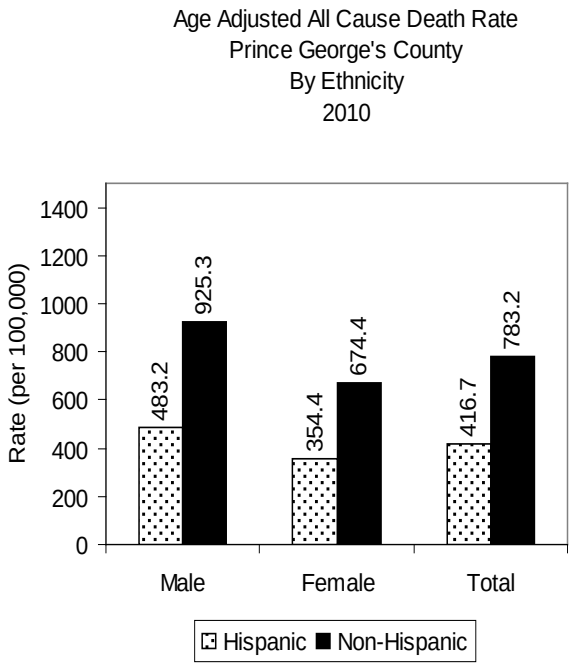
Females: All races, ethnicities, and ages combined

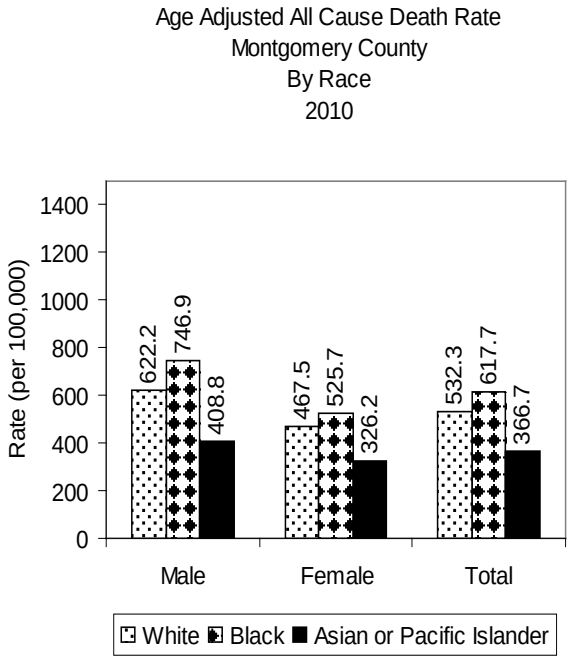
Cause	Rank	Rate
Diseases of the Heart	1	176.5
Malignant Neoplasms	2	150.1
Major Non-Cardiac Vascular Diseases	3	52.3
Diabetes Mellitus	4	29.1
Chronic Lower Respiratory Disease	5	21.9

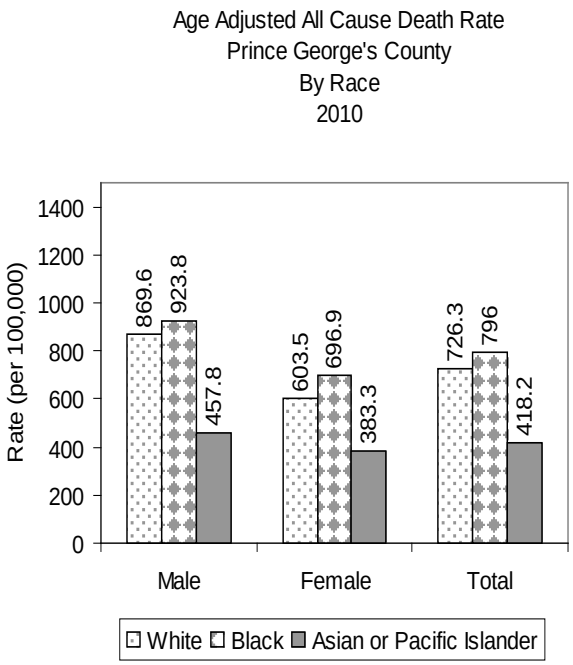
Source: Maryland Family Health Administration, Maryland Assessment Tool for Community Health, 2010

Mortality Rates/100,000 by county within the CBSA:









Source: Maryland Family Health Administration, Maryland Assessment Tool for Community Health, 2010

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)	(See Table II Supplements A)

Available detail on race, ethnicity and language within CBISA from SHIP County profiles for demographic information of Maryland jurisdictions.

Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	971,777	863,420	5,773,552
Age*, %			
Under 5 Years	6.6%	6.8%	6.3%
Under 18 Years	24.0%	23.9%	23.4%
65 Years and Older	12.3%	2.9%	12.3%
Race/Ethnicity, %*			
White	57.5%	19.2%	58.2%
Black	17.2%	64.5%	29.4%
Native American	00.4%	0.5%	0.4%
Asian	13.9%	4.1%	5.5%
Hispanic or Latino origin	17.0%	14.90%	8.20%
Median Household Income**	$92,451	$70,384	$70,017
Households in Poverty**, %	6.3%	7.2%	8.6%
Pop. 25+ Without H.S. Diploma**, %	9.6%	14.6%	12.1%
Pop. 25+ With Bachelor's Degree or Above**, %	56.2%	28.8%	35.6%
Language other than English spoken at home, pct age 5+***	37.5%	19.6%	15.9%

Sources: *U.S. Census (2010), **American Community Survey (2008-2010), ***American Community Survey (2006-2010)

Other:	(See Table II Supplements B and C)

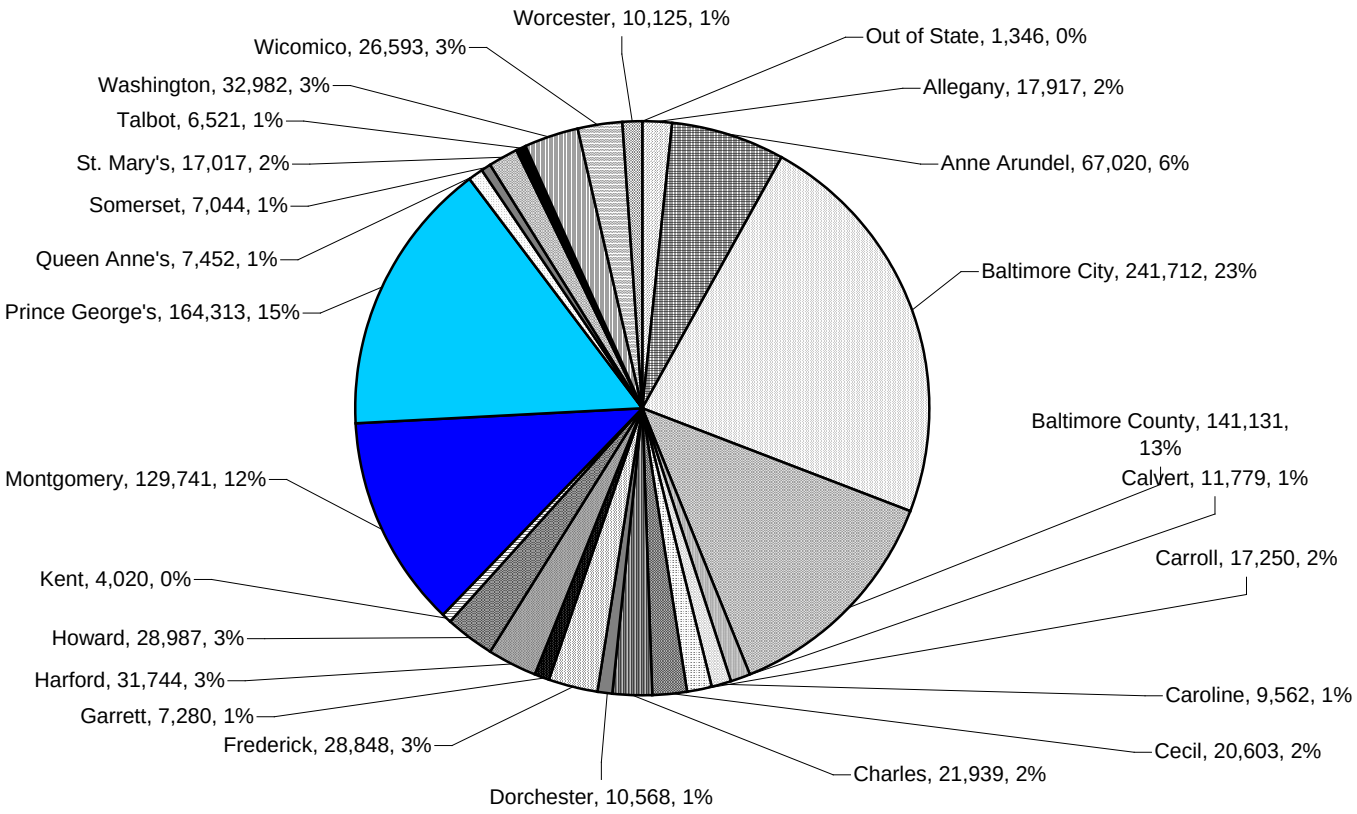
Table II Supplement A
State Health Improvement Process Measures

	Obj #	SHIP Measure (County Baseline Source)	Montgomery County Baseline	Prince George's County Baseline	Maryland Baseline	National Baseline	County by Race/ Ethnicity*	Maryland Target 2014	% Diff from Maryland Baseline	% Diff from National Baseline
Healthy Babies	1	Life expectancy at birth (VSA 2009)	83.8	77.5	78.6	77.9		82.5	6.6	7.6
	2	Infant Mortality Rate per 1,000 births(VSA 2007-2009)	5.7	10.4	7.2	6.7	White/NH-4.9 Black-11.3 Asian- 4.4 Hispanic-2.6	6.6	20.8	14.9
	3	Percentage of births that are LBW (VSA 2007-2009)	8.00%	10.60%	9.20%			8.50%		
	4	Rate of SUIDs (includes deaths attributed to Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB) and deaths of unknown cause) per 1,000 births (VSA 2005-2009)	0.5	0.9	1	0.9		0.89	54.6	49.6
	6	Percentage of births where mother received first trimester prenatal care (VSA 2007-2009)	82.80%	67.00%	80.20%			84.20%		
Healthy Social Environments	7	Rate of indicated non-fatal child maltreatment cases reported to social services per 1,000 children under age 18 (Dept of Human Resources FY2010)	3.2	3.6	5	9.4		4.8	35.6	65.7
	8	Rate of suicides per 100,000 population (VSA 2007-2009)	7.1	6.3	9.6	11.3		9.1	25.9	37
	9	Rate of deaths associated with fatal crashes wheredriver had alcohol involvement per 100 million Vehicle Miles of Travel (SHA 2009)	***, 11 (Count only)	0.3	0.27	0.4		0.27	N/A	N/A
	10	Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011)	74.00%	79.00%	81.00%	N/A		85.00%	-8.6	N/A
	11	Percentage of students who graduate high school four years after entering 9th grade (MSDE 2010)	85.00%	73.30%	80.70%			84.70%		
	12	Rate ED visits related to domestic violence/abuse per 100,000 population (HSCRC 2010)	30.7 ##	62.7 ##	69.6	N/A		66	55.9	N/A
Safe Physical Environments	13	Rate of new (incident) cases of elevated blood lead level in children under 6 per 100,000 (MDE 2009)	28.7	74.6	79.1	N/A		39.6	68.8	N/A
	14	Rate of deaths associated with falls per 100,000 population (VSA 2007-2009)	7.7	4.6	7.3	7		6.9	-5.1	-9.6
	15	Rate of pedestrian injuries (SHA 2007-2009)	44.2	47.8	39	22.6		29.7	-13.3	-95.6
	16	Rate of Salmonella infections per 100,000 (IDEHA 2010)	13.7	11.7	18.8	15.2		12.7	27.1	9.87
	17	Rate of ED visits for asthma per 100,000 population (HSCRC 2010)	406.0 ##	717.0 ##	850			671		
	18	Percentage of census tracts with food deserts (USDA 2000)	1.10%	13.6%	5.80%	10.00%		5.50%	81	89
	19	Number of days per year the AQI exceeded 100; not all counties are measured for AQI (EPA 2008)	5	N/A	8.4	11		8	40.5	54.5
Infectious Disease	20	Rate of new (incident) cases of HIV in persons age 13 and older per 100,000 (IDEHA 2009)	18.8	56.4	32	N/A		30.4	41.2	N/A
	21	Rate of Chlamydia infection for all ages per 100,000 (IDEHA 2009)	198.2	631	416.7	N/A	White- 101.6 Black-410.2 Asian- 50.9 Hispanic- 246.2 (all ages)	N/A	52.4	N/A
	24	Percentage of adults who have had a flu shot in last year (BRFSS 2008-2010)	49.20%	33.90%	43.00%	25.00%	White/NH-55.2% Black- 37.3% Hispanic- 40.2%	61.50%	14.4	96.8
Chronic Disease	25	Rate of heart disease deaths per 100,000 population (age adjusted) (VSA 2007-2009)	130.2	224.2	194			173.4		
	26	Rate of cancer deaths per 100,000 population (age adjusted) (VSA 2007-2009)	130.1	173.8	177.7			169.2		
	27	Rate of ED visits for diabetes per 100,000 population (HSCRC 2010)	168.8 ##	308.4 ##	347.2			330		
	28	Rate of ED visits for hypertension per 100,000 population (HSCRC 2010)	123.3 ##	257.7 ##	237.9			225		
	29	Rate of drug-induced deaths per 100,000 population (VSA 2007-2009)	5.9	6.1	13.4	12.6		12.4	56	53.2
	30	Percentage of adults who are at a healthy weight (not overweight or obese) (BRFSS 2008-2010)	47.70%	28.60%	34.00%	30.80%		35.70%		
	31	Percentage of youth (ages 12-19) who are obese (MYTS 2008)	8.40%	17.90%	11.90%			11.30%		
	32	Percentage of adults who currently smoke (BRFSS 2008-2010)	7.80%	20.60%	15.20%			13.50%		
	33	Percentage of high school students (9-12 grade) that have used any tobacco product in the past 30 days (MYTS 2010)	19.20%	26.00%	24.80%			22.30%		
	34	Rate of ED visits for a behavioral health condition per 100,000 population (HSCRC 2010)	741.2 ##	713.1 ##	1,206.30			1,146.00		
	35	Rate of hospital admissions related to dementia/ Alzheimer's per 100,000 population (HSCRC 2010)	9.4	11.5 ##	17.3	N/A		16.4	45.9	N/A
Healthcare Access	36	Percentage of civilian, non-institutionalized 18-64 yr olds with any type of health insurance (BRFSS 2008-2010)	87.60%	82.20%	86.50%			90.90%		
	38	Percentage of children 4-20 yrs enrolled in Medicaid that received a dental service in the past year (Medicaid CY2009)	66.80%	57.80%	59.00%			62.00%		
	39	Percentage of people who reported there was a time in the last 12 months they could not afford to see a doctor (BRFSS 2008-2010)	11.00%	15.80%	12.00%			11.40%		

Figures in Red/Green represent when the county baseline is worse/better than the sate and national baselines.
Three-year rolling averages are presented for many of the measures as a means to display more stable data (less year-to-year variation) while showing change over time. Data details for figures found in "National Baseline" and "Maryland Baseline" columns can be found on the Maryland SHIP webpage under MEASURES at http://dhmh.maryland.gov/ship/measures.html.
Only visits made by Maryland residents to Maryland hospitals were used for the analysis; visits made by Maryland residents to out-of-state hospitals were not included. Actual rates are likely to be higher.
* Race/ethnicity definitions based on the sources of data used. Hispanic origin can be from any race; White/NH denotes those who are
both White and of Non-Hispanic origin.
***Rates based on counts less than 20 are not shown due to instability.
^ Maryland baseline value for Objective #36 - Proportion of persons with health insurance -- has been adjusted to allow for comparison with county level data.
Percent difference formula: $\frac{x\ \text{county} - x\ \text{state}}{x\ \text{state}} \times 100$

Table II Supplement B

FY13 Average Number of All Medicaid Eligible Persons Per Month by County
Average for the State = 1,063,491



Source: Maryland Medicaid eHealth Statistics, Maryland Department of Health and Mental Hygiene, 2013

Table II Supplement C
CDC COUNTY HEALTH RANKING DATA GRID

Measures	Montgomery County	Prince Georoge's County	Maryland	US Benchmark/ Target	Source
HEALTH OUTCOMES					
MORTALITY					
Years of potential life lost/100,000 pop.	4,094	8,374	7,537	5,564	National Center for Health Statistics (NCHS)
MORBIDITY					
% Adults reporting fair or poor health	9%	12%	13%	10%	Behavior Risk Factor Serveillance System (BRFSS)
Avg. physically unhealthy days/month	2.7	3	3.2	2.6	BRFSS
Avg. mentally unhealthy days/month	2.6	3	3.3	2.3	BRFSS
% Live births with low birth weight <2500g	8.0%	10.5%	9.1%	6.0%	NCHS
HEALTH FACTORS					
HEALTH BEHAVIORS					
Tobacco: % Adults reporting currently smoking	10%	16%	18%	15%	BRFSS
Diet & Exercise: % Adults reporting obesity (BMI > 30)	19%	32%	27%	25%	National Center for Disease Prevention & Health Promotion (CDC)
Alcohol Use: %Adults reporting binge drinking	13%	10%	15%	8%	BRFSS
Motor-vehicle related mortality/100,000 pop.	7	17	13	12	NCHS
Hi-Risk Sexual Behavior: Births/1,000 teen females, ages 15-19	20	38	34	22	NCHS
New Chlamydia cases/100,000 pop.	207	638	439	83	NCHS
Access to Care: % Adults 18-64 without insurance	17%	22	17	13	Small Area Health Insurance Estimates
Quality of Care: discharges for ambulatory care sensitive conditons/1,000 Medicare en	44	62	70	52	Medicare/Dartmouth Institute
% Diabetic Medicare enrollees receiving HbA1c test	83%	76%	81%	89%	Medicare/Dartmouth Institute
% Chronically ill Medicare enrollees admitted to hospice in last 6 mos. of life	27%	23%	28%	35%	Medicare/Dartmouth Institute
SOCIOECONOMIC FACTORS					
Education: % high school students graduating in 4 yrs	85%	70%	80%	92%	National Center for Education Statistics
% Population age 25+ with 4-year college degree or higher	56%	30%	35%	34%	Census/American Community Survey (ACS)
Employment: % Population age 16+ unemployed & looking for work	5.3%	6.9%	7.0%	5.3%	Bureau of Labor Statistics
Income: % Children (<age 18) living in poverty	7%	8%	10%	11%	Small Area Income & Poverty Estimates
Gini coefficient of household income inequality (multiplied by 100)	44	38	44	38	Census/ACS
Family & Social Support: % Adults reporting not getting social/emotional support	19%	24%	21%	14%	BRFSS
% Households that are single-parent households	22%	40%	32%	20%	Census/ACS
PHYSICAL ENVIRONMENT					
Air Quality: # Days air quality was unhealthy due to fine particulate matter	0	4	4	0	Environmental Protection Agency (EPA)/CDC
# Days that air quality was unhealthy due to ozone	10	29	16	0	EPA/CDC
BUILT ENVIRONMENT					
% Zip Code in county with healthy food outlet	74%	91%	62%	92%	Zip Code Business Patterns
Liquor stores/10,000 pop.	12	18	20	n/a	County Business Patterns
Recreation Facilities/100,000 pop.	15	8	12	17	County Business Patterns

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

For the purposes of this report, the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-

based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);
A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and
A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Examples of sources of data available to develop a CHNA include, but are not limited to:

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

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the Public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need; or
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

   _X_ Yes
   ____No

   Provide date here. 10/27/11 (mm/dd/yy)

   If you answered yes to this question, provide a link to the document here.

   http://www.holycrosshealth.org/documents/community_involvement/HCH_CommunityHealthNeedsAssessment_FY13.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

   _X_ Yes
   ___No

   If you answered yes to this question, provide the link to the document here.

   http://www.holycrosshealth.org/documents/community_involvement/HCH_CommunityBenefitImplementationStrategy_FY13.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

   _X_ Yes
   ___No

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

   i. Senior Leadership

      1. _X_ President & CEO, Holy Cross Health
      2. _X_ CFO, Holy Cross Health

3. _X_Other (Chief Strategy Officer, Holy Cross Health; Chief Mission Officer, Holy Cross Health; Chief Executive and Governance Operations, Holy Cross Health; Vice President, Community Health, Holy Cross Health; President, Holy Cross Hospital; Vice President, Revenue Cycle Management, Holy Cross Health; President, Holy Cross Health Network; Vice President, Operations, Holy Cross Health Network;)

ii. Clinical Leadership

1. _X Physician (Medical Director, Community Care Delivery, Holy Cross Health Network)
2. _X Nurse (Chief Nursing Officer, Holy Cross Hospital; Senior Director, Women's and Children's Services, Holy Cross Hospital; Directors, HCH Health Centers at Silver Spring, Gaithersburg and Aspen Hill, Holy Cross Health Network)
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _X_ Individual (Manager, 1.0 FTE)
2. ___Committee (please list members)
3. ___Other (please describe)

The CEO Review Committee on Community Benefit meets quarterly made up of all individuals listed above. Community Benefit Operations is administered by the Manager, Community Benefit with oversight by the Chief Strategy Officer and the Vice President, Community Health. The Vice President, Community Health also serves as the Chief Community Benefit Officer.

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

In addition, it undergoes an external audit as part of the audited financials.

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

Spreadsheet __X_yes ____no
Narrative __X_yes ____no

If you answered no to this question, please explain why.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES
This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached examples of how to report.

For example: for each principal initiative, provide the following:

a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (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. How 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 to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

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

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

Initiative 1.

Identified Community Need: Cancer – viewed through the lenses of lack of access and health inequities

Incidence and death rates for all cancers have been declining due to advances in research, detection and treatment, yet cancer remains a leading cause of death in the United States (U.S. Department of Health and Human Services, 2010). It is also the second leading cause of death for both Montgomery and Prince George's Counties residents (Vital Statistics, 2009) and is the top leading cause of death among Montgomery County Asians and Pacific Islanders. The burden of battling cancers within our community varies; with disparities clearly present (DHHS, 2011). For example, in Montgomery County almost 19% more White women are diagnosed with breast cancer each year when compared to African American/Black women, however, 50% more African American/Black women in the county die from breast cancer when compared to White women. The incidence and death rates between counties also shows disproportionate results. Montgomery County has a 10.5 % higher incidence rate of breast cancer when compared to Prince George's County; however, the death rate for Prince George's County is 40% higher when compared to Montgomery County.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Komen - Community Assisted Mammogram Program (K-CAMP)	Overarching Objective: To reduce breast healthcare disparities in low-income, medically underserved, uninsured racial and ethnic women and men. To provide high quality, culturally competent outreach and education to 30,000 individuals over three years. ▪ To provide early detection of breast cancer by screening 2,250 individuals over three years. ▪ To provide high quality, culturally competent and comprehensive breast health care navigation and case management services to an estimated 450 uninsured or underinsured racial and ethnic	Multi-Year CY2010-CY 2013 (YTD June 30, 2013)	▪ Holy Cross Health d/b/a Holy Cross Hospital ▪ Diagnostic Medical Imaging, PA ▪ Holy Cross Health Centers: Aspen Hill, Gaithersburg and Silver Spring ▪ Community Clinic Inc. ▪ Community Ministries of Rockville's Mansfield Kaseman Clinic ▪ People's	FY2013	<u>Process</u> - Average time from diagnosis to treatment is three weeks. - Case management and navigation services were provided for 227 participants with abnormal findings. - 55,756 participants were educated. - Achieved 100% success rate in linking low-income eligible participants with symptoms to the State of Maryland Breast and Cervical Cancer Diagnosis and Treatment Program for annual medical expense coverage.	Dependent upon grant funding	$187,282

	women over three years.		Community Wellness Center ▪ Proyecto Salud, Wheaton ▪ CASA de Maryland, Inc. ▪ Montgomery County Minority Health Initiatives: - African American Health Program - Asian American Health Initiative		<u>Impact</u> K-CAMP: - 899 mammograms (631 screening, 268 diagnostic), - 188 breast ultrasounds, - 192 surgical referrals - 7 diagnosed cancers		

Initiative 2.

Identified Community Need: Cardiovascular health – viewed through the lens of unhealthy behaviors As the senior population increases in Montgomery and Prince George's Counties, the need for senior health services also increases. It is estimated that by the year 2030 the 60+ population in Montgomery and Prince George's Counties will increase by 142% (316,495) and 162% (236,973), respectively (Maryland Department of Planning Population Projections, 2008). Currently, the two counties also have the second and third highest percentage of senior minorities in the state with 24.4 percent residing in Prince George's County and 15.7 percent in Montgomery County. Older adults are at high risk for developing chronic illnesses and related disabilities and experience disproportionate rates of heart disease, cancer, diabetes, congestive heart failure, arthritis and dementia (including Alzheimer's). For example, one out of every two Montgomery County senior residents, 65 years and older, has hypertension. African American /Black adult residents are approximately one and a half times more likely (39.9%) than White residents (24.6%), twice as likely as Asian/Pacific Islander residents (17.1%) and three times more likely than Hispanic/Latino residents (14.4%) to experience high blood pressure.							
Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Senior Fit	Overarching Objective: provide age appropriate exercise classes to minimize symptoms of chronic disease and improve strength, flexibility and cardiovascular endurance and encourage self-management. ▪ To improve the health of older adults in our community by offering free, accessible exercise classes designed to increase strength and flexibility. ▪ To reduce the pain level of people with chronic illness and pain. ▪ To teach self-management skills related to physical activity. ▪ To improve socialization of	Multi-Year, in operation since 1995	▪ Holy Cross Health d/b/a Holy Cross Hospital ▪ Kaiser Permanente of the Mid-Atlantic States ▪ Montgomery County Department of Recreation (community and senior centers) ▪ Maryland National Capital Park and Planning Commission (community and senior centers) ▪ Faith-Based	Process – 2013 Impact – 2012	<u>Process</u> - 2,801 enrolled participants - 68 weekly classes held at 23 sites with average daily attendance of 1,016 - 102,657 encounters during FY13 - Approximately 50% participants are aged 70 - 79 - Weighted Community Need Index score for all participants is 2.85. - 79% Female, 21% Male - 19% Asian American, 20% Black/African American, 3% Hispanic/Latino American, 56% White Non-Hispanic, 2% other <u>Impact</u>	Yes	$265,410

	participants and reduce social isolation. ▪ To build a referral network among physicians, nurses, community center staff and allied health professionals.		Organizations ▪ Retirement Communities ▪ Housing Opportunities Commission, Montgomery County		Participants complete the evidence-based Rikli and Jones Senior Fitness Test twice a year to measure <u>functional fitness</u> by assessing: upper body strength (arm curl), lower body strength (chair stand), upper body flexibility (back scratch) and speed and agility (8-foot up and go). The April 2012 results showed: - 742 participants completed the test - 86% scored above or within standard on all of the tests - Results strongly indicate participants have the ability to maintain an independent lifestyle. Results from the FY13 <u>qualitative evaluation</u> showed: - 22% (172) of the 780 respondents reported that they participate in *Senior Fit* because it was recommended by their physician - 92% reported improved strength - 94% reported better flexibility - 75% reported a decrease in pain. - 89% reported improvement in		

					balance - 85% reported improvement in ability to handle activities of daily living Information on health care utilization: - 70% visited a physician in the past 3 months (planned visit). - 5% were treated at an emergency room in the past 3 months (unplanned provider visit) - 2% stayed in the hospital overnight or longer in the past 3 months - 9% were admitted to a hospital in calendar year 2012 The three most common chronic diseases among participants were hypertension (44%), arthritis/rheumatic disease (36%) and osteopenia/osteoporosis (27%).		

Initiative 3.

Identified Community Need: Obesity – viewed through the lens of unhealthy behaviors and health inequities

During the past twenty years, obesity rates have increased in the United States; doubling for adults and tripling for children (see Figure 7). More than 50% of Montgomery County residents and more than 65% of Prince George's County residents are overweight or obese. Obesity affects all populations, regardless of age, sex, race, ethnicity and socioeconomic status (U.S. Department of Health and Human Services, 2010), however, disparities do exist and rates are affected by race/ethnicity, sex and age.

Men (61%) are more likely to be at least overweight. Seven out of every ten Hispanic/Latino adults and African American/Black adults are either overweight or obese. Obesity levels (BMI at or above 30.0 see figure 8) are lowest among the Asian/Pacific Islander adults (2.6%) and highest among African American/Black (28%) and Hispanic/Latino American adults (30%). Men and adults aged 45-64 are also less likely to engage in 30 minutes of moderate activity for 30 minutes or more per day. Hispanic/Latino adults (39.7%) and White adults (35.2%) are more likely than Asian/Pacific Islander (25.3%) and African American/Black (29.1%) adults to engage in at least light-to-moderate physical activity.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Kids Fit	Increase awareness of healthy behaviors and provide exercise classes to prevent or decrease obesity in children aged 6-12.	Multi-Year, in operation since 2008	▪ Holy Cross Health d/b/a Holy Cross Hospital ▪ Montgomery County Housing Opportunities Commission sites: ▪ Georgian Court ▪ Olney Towne ▪ Center ▪ Shady Grove Center ▪ Stewartown Homes	Jan. and June 2013	<u>Process</u> - 120 enrolled participants - 8 weekly classes held at 5 sites - 5,295 encounters for FY13 - Age of participants: 6 - 12 - Majority of participants are Black/African American and Hispanic/Latino American <u>Impact</u> - At every class, participants receive healthy lifestyle information and a nutritious snack. - Participants are tested twice a year using the evidence-based President's Challenge Fitness test which measures upper body strength (push-ups), core strength (curl ups), speed and agility (shuttle run) and hamstring flexibility (sit and reach). FY12 test scores showed an improvement:	Yes	$59,527

			▪ The Willows		8% for girls; 7% for boys		

Initiative 4.

Identified Community Need: Cardiovascular disease and diabetes – viewed through the lens of unhealthy behaviors Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, they are also among the most preventable (U.S. Department of Health and Human Services, 2010). In Montgomery and Prince George's Counties heart disease is the leading cause of death and stroke is the third leading cause of death. Heart disease is the leading cause of death for African American/Black, Hispanic/Latino American and White residents and is the second leading cause of death among Asian and Pacific Islander residents. African American/Black residents die from stroke at a rate that is 15% (34.4 deaths per 100,000 population) higher than White residents (29.8 per 100,000 population) and more than double the rate experienced by Hispanic/Latino residents (14.5 per 100,000 population). Men are disproportionately affected by heart disease mortality with a death rate that is more than 50% higher than it is for women. (167.5 deaths per 100,000 population vs. 106.2 per 100,000 population, respectively). African Americans/Blacks are also disproportionately affected by heart disease mortality. The mortality rate for African Americans/Blacks (159.5 per 100,000 population) is three times the rate Hispanic/Latino American residents (53.9 per 100,000 population) and more than doubles the Asians and Pacific Islanders rate (71.7 per 100,000 population). Diabetes Mellitus affects an estimated 23.6 million people in the United States and is the 7th leading cause of death (CDC, 2008) It is the ninth leading cause of death in Montgomery County and the fourth leading cause of death in Prince George's County (Maryland Vital Statistics, 2009). Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. It is also the leading cause of kidney failure, lower limb amputations and adult-onset blindness (U.S. Department of Health and Human Services, 2010).

Further analysis of Montgomery County data reveals that it is the fourth leading cause of death among African Americans/Blacks, fifth leading cause of death among Hispanics/Latinos, and sixth leading cause of death among Asians and Pacific Islanders (DHHS, 2011). African American/Blacks also die from diabetes more often when compared to the overall county (see Figure 6). The mortality rate (28.8/100,000) for African American/Black residents is more than twice the overall county rate (12.7/100,000). Among African American/Black women, diabetes is the third leading cause of death. The overall mortality rate for Prince George's County is 31.4/100,000.							
Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Stanford University's evidence-based: **Chronic Disease Self-Management Program (CDSMP)**	Overarching Objective: To enable participants to build self-confidence and assume a major role in maintaining their health and self-managing their chronic health conditions. ▪ To increase healthy behaviors (i.e., exercise and cognitive symptom management techniques, such as relaxation) ▪ To attain a positive change in health status (less pain and fatigue) ▪ To achieve a positive change in self-esteem (less worry and health distress) ▪ To increase self-efficacy To have better communications with health providers ▪ To have fewer emergency	Multi-year, in operation since 2007	▪ Holy Cross Health d/b/a Holy Cross Hospital ▪ Montgomery County Department of Health and Human Services ▪ Maryland Department on Aging ▪ Holy Cross Health Foundation	Pre- and post-tests are completed for each 6-week workshop	<u>Process</u> - 5 workshops were held in FY13 - 44 participants - 36 completers - 181 encounters - Average age of participants: 76 - 64% Non-Hispanic White, 20% Black/African American and 8% Asian American - Peer leaders who took the update training: 12 - ZIP codes for sites: 20832, 20877, 20878, 20904 - Master trainers for program: 3 <u>Impact</u> (evidence-based program): - Increased exercise - Better coping strategies and symptom management - Better communication with their physicians - Improvement in their self-rated health, disability, social and role activities, and health distress - More energy and less fatigue - Decreased disability - Fewer physician visits and hospitalizations After 2 years: - No further increase in disability	Yes	$58,849

	room and unplanned medical provider visits				- Reduced health distress - Fewer visits to physicians and emergency rooms - Increased self-efficacy. *Chronic Disease Self-Management: A Toolkit for Hospitals* was developed by Holy Cross Hospital to assist other hospitals and community organizations in rolling out the CDSMP. The toolkit is available on the Agency for Healthcare Research and Quality (AHQR) and the National Council On Aging websites. An article on the toolkit was published in *The Case Manager's Guide to Readmissions published by Dorland Health* in November of 2012.		

Initiative 5.

Identified Need: Lack of access

Despite the median income of both Montgomery and Prince George's Counties being well above the national average, many residents are without health insurance. Barriers like lack of health insurance and the high cost of medical care decrease access to quality health care and can lead to unmet health needs. This includes delays in receiving appropriate care, inability to get preventive services, and potentially preventable hospitalizations thus increasing mortality and morbidity (HHS, 2010). Approximately 10% of Montgomery County residents and 15% of Prince George's County residents were without health insurance; however, racial disparities exist in both counties (see figure 4). Hispanics are more than five times as likely to be without health insurance in Montgomery County and more than two and a half times as likely in Prince George's County when compared to their White counterparts. Almost 65% of the Montgomery County uninsured population and almost 60% of the Prince George's County uninsured population come from households with combined incomes of less than $75,000 annually. Montgomery County has the largest number of non-citizen residents (64,000) with no health insurance among all the jurisdictions in Maryland with 38% of the State's 170,000 non-citizen residents with no health insurance (Healthy Montgomery, 2011). In addition to high rates of uninsured, one in every five adults (18-44 years), one in every four Hispanic/Latino adults, one in every six African American/Black adults, and one in every six adult males living in Montgomery County reported they were unable to see a doctor in the past year because they could not afford it (Healthy Montgomery, 2011). Almost all Community Conversation groups ranked affordable/accessible health care as a priority. Concerns about poverty, employment, income and transportation created anxiety about health care access.

Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Transitional Care Program	Overarching Objective: To prevent hospital readmission within 30 days upon discharge from the hospital to home. ▪ To link established *and* new (never have been seen at our health centers) uninsured patients to primary care at one of our three health centers. ▪ To facilitate the coordination of care	Multi-Year, in operation since 2010	▪ Holy Cross Health, Community Health ▪ Montgomery Cares ▪ Holy Cross Hospital Health Centers in: - Silver Spring - Aspen Hill - Gaithersburg	FY2013	<u>Process</u> - 1,889 people met program criteria (not: obstetrical, pediatric, skilled care, palliative care, hospice, or admitted to another facility) - 369 (20%) were established HCH Health Center patients - 624 (33%) were new HCH Health Center patients - 896 (47%) received follow-up care outside of HCH or with no confirmed follow-up care - 1,540 (82%)received successful telephone contacts - 1,474 (78%) had confirmed appointments within first week of discharge or as directed	Yes	$163,032

	by a certified health coach to ensure health center follow-up, patient education, accessible medication and medication management, and transportation assistance to provider appointments ▪ To link the patient to self-care management programs.				by the discharge instructions - 1,334 (90%) appointments kept overall including 539 patients that are new to the HCH Health Centers. <u>Impact</u> Rate of readmissions in ≤ 30 days: 7.8%		

2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Healthy Montgomery, the health improvement process for Montgomery County organized a steering committee of representatives from county government agencies, county boards, committees and commissions, non-profit organizations, local health providers, and hospitals. The steering committee used data collected from 100 indicators to determine the most pressing needs of the county. These data are organized into 13 categories: access to health services; cancer; diabetes; exercise, nutrition and weight (obesity); heart disease and stroke; maternal, fetal and infant health; family planning; immunizations and infections disease; mental health and mental disorders; respiratory diseases; substance abuse and illicit drug use; wellness and lifestyle; and prevention and safety.

The Healthy Montgomery steering committee conducted a priority setting process and identified six priority community needs based on three lenses, unhealthy behaviors, lack of access and health inequities; six categories emerged as top priorities. The top priorities selected are behavioral health, cancers, cardiovascular health, diabetes, maternal and infant health, and obesity. We took this information and juxtaposed our strengths with the identified needs and incorporated five of the six top priorities into our community benefit plan and chose to add access to health services as a top priority for hospital programming. The top priorities of the hospital are access to health services, cancer, diabetes, obesity, cardiovascular health, and maternal and infant health.

We recognize that we cannot pursue all of the identified health needs and that choices need to be made. We made choices using a rigorous process to ensure that documented unmet community health needs intersect with our mission commitments and key clinical strengths (see figure 1). At this time, behavioral health has not been incorporated into our community benefit plan because it is not a key clinical strength of the hospital and we do not have the infrastructure needed to sustain programs that would make an impact in this area. Although we currently cannot sustain programs aimed to improve the behavioral health of the county, Holy Cross will continue to participate in the ongoing needs assessment process to determine how we can play a role in improving outcomes in this area.

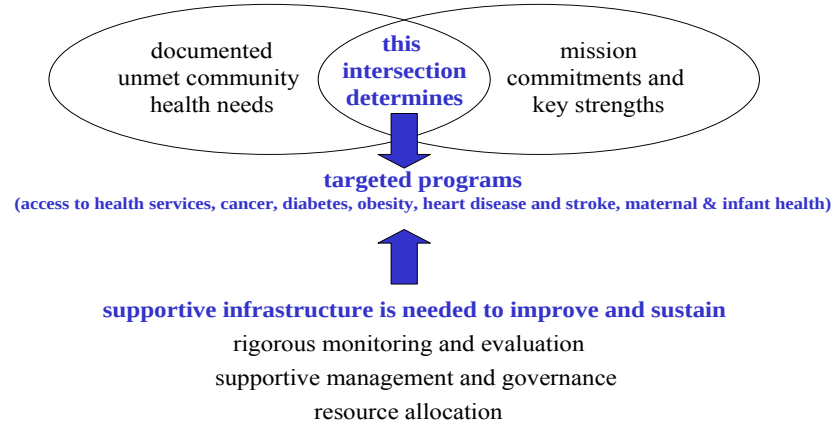


Figure 1. HCH's approach to meeting community health needs aligned with the strengths of the hospital.

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.

Providing care for uninsured patients is challenging for many of the independent medical staff members, especially by "on call" specialty physicians in the emergency center who feel the liability and financial burden of caring for these patients is too great.

Inpatient specialty care is provided by specialty physicians, hospitalists, and other professional staff that provide care in the following specialties: Neurology, cardiology, pulmonary, orthopedics, dermatology, infectious disease, oncology, hematology, medical imaging, laboratory, infusion center, anesthesiology, pre-surgical testing, surgery, obstetrics, gynecology, physical therapy, home care, hospice, patient education, pharmacy, sleep lab, electrocardiogram, and pain management. Gaps will occur when the ratio of uninsured patients to insured patients threatens sustainability.

Uninsured outpatients have access to hospital services but are in need of outside resources for most of their specialty care. All three of the Holy Cross Hospital Health Centers, the only safety net clinics in the county operated by a hospital, are fortunate to have experienced, full-time physicians who are able to treat and manage many of the patients requiring specialty care. The Holy Cross Hospital Health Centers are able to provide specialty care in neurology, orthopedics, hematology, ophthalmology, and otorhinolaryngology on-site, on a limited basis. These specialists can accommodate the immediate needs of the health centers. Nurses also report having a difficult time referring patients for urology.

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.

In order to meet the needs of the uninsured/underinsured population, Holy Cross Hospital has approximately 100 physician contracts for the provision of on-call clinical services as needed. These services are provided on a 24-hour/7-day a week basis, operate on a negative margin and are frequently used by the uninsured/underinsured population. If subsidies were discontinued, the following services would not be available and patients would need to be transported to other facilities or have unmet needs:

Category One: Hospital-based physician subsidies with which the hospital has an exclusive contract and/or subsidy in order to retain services that represent a community benefit

- We provide a $366,803 subsidy to anesthesiology to bring in a third (or more) anesthesiologist in off hours. This is required in part because of our very large maternity partnership program that serves uninsured, pregnant women and our very busy emergency department that drives off-hours demand for specialty care, disproportionately by uninsured patients.

Category Two: Non-Resident house staff and hospitalists

- The hospital contracts/employs non-resident house staff and hospitalists and medical directors to provide inpatient services, including night coverage to admit and cover the uninsured/underinsured population. In FY13, Holy Cross Hospital provided a net benefit of $1,244,370.
- The hospital contracts/employs pediatric hospitalists to meet the inpatient need of uninsured/underinsured infants and children. In FY13, Holy Cross Hospital provided a net benefit of $1,347,144.

Category Three: Coverage of Emergency Department call

- The hospital contracts with individual physicians and physician groups to ensure the needs of the uninsured/underinsured population are met by providing subsidies for the coverage of emergency department calls. In FY13, Holy Cross Hospital provided a net benefit of $2,392,905 to ensure medical directors and emergency coverage in the following specialty areas:
    - General Surgery, Orthopedic Surgery, Neurology/Stroke Care, Neurosurgery, ENT, Oral Surgery, Interventional Cardiology, Plastic Surgery, Urology, Ophthalmology, Vascular Surgery, Thoracic Surgery, Psychiatry and Anesthesiology

Category Four: Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

- No additional subsidies provided beyond those described above, however, all hospital based contracted physicians and on-call physicians follow the hospital's charity care policy.

Category Five: Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- No subsidies provided

VI. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

Financial Assistance Policy Description

All Holy Cross Hospital registration, financial counseling and customer service staff members are trained to be familiar with the availability of financial assistance and the criteria for such assistance.

In addition:

- The financial assistance application and information about the program are prominently displayed in all registration areas, the emergency center and each cashier's office. The information available is offered in both English and Spanish, the predominant languages in our patient population at Holy Cross Hospital.
- Material describing the financial assistance program and an application are to be given or sent to all patients who request this information.
- Staff is responsible for being particularly alert to those who are registered as self-pay patients and provide them with information on how to contact a financial counselor or provide them financial assistance information. All financial assistance applicants are screened for eligibility for federal, state or other local programs before financial assistance is offered.
- All financial counselors are bilingual (English/Spanish).
- The financial assistance application is accessible through the hospital's external website
- Notice of financial assistance availability is indicated on all hospital billing statements
- Holy Cross Hospital uses community-based culturally competent health promoters that inform community members about our financial assistance policy on a one-on-one basis or in group settings where people gather in the community (e.g., hair salons, churches, community centers).
- A written notice is published annually in local newspapers in English and Spanish to advise the public of our financial assistance policy.

The Holy Cross Hospital financial assistance policy provides systematic and equitable clinical services to those who have medical need and lack adequate resources to pay for services. In FY13, Holy Cross Hospital provided $26.8 million in financial assistance. Individuals who are uninsured are able to obtain primary health care services at three Holy Cross Hospital health centers located in Silver Spring, Gaithersburg and Aspen Hill, Maryland. The health centers provide a convenient option for uninsured residents in need of high quality, discounted medical care. In FY13, health center visits increased 28.8 percent from 23,155 in FY12 to 29,817 and exceeding our target of 29,325 by 1.7 percent. Financial assistance also increased 13.1 percent from $23.7 million to $26.8 million and exceeded our budget of $22.5 million.

HOLY CROSS HOSPITAL

Patient Financial Assistance

Owner/Dept: JULIE KEESE, VP Revenue Cycle Management/ Office of CFO	**Date approved: 08/01/2013**
Approved by: Ann Gillis (Chief Financial Officer), JULIE KEESE (VP Revenue Cycle Management), Kevin Sexton (President and CEO of Holy Cross Health), Rachel Callahan (Chief Mission Officer, Holy Cross Health), Roseanne Pajka (Chief, Executive and Governance Operations - Holy Cross Health), YANCY PHILLIPS (Chief Quality Officer)	**Next Review Date:** 08/01/2015
Affected Departments: Finance, Legal Services, Office of CFO, Patient Accounting	

Purpose

It is part of the Holy Cross Health mission to make medically necessary care available to those in our community who are in need regardless of their ability to pay. Since all care has associated cost, any "free" or "discounted" service provided through this program results in that cost being passed on to other patients and their payers. Holy Cross Hospital therefore has a dual responsibility to cover those in need while ensuring that the cost of care is not unfairly transferred to individuals, third party payers and the community in general.

It is the purpose of this policy to:

- Ensure a consistent, efficient and equitable process to provide free or reduced-cost medically necessary services to patients who reside in the state of Maryland or who present with an urgent, emergent or life-threatening condition and do not have the ability to pay.
- Ensure regulatory agencies and the community at large that the hospital documents the financial assistance provided to these patients so that their eligibility for the assistance is appropriately demonstrated.
- Protect a stated level of each patient's assets when determining their eligibility for financial assistance under this policy.
- Provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance under this policy.

Applies to:

- Financial counseling and revenue cycle staff
- Hospital professional service providers
- Hospital contracted physicians

Policy Overview

The Holy Cross Hospital patient financial assistance policy applies in those cases where patients do not have sufficient income or assets to pay for their care and fulfill their obligation as patients to cooperate with and avail themselves of all programs for medical coverage (including Medicare, Medicaid, commercial insurances, workers compensation, and other state and local programs). The Hospital's financial assistance policy is comprised of the following programs – each of which may have its own application and/or documentation requirements:

- **Scheduled Financial Assistance Program:** Holy Cross makes available financial assistance to eligible patients who have a current or anticipated need for inpatient or outpatient medical care. This assistance requires completion of an application and provision of supporting documentation. Once approved, such financial assistance remains in effect for a period of six months after the determination unless the patient's financial circumstances change or they become eligible for coverage through insurance or available public programs during this time.

- **Presumptive Financial Assistance Program:** Holy Cross makes available presumptive financial assistance to eligible patients as follows:

  - Patients, unless otherwise eligible for Medicaid or CHIP, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
    - Households with children in the free or reduced lunch program;
    - Supplemental Nutritional Assistance Program (SNAP);
    - Low-income-household energy assistance program;
    - Primary Adult Care Program (PAC) until such time as inpatient benefits are added to the PAC benefit package;
    - Women, Infants and Children (WIC)

  - Patients who are beneficiaries of the Montgomery county programs listed below are eligible for 60% financial assistance, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
    - Montgomery Cares;
    - Project Access;
    - Care for Kids

Note: Patients in these county programs may also be eligible and evaluated for 100% financial assistance based upon completion of a standard financial assistance application and provision of supporting documentation.

- Services provided to uninsured patients within the Holy Cross Health Centers and the Obstetrics and Gynecology Clinic. In some cases both the eligibility and documentation requirements will reflect the processes and policies of county or other public programs for financial assistance. This assistance is based on the same financial assistance eligibility schedule, but normally requires a less extensive documentation process. In accordance with County policy, patients are expected to make the minimum required co-payments and/or contractual payments regardless of the level of charity care for which the patient would otherwise be eligible.

- Non-covered medically necessary services provided to patients qualifying for public assistance programs.

- **Medical Financial Hardship Program:** Holy Cross also makes available financial assistance to eligible or "medically indigent" patients who demonstrate a financial hardship as a result of medical debt. This program requires a more extensive documentation process. Reduced-cost financial assistance will remain in effect during the 12-month period after the date the reduced-cost medically necessary care was initially received and will apply to the patient or any immediate family member of the patient living in the same household when seeking subsequent care at Holy Cross Hospital.

  If a patient meets the eligibility requirements of more than one of the programs listed above, the Hospital shall apply the reduction in charges that is most favorable to the patient. If reduced-cost care is approved for a patient, the maximum patient payment for care will not exceed the charge minus the hospital mark-up.

  The documentation requirements and processes used for each financial assistance program are listed in the financial assistance and billing and collection procedures maintained by the Revenue Cycle Management division.

  Within two business days of the receipt of a completed application for financial assistance, medical assistance or both, a determination of probable eligibility will be made.

Covered Services

The financial assistance policy applies only to charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Health; i.e., inpatient, outpatient, emergency center, clinic, and Health Center. It does not apply to services that are operated by a "joint venture" or "affiliate" of the hospital. Hospital contracted physicians (Emergency Center, Anesthesia, Pathology, Radiology, Hospitalists, Intensivists and Neonatalogists are contracted) also honor scheduled financial assistance determinations made by the hospital. Financial assistance is only applicable when a patient takes advantage of the most appropriate cost effective setting to obtain their care.

Provision of services specifically for the uninsured: In the event that Holy Cross provides a more cost effective setting for needed services (such as the Obstetrics and Gynecology Clinic or the Health Centers), in cooperation with community groups or contracted physicians, specific financial assistance and payment terms apply that may differ from the general Holy Cross Hospital financial assistance program. In these heavily discounted programs, patients are expected to make the minimum co-payments that are required regardless of the level of charity care for which the patient would otherwise be eligible. Those minimum obligations are not then eligible to be further reduced via the scheduled financial assistance policy.

Services Not Covered

Services not covered by this financial assistance policy are:

- Private physician services or charges from facilities in which Holy Cross Health has less than full ownership.
- Cosmetic, convenience, and/or other Hospital services, which are not medically necessary. Medical necessity will be determined by the Holy Cross Health Chief Medical Officer after consultation with the patient's physician and must be determined prior to the provision of any non-emergent service.
- Services for patients who do not cooperate fully to obtain coverage for their services from County, State, Federal, or other assistance programs for which Holy Cross believes they are eligible.

  Exception: Holy Cross recognizes that not all patients are able to provide complete financial and/or social information and may elect to approve financial support based on available information prior to referring an outstanding balance to an external collection agency to ensure those patients who cannot afford to pay for care are appropriately identified regardless of documentation provided.

Patient Eligibility Requirements

Holy Cross provides assistance to Maryland residents and patients who present with an urgent, emergent or life-threatening condition whose income is less than 300% of the federal poverty level and whose monetary assets (assets that are convertible to cash excluding up to $150,000 in equity in their primary residence, personal tools used in their trade or business, and deferred retirement plan assets) do not exceed $10,000 as an individual or $25,000 within a family. Holy Cross

will also provide assistance to patients with family income up to 500% of the federal poverty level that demonstrate a financial hardship as a result of incurring hospital medical debt that exceeds 25% of family income over a 12-month period.

Any individual may make a request to reconsider the level of reduced-cost care approved or denial of free or reduced-cost by the Hospital for the individual. In such cases, requests are to be made to the financial counseling manager who will consider the total financial circumstances of the individual including outstanding balances owed to the Hospital, debt and medical requirements as well as the individual's income and assets. The financial counseling manager will assemble the patient's request and documentation and present it to the financial assistance exception committee (comprised of the Chief Mission Officer, Chief Financial Officer, Chief Quality Officer and the Vice President, Revenue Cycle Management) for consideration.

In any case where the patient's statements to obtain financial assistance are determined to be materially false, all financial assistance that was based on the false statements or documents will be rescinded, and any balances due will be processed through the normal collection processes.

The scheduled financial assistance program provides free medically necessary care to those most in need – patients who have income equal to or less than 200% of the federal poverty level. It also provides for a 60% reduction in charges for those whose income is between 201% and 250% of the poverty level, and 30% assistance from 251% to 300% of the federal poverty level. For those patients who demonstrate a medical financial hardship, a minimum of 30% assistance may be provided from 301% to 500% of the federal poverty level. The Hospital's schedule of financial assistance will change according to the annual update of federal poverty levels published in the HHS Federal Register.

Continuing financial obligation of the patient: Patients who receive partial financial assistance have been determined to be capable of making some payment for their care. Unless a specific patient financial assistance exception request is made and approved, or hospital management formally adopts a procedure that exempts collection processes for particular services, patients are expected to pay the amount of the reduced balance. In cases other than the above, any patient who fails to pay their reduced share of the account in question will have that account processed through our normal collection procedures, including the use of outside agencies and credit reporting. However, the hospital will not pursue a judgment against anyone who has legitimately qualified for any scheduled level of Holy Cross Hospital financial assistance. Payment plans are also made available to uninsured patients with family income between 200% and 500% of the federal poverty level that request assistance.

Notice of Financial Assistance

The financial assistance program is publicized to patients of Holy Cross Hospital to whom it may apply. The information will be made available via the following methodologies:

1) A plain language summary of the Hospital's financial assistance policy, financial assistance applications, and the Hospital patient information sheet will be prominently displayed in all hospital registration and cashier areas, the hospital main lobby and cafeteria, the emergency center, and health center campuses in English, Spanish and in the predominant languages represented by our patient population as defined by applicable regulations. All documents can also be accessed, viewed, downloaded and printed from the hospital's external website.
2) Notice of financial assistance availability is indicated on all hospital billing statements along with a reference to the external website and phone number where inquiries can be made.
3) All self-pay patients are advised of the existence of the financial assistance program during the pre-registration and registration process.
4) Information regarding eligibility and applications for financial assistance will be mailed to any patient who requests it at any time – including after referral to collection agencies.
5) A notice will be published each year in a newspaper of wide circulation in the primary service area of the hospital.

Related Documents

- Billing and Collection of Patient Payment Obligations Policy

References

- Trinity Health. "Billing, Collection and Support for Patients with Payment Obligations", Trinity Health system policy 6-11-1, February 28, 2013.
- Federal Poverty Guidelines, HHS Federal Register

Questions and More Information

Contact the financial counseling department at extension 7195 or the financial counseling manager at extension 7155 with questions and for more information.

Policy Modifications

The Holy Cross Health Board of Trustees must approve modifications to this policy. In addition, this policy will be presented to the Board for review and approval every two years.

Approval

This policy was reviewed and approved by the Holy Cross Health Regional Executive Team and the Holy Cross Health Board of Trustees on July 25, 2013

HOLY CROSS HOSPITAL

1500 Forest Glen Road
Silver Spring, MD
20910-1484
Phone: (301) 754-7195
www.holycrosshealth.org

PATIENT INFORMATION SHEET

Holy Cross Hospital is committed to being the most trusted provider of healthcare in our community. That involves a commitment to provide accessible services to individuals who are uninsured or underinsured and do not have the resources to pay for necessary care. In addition, Holy Cross Hospital provides urgent or emergent care to all patients regardless of ability to pay.

Our Financial Assistance Program

Holy Cross Hospital provides substantial financial assistance to low-income patients who do not qualify for public programs such as Medicaid, MCHIP, MHIP, etc. or have insurance that does not cover medically necessary care. For qualifying patients, our program covers all medically necessary services charged and billed by the hospital and our hospital-based physicians such as emergency physicians, radiologists, pathologists, hospitalists, anesthesiologists and neonatologists.

Eligibility for our financial assistance program is determined on an individual basis, evaluating both income and assets. Qualifying patients must make less than 300% of the federal poverty level. Income limits vary by family size. In addition, qualifying patients must demonstrate less than $10,000 of net assets for an individual or less than $25,000 in net assets for a family. Once granted, the eligibility applies to all medically necessary services not covered by other programs unless the patient becomes eligible for coverage under public programs during this time.

Holy Cross Hospital offers financial assistance for individuals whom qualify under specific means-tested County, Local and State programs. These programs include Household with Children in the National School Lunch, Food Stamps or Supplemental Nutritional Assistance, Maryland Energy Assistance, Primary Adult Care, and Women, Infant and Children Programs. Additionally, Medical Financial Hardship assistance is also available if you have Holy Cross debt greater than 25% of your family income (not including co-insurance, co-payments, hospital based physician bills, and/or deductibles).

In order to evaluate eligibility, documentation must be provided to verify income and assets. For a listing of required documents and further details on how to apply for financial assistance, please request an application from any of our registration representatives or contact our financial counseling office at **301-754-7195**. The application can also be accessed through our website at www.holycrosshealth.org on our "For Patients & Visitors" page.

Patient's Rights and Obligations

Maryland law requires that each hospital notify patients' of their right to receive assistance in paying their hospital bill. Maryland law also requires that each hospital notify patients' of their obligation to pay the hospital bill and provide complete and accurate information to the hospital in the timeframes specified.

Patients' have the **Right** to:

- Apply for financial assistance and if criteria are met, receive assistance from the hospital in paying their bill.
- Contact the hospital to request an explanation of their hospital bill and an itemization of services received.
- Contact the hospital for assistance if they feel they have been wrongly referred to a collection agency.

Patients' are **Obligated** to:

- Pay the hospital bill in a timely manner if they have the ability to pay.
- Contact the hospital immediately if the patient cannot afford to pay the bill in full and seek assistance in resolving their outstanding balance.
- Provide accurate and complete information to the hospital regarding insurance coverage prior to or at the time of service and upon request.
- Contact the hospital promptly to provide updated/corrected information if their financial position changes.

Hospital Contact Information

If you have questions about your bill, would like to request an itemized statement or to pay or establish payment arrangements for your bill, please contact a customer service representative at 301-754-7680, Monday through Friday, between 9:00 a.m. to 4:00 p.m. For your convenience, you may make an online payment using a major credit card by visiting our website at www.holycrosshealth.org.

Refer to "Our Financial Assistance Program" section for financial assistance contact information.

Applying for the Maryland Medical Assistance Program

For assistance in determining whether you qualify for Medicaid or other available programs, please contact one of the numbers below or visit the Maryland Department of Health and Mental Hygiene at www.dhmh.state.md.us/gethealthcare for more information.

Eligibility is based on medical conditions, economic situation, citizenship, age, and family size.

Silver Spring	Rockville	Germantown	Prince Georges Co.
Local Office 8818 Georgia Ave., 1st Fl. Silver Spring, MD 20910 Phone: 240-777-3100	**Local Office** 1301 Piccard Dr., 2nd Fl. Rockville, MD 20852 Phone: 240-777-4600	**Local Office** 12900 Middlebrook Rd., 2nd Fl. Germantown, MD 20874 Phone: 240-777-3420	**Local Office** 6505 Belcrest Rd. Hyattsville, MD 20782 Phone: 301-209-5000
Service Eligibility Unit 8630 Fenton Street, 10th Fl. Silver Spring, MD 20910 Phone: 240-777-3066	**Service Eligibility Unit** 1335 Piccard Dr., 1st Fl. Rockville, MD 20852 Phone: 240-777-3120	**Service Eligibility Unit** 12900 Middlebrook Rd., 2nd Germantown, MD 20874 Phone: 240-777-3591	

Physician Services

Holy Cross Hospital does not employ the physicians who practice at the hospital, so each physician group that provided services to you will bill you separately for their services.

Holy Cross Hospital Mission, Vision and Value Statement

Our Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.

Our Core Values

- Respect
- Social justice
- Compassion
- Care of the poor and underserved
- Excellence

Our Role

Holy Cross Health in Silver Spring, Maryland, exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area.

Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

2013 COMMUNITY REPORT

HOLY CROSS HEALTH

December 2013

Commitment. Collaboration. Change. Those three words embody our long-standing tradition of working to improve the health of the diverse populations and communities we serve. For more than 50 years, we've been committed to ensuring that all community members, including the most vulnerable among us, have access to the same high quality care. We've collaborated with like-minded organizations to share talent and resources, multiplying our combined effectiveness while stretching precious dollars. And along the way, we have changed lives.

In the pages that follow are real-life examples of four of our innovative programs—developed by Holy Cross Health in concert with our partner organizations—that empower community members to manage and improve their own health, therefore improving the overall health of the community. These people's stories represent a tiny slice of our efforts. In fact, through free life-saving screenings, support groups, health education, wellness and exercises classes—and the provision of vital health care services, regardless of ability to pay—we recorded nearly 350,000 encounters with community members in 2013. That amounts to more than $48 million worth of low or no cost services—or nearly $130,000 each day—to advance the health and well-being of our growing community.

But the needs remain great. Even with the advent of the Affordable Care Act, thousands of adults in our community will still be uninsured, without adequate funds to keep themselves and their families healthy. For them, our network of Holy Cross Health Centers in Silver Spring, Gaithersburg and Aspen Hill are an essential safety-net, providing affordable and sustainable primary care to low-income individuals through nearly 30,000 patient visits each year.

Altogether, these programs and more are designed to fulfill our commitment to the community—a commitment that lies at our core. That commitment has been, and will always be reflected in the day-to-day operations of Holy Cross Hospital. And now—with the October 2014 opening of Holy Cross Germantown Hospital on the horizon—we look forward to expanding that commitment.

As you review the highlights of our achievements for the past year, I hope you, too, will see how Holy Cross Health brings its mission—to be the most trusted provider of health care in our area—to life, both within our walls and beyond.

Kevin J. Sexton
President and Chief Executive Officer
Holy Cross Health

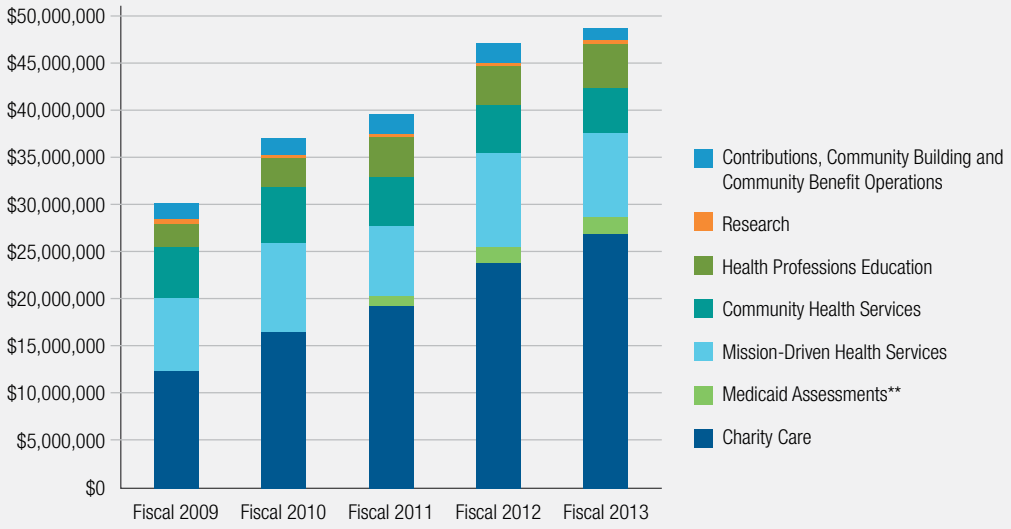
Highlights of Fiscal 2013 Quantifiable Community Benefits*

In fiscal 2013, Holy Cross Health provided more than $48 million in community benefits including more than $26 million in financial assistance.

	DIRECT COST	INDIRECT COST	OFFSETTING REVENUE	ENCOUNTERS	NET COMMUNITY BENEFIT
Charity Care *Providing services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay*	Not Applicable	Not Applicable	Not Applicable	25,289	$26,812,613
Medicaid Assessments *Unpaid costs due to Medicaid shortfalls*	$12,042,149	$0	$10,297,543	Not Applicable	$1,744,606
Mission-Driven Health Services *Offering services that otherwise might not be available and are not expected to result in revenue*	$4,189,092	$5,653,509	$793,331	40,367	$9,049,270
Community Health Services *Providing health screenings with links to treatment, as well as education, lecture and exercise programs*	$3,244,742	$1,790,440	$321,510	215,951	$4,713,672
Health Professions Education *Hosting physician residency programs, training students of nursing and other disciplines, and operating a School of Radiologic Technology*	$2,820,693	$1,933,134	$11,550	7,608	$4,742,277
Research *Participating in studies on health care delivery and clinical trials sponsored by government agencies, universities and foundations*	$170,897	$117,921	$0	1,305	$288,818
Financial Contributions, Community Building and Community Benefit Operations *Providing administrative support for community benefit operations and supporting community organizations by providing in-kind services and hospital space*	$921,404	$469,080	$0	40,955	$1,390,484
	$23,388,977	$9,964,084	$11,423,934	306,186	**$48,741,740**

A Tradition of Meeting the Needs of the Community

In the past five fiscal years, Holy Cross Health has provided more than $202 million in community benefit including more than $98 million in financial assistance.*



*Prepared according to guidelines established by the Maryland Health Services Cost Review Commission.

**Beginning in fiscal 2011, the Maryland Health Services Cost Review Commission required Maryland hospitals to account for Medicaid provider taxes for which hospitals do not receive offsetting revenue.

COMMITMENT

Holy Cross Health Network's three primary care health centers delivered services worth approximately $3.5 million through nearly 30,000 patient visits during 2013. Holy Cross Health is one of the area's largest safety-net providers and the only health system in Montgomery County to operate its own health centers.

COLLABORATION

With support from CareFirst BlueCross BlueShield, the Holy Cross Health Center in Aspen Hill is one of two local providers selected by the Primary Care Coaltion of Montgomery County to implement a Patient-Centered Medical Home pilot project.

CHANGE

During the PCMH's first year, the Holy Cross Health Center enrolled 62 seriously ill patients with multiple chronic, complex conditions. After 18 months, approximately 60 percent of those with high-blood pressure had lower readings; 43 percent of diabetic patients experienced better blood sugar control; and elevated cholesterol levels dropped by one-third among previously high-risk patients.

Patient-Centered Medical Home

A new care model is helping patients with chronic medical issues and complex social needs learn how to keep their conditions under control…and keep themselves healthy. It's a variation of a Patient-Centered Medical Home (PCMH).

And it's currently offered to a select group of patients at the Holy Cross Health Center in Aspen Hill—one of only two local safety-net providers selected as test sites by the Primary Care Coalition of Montgomery County.

Health care spending is highly concentrated among people with multiple chronic conditions. In fact, nearly two-thirds of all health care expenditures are spent on a mere 10 percent of the population.

With support from CareFirst BlueCross BlueShield, the three-year pilot program is designed to evaluate whether the PCMH approach—already validated among insured patients—works as well with uninsured populations.

"Many of these patients are simply overwhelmed by their health problems, combined with the lack of insurance or finances, struggles with language or literacy, and other issues," explains Cal Robinson, vice president, Operations, Holy Cross Health Network. "In addition to health care, they need help handling the competing priorities in their lives."

How it Works

"The PCMH program strives to decrease preventable hospital admissions and re-admissions by teaching patients self-care, and by giving them the encouragement, resources and support they need to achieve that objective," says Elise Riley, MD, medical director for the Holy Cross Health Centers.

Toward that end, health center physicians or staff identify patients with multiple medical conditions whom they believe could benefit from the intensive, hands-on relationship that lies at the heart of the PCMH model. Potential participants also are referred from Holy Cross Hospital's Emergency Center and Transitional Care Program. To date, 62 medically complex patients—most suffering from a combination of heart failure, diabetes or high blood pressure, often compounded by depression—have joined.

A dedicated nurse care manager, working exclusively with the PCMH population, meets with each patient to discuss, select and agree upon goals to address medical issues. At the same time, a health care coach—sponsored through the *We Care Program* of CHE Trinity Health, of which Holy Cross Health is a member—devises a wellness plan with the patient's input. The nurse, health care coach and primary care physician are in frequent contact with the patient, in person and by phone, to identify and resolve barriers to self-management.

Investing in the Future

Evan Ploussiou is a typical PCMH participant. At 45, he is a severe diabetic and overweight, with high blood pressure and high cholesterol. He's also a smoker, currently unemployed and the primary caregiver for his ill and elderly parents.

"I'm trying to conform to my promise to manage my health," Evan says. "Through this program, I'm now monitoring my sugar levels daily, taking my medications as directed, keeping health center appointments, and trying to lose weight. As a result, my diabetes is under more control. I've also joined a smoking cessation program, and Holy Cross Health's adult caregivers support group and nutrition classes. The people at the health center support me in everything I do."

Program results may help refine efforts to both improve health and reduce health care costs for those with complex medical and social needs in the future. So far, Dr. Riley is optimistic.

"Based upon what we've seen to date, the pilot program is already making a difference," she says.

"The people at the Holy Cross Health Center in Aspen Hill are so friendly and helpful, I feel like they're family," says Evan Ploussiou, a patient for the past five years. "Before, I didn't have a primary care provider. Now I'm in almost all of their programs, and making progress."

Community Health Workers

COMMITMENT

Holy Cross Health invested more than $300,000 in the Community Health Workers program in 2013. The program advances health awareness for self-management, healthful behaviors and access to primary care within underserved racial and ethnic communities.

COLLABORATION

With support from Maryland's Minority Outreach and Technical Assistance program, Holy Cross Health leads a collaboration with the Asian American Health Initiative and the African American Health Program of Montgomery County, Community Ministries of Rockville and the Maryland Commission on Indian Affairs.

CHANGE

In 2013, the Holy Cross Health Community Health Workers program:

- Distributed nearly 38,000 health brochures and fliers
- Held 171 health events, targeting African American, Asian American/Pacific Islander, Latino/Hispanic, Native American and female populations
- Recorded more than 15,000 encounters through health education sessions and other interactions with community members

Brimming with pamphlets, resources and enthusiasm, Holy Cross Health's community health workers visit homeless shelters and apartment complexes. They chat with people in beauty and barber shops, flea markets and laundromats, churches and YMCAs.

Their goal: To help reduce health disparities and inequities among underserved racial and ethnic communities in Montgomery County by promoting health awareness, lifestyle improvements and the importance of regular, primary care.

Holy Cross Health started the program in 2001 to reach the poor and vulnerable within these populations. A dozen years later, it is more important than ever.

"Montgomery County today is one of the most culturally and ethnically diverse in the nation, with African Americans, Latino Americans and Asian Americans accounting for more than 50 percent of the population," says Wendy Friar, RN, MS, Holy Cross Health's vice president, Community Health, and community benefit officer. "Cultural and linguistic differences can pose huge barriers to understanding how to navigate the nation's complex health care system. A low income or lack of health insurance can be a barrier as well."

Holy Cross Health's community health workers help bridge those gaps by informing and linking racial and ethnic groups in need to available services, providers and programs. Interactions range from informal one-on-one conversations to presentations to audiences of 100 or more.

Walking the Walk

"Community health workers reach people where they're comfortable, in their own settings, using the same language and familiar terms," says Shelly Tang, MPH, Holy Cross Health's manager of Minority and Community Outreach, noting that the staff includes native Spanish and Russian speakers. "Since most staff come from the community they're serving, their messages are more readily accepted and trusted."

The approach works. Over the years, community health workers have introduced uninsured community members to the Holy Cross Health Network's three health centers, where they can receive affordably priced, sustainable health care—the program's ultimate objective. They also recruit people to free screenings and seminars run by Holy Cross Health on women's health, cancer, heart disease, obesity, diabetes and other issues that disproportionately affect racial and ethnic communities. When needed, community health workers even transport individuals to and from appointments, provide referrals to support groups, and assist with paperwork for financial assistance.

Since the advent of the Affordable Care Act, raising awareness of the new health insurance exchanges—and how to get more information about eligibility, enrollment and possible subsidies—has been added to the list.

Next Steps

Now a new initiative, the Community Health Education Course, promises to take the program's effectiveness to the next level. Launched in 2013, the course focuses on six priorities identified by the Montgomery County Community Health Needs Assessment—cardiovascular health, diabetes, obesity, cancer, maternal/child health and behavioral health—with the goal of standardizing community health workers' knowledge and boosting their confidence as educators.

The eight-week course was designed to include cultural perspectives in addition to topical knowledge. Through class interaction, it also considers how different racial and ethnic communities perceive, access and receive health care, and the best ways to reach them.

Debra Wylie, a Holy Cross Health community health worker, was one of the first to complete the course and "loved it. Now I have more understanding and information about medical tests, treatments and resources. By sharing that knowledge with the community, I can help change, and even save, lives."

"Sometimes, I speak at three health fairs a day," says Debra Wylie, a community health worker for Holy Cross Health. "Other days, I visit public places, pass out educational material, and talk to anyone who's interested in improving their health. I tell them about valuable resources, including our affordable health centers."

Faith Community Nursing

COMMITMENT

Holy Cross Health devoted $310,935 to the Faith Community Nurse Program during fiscal 2013 alone, through church needs assessments, program design and implementation, educational classes for congregations, and serving as a resource to faith community nurses.

COLLABORATION

Holy Cross Health's Faith Community Nurse Program empowers 65 congregations, of all traditions and denominations, to improve members' health through health promotion, awareness and educational classes, screenings and more.

CHANGE

Through personal health counseling, advocacy, classes and home/hospital visits, faith community nurses had approximately 9,000 encounters last year throughout Montgomery and Prince George's counties, the District of Columbia and northern Virginia. Altogether, the program helps a potential audience of 100,000 congregational members attain and maintain good health.

In 1993, Holy Cross Hospital became one of the first hospitals nationwide to adopt a new outreach model called faith community nursing. The concept focuses on the holistic and spiritual side of health and well-being, with houses of worship partnering with a hospital to promote health within their congregations.

For Holy Cross Hospital, it was a match made in heaven.

Five local churches signed on immediately, making the hospital's Faith Community Nurse Program the area's first. Now celebrating its 20th anniversary, the program today serves 65 congregations.

"Each congregation's needs, desires and cultures are different," says Carmella Jones, RN, M. Div., director of Holy Cross Health's Faith Community Nurse Program. "We don't dictate what they should do; rather, we support individual congregations' efforts to achieve their own goals as they define them."

That insider perspective is key to the program's success. In Holy Cross Health's model, each faith partner program is, ideally, led by a nurse who is a member of the congregation. Clergy endorsement and a congregational health committee help support and sustain the program.

For example, Silver Spring's Lutheran Church of St. Andrew—one of Holy Cross Health's oldest and largest faith community nursing partners, with 2,000 members—depends upon volunteers to fulfill its health ministry.

"It's the only way I can accommodate the many requests we receive," says St. Andrew's member and program leader, Marilee Tollefson, RN.

Working Together

Throughout the partnership, Holy Cross Health's staff advises and supports faith community nurse leaders. Work begins by defining each ministry's mission and vision and assessing the congregation's current health needs, followed by introducing programs to address them. Other activities include annual retreats and educational programs for faith community nursing leaders; listservs and networking events to connect participating nurses to each other; and a newsletter to share useful tips, new programs and resources. A real and virtual library on pertinent subjects is also available.

Most congregational programs begin with preventive health activities, such as blood pressure screenings, flu clinics and exercise classes. From there, individual programs evolve to follow their own paths, with many of the more active congregations, like St. Andrew's, offering extensive services.

"We now feature educational classes and seminars run by Holy Cross Health, home/hospital visitation, support groups and more," says Marilee. "Among the elderly and chronically ill, the need is especially great and growing."

Giving and Receiving

St. Andrew's member Judy Gundersen, a former nurse, has been on both sides of the program.

Having developed muscular dystrophy in her late 50s, Judy functioned fairly well for years. But as her disease progressed—and her husband suddenly fell ill and died—Marilee and her faith community nursing program volunteers stepped in.

"Through the program, I found a live-in, home health worker; borrowed a walker, wheelchair and other equipment; got rides to doctor's appointments; and so much more," says the 68-year-old. "I don't know what I would have done without it."

The experience also renewed her desire to help others. Today, she volunteers for St. Andrew's faith community nursing ministry, calling disabled and other housebound church members to check on their health, well-being and spirits.

"Being a recipient really made me want to give back," says Judy. "Faith community nursing changed my life."

"I serve as a health educator, counselor and resource to St. Andrew's health ministry volunteers and the congregation," says Marilee Tollefson, RN, who's led her church's program for 14 years. "And Holy Cross Health's Faith Community Nurse Program fulfills those same functions for me."

Senior Fit

COMMITMENT

Holy Cross Health offers 68 free Senior Fit classes each week at 23 facilities in Montgomery and Prince George's counties and the District of Columbia. In 2013, the cost of the program was $148,951, primarily accrued through personnel costs for the specially trained fitness staff.

COLLABORATION

Kaiser Permanente of the Mid-Atlantic States helps fund Senior Source, with the Montgomery County Department of Recreation, the Maryland National Capital Parks and Planning Commission, Asbury Methodist Village and local churches contributing space for classes.

CHANGE

The largest physical activity program for older adults in the community, Senior Fit welcomed 880 new members and recorded more than 103,000 encounters during the last fiscal year alone.

Staying physically active and exercising regularly can help prevent, delay or manage many diseases and disabilities, including arthritis, heart disease, high blood pressure and cancer.

In order to make it easier and more convenient for older Americans to remain physically active, Holy Cross Health launched its innovative Senior Fit program in 1995. Thriving ever since, the exercise program is now the area's largest for those age 55 and over, extending from Washington, D.C., and Prince George's County throughout Silver Spring and into northern Montgomery County, near the soon-to-open Holy Cross Germantown Hospital. And it's free.

That's good news for area residents, where the population age 65 and older is projected to nearly double over the next 20 years.

A Moving Experience

"Over the years, we've developed a consistent, evidenced-based approach to advancing the health of older adults," says Wendy Friar, RN, MS, Holy Cross Health's vice president, Community Health, and community benefit officer. "Our objective is to maintain and improve the health of seniors while prolonging their independence and quality of life."

Certified fitness professionals with special expertise in training both seniors and people with chronic conditions lead the classes. The program has proven its effectiveness at promoting strength, cardiovascular endurance, flexibility and balance.

Octogenarian Olavee Pogue, a Senior Fit member for the last three years, says, "We walk, stretch, do some aerobics. Our instructor sure puts us through a good routine, and makes it interesting! I know that my health, both physically and psychologically, is much better because of the program."

Like Olavee, the majority of Senior Fit participants are in their 70s and 80s, with most attending at least two classes weekly. Beyond its physical benefits, Senior Fit also gives older people—many of whom have lost spouses or may be alone and isolated—an opportunity to connect with others.

Participants annually rate their progress, with more than 90 percent reporting an increase in overall strength and flexibility. Well over three-quarters notice less pain, better balance and an improved ability to handle daily activities.

Such personal assessments are verified through more scientific means.

"Twice a year, we administer an evidence-based test to measure upper and lower body strength, speed/agility and upper body flexibility," says Holy Cross Health's Sarah McKechnie, manager, Community Fitness. "Our most recent results showed above average performance in all four areas, with a corresponding decline of 'at risk' or 'below average' scores for flexibility, a goal we have worked toward over the past few years."

Rising Requests

The National Council on Aging recognized Holy Cross Health's Senior Fit as one of the nation's top 10 fitness programs for older adults in 2003. Ten years later, demand for the program is still strong and growing, here and elsewhere, with many current organizational partners eager to add more sessions. Over the years, several other hospitals in the CHE Trinity Health system, of which Holy Cross Health is a member, have launched programs of their own in Michigan, Iowa and Indiana.

Olavee, who was recruited by friends and has recruited others in turn, understands the program's popularity.

"Senior Fit is a blessing," she says. "Even if I sometimes don't feel like going, I always feel so much better after I exercise. I'd like to thank Holy Cross for providing such a wonderful benefit to our community."

"I've been participating in Holy Cross' Senior Fit program for three years now, and I really notice a difference," says 82-year-old Olavee Pogue. "On the days I exercise, my energy is up and I sleep better. Plus, I enjoy the camaraderie. It's just all around good for you!"

About Holy Cross Health

Holy Cross Health is a not-for-profit health system based in Montgomery County, Md., that serves nearly 200,000 patients each year through a full range of inpatient, outpatient and innovative community-based services, with the mission to be the most trusted health care provider in the area. **Holy Cross Hospital**, one of the largest hospitals in Maryland, is home to the nation's first and region's only Seniors Emergency Center and is the only three-time winner of The Joint Commission's highest quality award in the region. **Holy Cross Germantown Hospital** will be the first new hospital in the county in 35 years when it opens in October 2014. **Holy Cross Health Network** operates Holy Cross Health Centers in Silver Spring, Gaithersburg and Aspen Hill and manages relationships with physicians and insurers. Holy Cross Health is a member of CHE Trinity Health of Livonia, Mich., one of the largest health care systems in the country.

Mission and Values

We, CHE Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our core values are reverence, commitment to those who are poor, justice, stewardship and integrity.

In Holy Cross Health's community, we carry out our mission to be the most trusted provider of health care services through:

- Innovative, high-quality and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Outreach that responds to community health need and improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

For additional information about Holy Cross Health's community benefit, contact Wendy Friar, vice president of Community Health and community benefit officer, at 301-754-7161 or friarw@holycrosshealth.org, or Kimberley McBride, manager, Community Benefit, at 301-754-7149 or mcbrik@holycrosshealth.org.

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