COMMUNITY BENEFIT NARRATIVE

Effective for FY2013 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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. General Hospital Demographics and Characteristics

Bed Designation	Inpatient Admissions	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients (WAH), by County:	Percentage of Patients (WAH) who are Medicaid Recipients, by County:
252	14,745	20783 – Hyattsville 20912 – Takoma Park 20782 – Hyattsville 20903 – Silver Spring 20904 – Silver Spring 20901 – Silver Spring 20910 – Silver Spring 20740 – College Park 20902 – Silver Spring 20906 – Silver Spring 20737 – Riverdale 20011 – Washington 20705 – Beltsville	Holy Cross: 20904, 20906, 20902, 20910, 20901, 20903, 20853, 20877, 20783, 20705, 20874, 20912, 20878, 20706, 20895, 20774, 20707, 20852, 20886, 20708, 20770 Medstar Montgomery General: 20853, 20904, 20906 Suburban: 20852, 20878, 20895, 20902, 20906 Adventist Rehabilitation Hospital of Maryland: 20706, 20774, 20783, 20852, 20853, 20874, 20877, 20878, 20886, 20895, 20901, 20902, 20903, 20904, 20906, 20910, 20912, 20706, 20770, 20774	Montgomery County: 11.9% Prince George's County: 15.6%	Montgomery County: 13.1% Prince George's County: 10.7%

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

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

The Community We Serve

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

County	**Percentage**
Prince George's	45.8%
Montgomery	39.1%
Washington, D.C.	7.0%
Other	8.1%

Figure 1. WAH discharges by county, 2012.

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

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

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

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

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

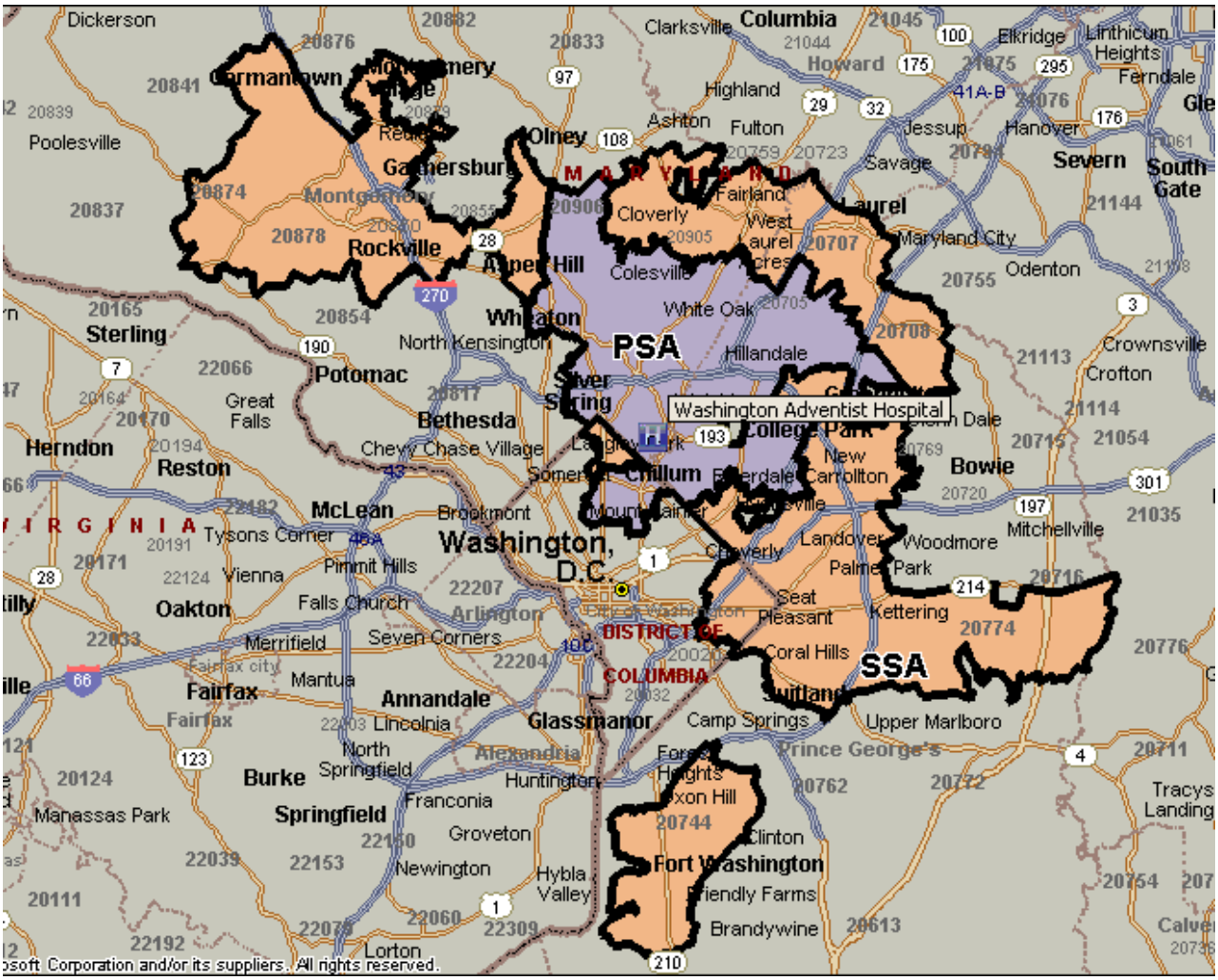


Figure 2. Map of Washington Adventist Hospital's Primary and Secondary Service Areas based on 2012 inpatient discharges

Our Community Benefit Service Area (CBSA), covering approximately 80% of discharges, includes 1,208,643 people, of which approximately 68.7% are minorities (see Figure 3 below).

	FY 2013 Estimates					
	WHITE	**BLACK/ AF AMER**	**ASIAN**	**AMER INDIAN/ ALSK NATIVE**	**NATIVE HI/ PI**	**HISP/ LATINO**
Community Benefit Service Area (CBSA)	378,612	543,940	99,389	6,348	769	255,546
	31.3%	45.0%	8.2%	0.5%	0.1%	21.1%

Figure 3. Population estimates (FY 2013) by race/ethnicity for Washington Adventist Hospital's Community Benefit Service Area (80% of discharges).

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

Prince George's County's foreign-born population has also steadily increased over the last two decades; from 2000 – 2007 it increased at the highest rate in Maryland – 199.9 percent compared to a state average of 70.7 percent[2]. Currently, 24 percent of the county's residents are foreign-born. One fifth of the county's households speak a language other than English at home, and

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

[2] "Immigration and the 2010 Census." *Maryland Data Center: Census.* http://www.census.state.md.us/Immigration%20and%20the%202010%20Census_final.pdf

over 15 percent of the population speaks English less than "very well." Spanish is the most frequently spoken language other than English, and among Spanish-speaking homes, about half speak English less than "very well."

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

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

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

Further exacerbating the problem is the fact that racial and ethnic minorities often have challenges accessing quality healthcare, either because they lack health insurance or because the communities in which they live are underserved by health professionals. As the proportion of racial and ethnic minority residents continues to grow, it will become even more important for the healthcare system to understand the unique characteristics of these populations in order to meet the health needs of the community as a whole. As a result, this report examines health status and outcomes among different racial and ethnic populations in Montgomery and Prince George's Counties, with the goal of identifying health disparities, achieving health equity, and improving the health of all groups.

[3] "Literacy, ESL and Adult Education." *Literacy Council of Montgomery County.* http://www.literacycouncilmcmd.org/litadultedu.html

[4] "Foreign-Born Population of Montgomery County Region, 1950-2000-Census Years." *Montgomery Planning.* 2000. http://www.montgomeryplanning.org/research/data_library/population/po34.shtm

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

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

Table II Significant Demographic Characteristics and Social Determinants

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

Prince George's County & Montgomery County Demographics:

Demographics	Prince George's County	Montgomery County	Maryland
Total Population*	881,138	1,004,709	5,884,563
Age*, %			
Under 5 Years	6.7%	6.5%	6.2%
Under 18 Years	23.1%	23.5%	22.8%
65 Years and Older	10.3%	12.9%	13.0 %
Race/Ethnicity*, %			
White	14.8%	47.8%	53.9%
Black	65.3%	18.3 %	30.0%
Native American	1.0%	0.7%	0.5%
Asian	4.4%	14.7%	6.0%
Hispanic or Latino origin	15.7%	17.9%	8.7%
Median Household Income*	$73,447	$95,660	$72,419
Households in Poverty**, %	8.2%	6.3%	9.0%
Pop. 25+ Without H.S. Diploma**, %	14.2%	8.9%	11.8%
Pop. 25+ With Bachelor's Degree or Above**, %	29.7%	56.8%	36.1%

Sources: * U.S. Census (2012), ** American Community Survey (2007-2011); Accessed: http://dhmh.maryland.gov/ship

Median Household Income within the CBSA: $68,305 (Source: Nielsen Population Estimates: FY 2013)

Household income has a direct influence on a family's ability to pay for necessities, including health insurance and healthcare services. A wide body of research points to the fact that low-income individuals tend to experience worse health outcomes than wealthier individuals, clearly demonstrating that income disparities are tied to health disparities. Throughout the CBSA area served by Washington Adventist Hospital across racial and ethnic groups, non-Hispanic whites have the highest median household income, while blacks and Hispanics are more likely to live in poverty (see Figure 4) (U.S. Census Bureau, ACS, 2011). However, when looking at the state of Maryland as a whole, Asians have the highest median income. The median household income in Maryland in 2009 was $61,193, which is higher than the U.S. median of $50,221. The median household income in the CBSA of Washington Adventist Hospital is $68,305 but great income disparities exist when broken down by county and by racial/ethnic groups. White households in Montgomery County had a much higher median household income of $110,580, while black households in Prince George's County had a lower median household income of $46,318; Hispanic and black households had much lower median household incomes than white households in both Montgomery and Prince George's Counties (see Figure 4).

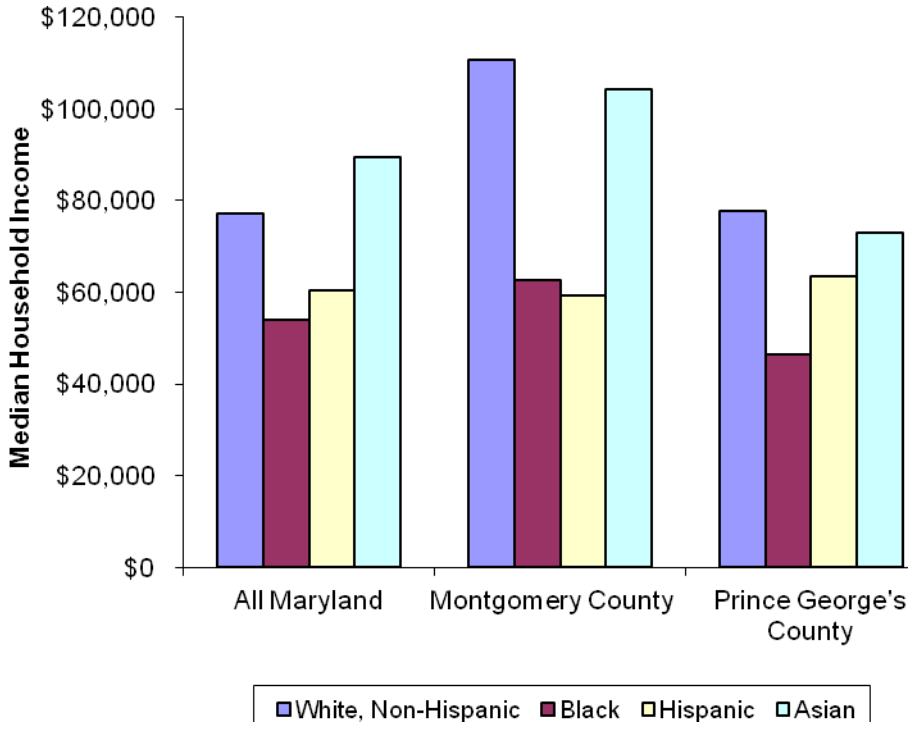


Figure 4. Median Household Income, Montgomery and Prince George's Counties, and all Maryland, by Race, 2009. Source: U.S. Census Bureau. (2011). American Community Survey 1-Year Estimates

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

7.3%

Source: U.S. Census Bureau, 2012 American Community Survey

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

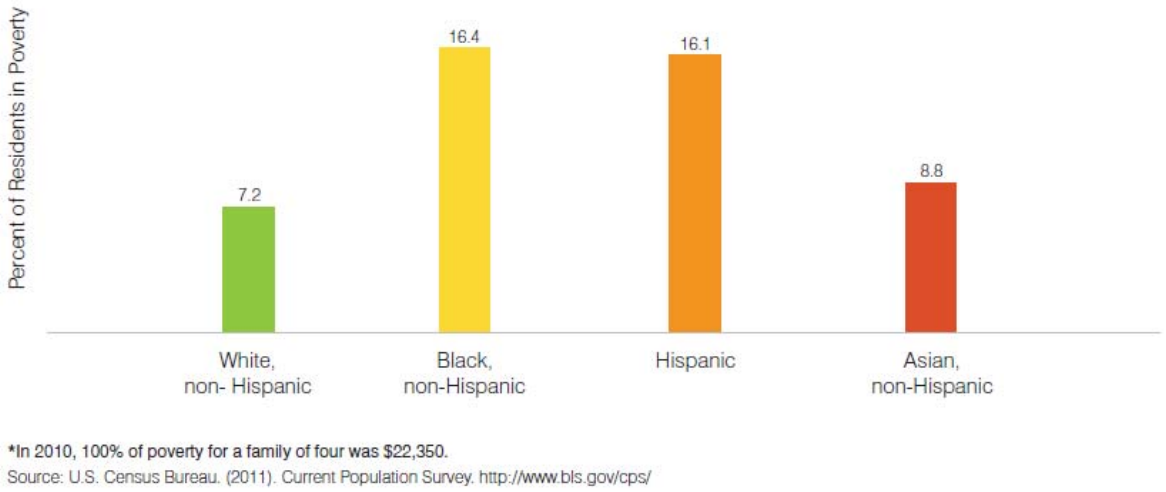


Figure 5. Poverty Rate by Race, Maryland, 2010

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

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

Prince George's County: 15.6%

Montgomery County: 11.9%

Source: U.S. Census Bureau, American Fact Finder: 2012 American Community Survey

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

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

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

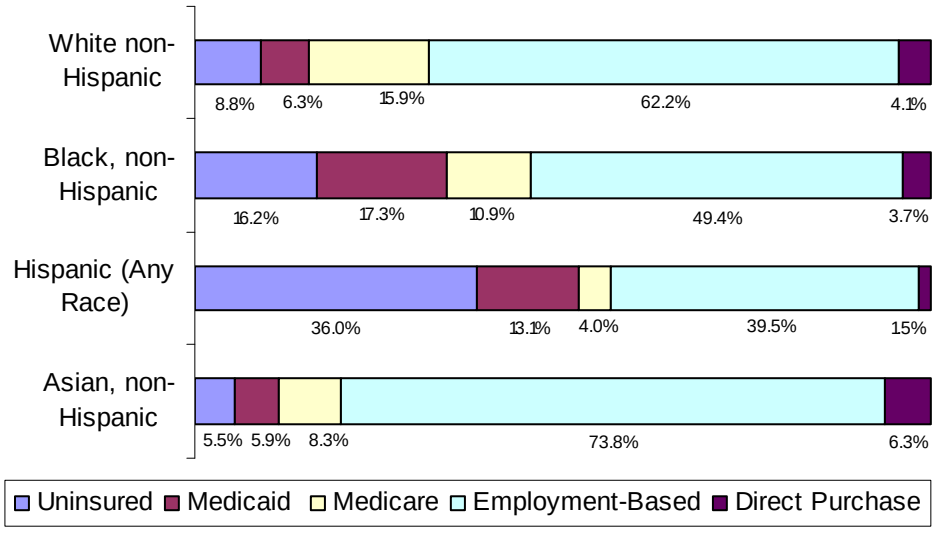


Figure 6. Health Insurance Coverage of Non-Elderly by Race/Ethnicity, Maryland, 2010. Source: Current Population Survey (2010). Health Insurance Coverage of Non-Elderly. http://www.bls.gov/cps/#data.

According to the U.S. Census Bureau, approximately 10.3 percent of all Maryland residents under the age of 65 were uninsured. Approximately 16.1 percent of Prince George's County residents and 12.5 percent of Montgomery County residents were uninsured in 2010 (U.S. Census Bureau, Fact Finder). Across the state, Hispanic males are more likely (37 percent) not to have health insurance coverage than white, non-Hispanic men (10 percent) and black, non-Hispanic men (17 percent). The trend is similar among females in Maryland: Hispanic women are uninsured at a rate of 30 percent, while almost 8 percent of white, non-Hispanic women and 12 percent of black, non-Hispanic women are uninsured.

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

Percentage of Medicaid recipients by County within the CBSA:

Prince George's County: 10.7%

Montgomery County: 13.1%

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

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

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

Male (Total) = 73.9 years

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

Female (Total) = 79.5 years

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

(Source: Institute for Health Metrics and Evaluation)

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

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

Male (Total) = 81.4 years

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

Female (Total) = 85 years

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

(Source: Institute for Health Metrics and Evaluation)

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

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

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

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

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

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

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

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

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

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

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

EDUCATION:

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

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

Prince George's County Education:

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

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

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

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

Source: www.mdreportcard.org

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

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

Montgomery County Education:

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

High School Graduation Rates (Montgomery County, 2011):

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

Source: www.mdreportcard.org

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

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

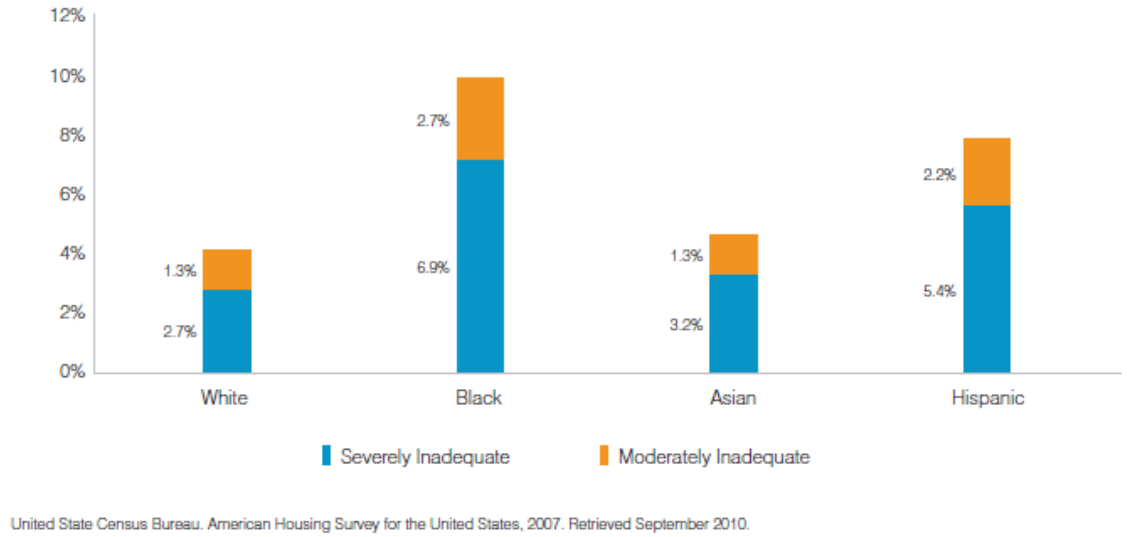
Source: http://factfinder2.census.gov

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

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

HOUSING:

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



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

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

Montgomery County Housing:

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

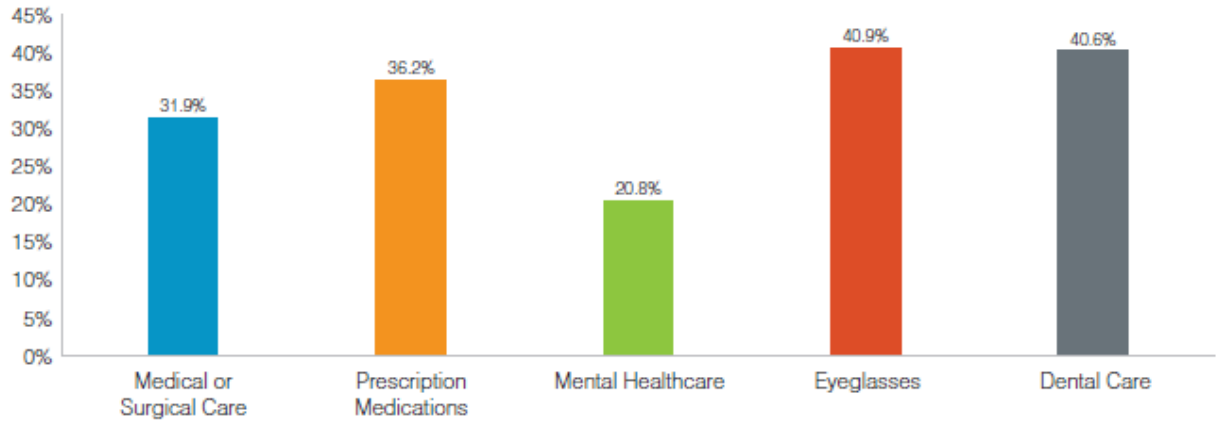
Source: U.S. Census, ACS, 2010

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

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

Spotlight on Homelessness:

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



Baggett, T. et al., The Unmet Healthcare Needs of Homeless Adults: A National Study. *American Journal of Public Health*. July 2010.

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

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

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

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

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

TRANSPORTATION:

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

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

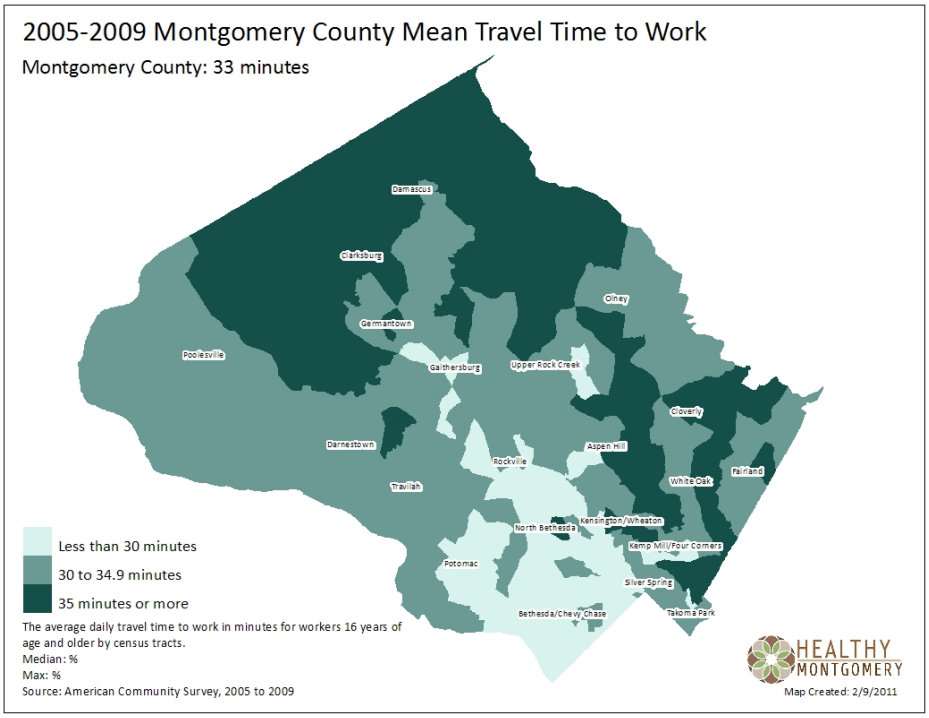


Figure 9. Mean Travel Time to Work, Montgomery County, 2005-2009

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

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

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

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

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

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

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

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

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

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

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

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

Public Transportation Options in Prince George's County:

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

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

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

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

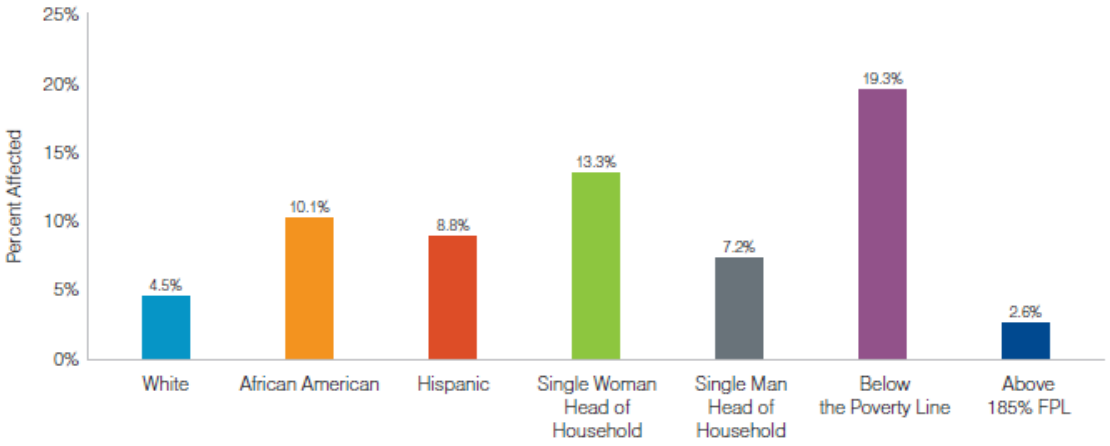
Source: http://ideha.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/PrinceGeorgesCounty_Final.pdf)

FOOD

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

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

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



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

Figure 10. Food Insecurity by Household Demographics (2008)

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

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

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

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

Source: www.countyhealthrankings.org (2012)

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

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

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

Source: www.countyhealthrankings.org (2012)

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

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

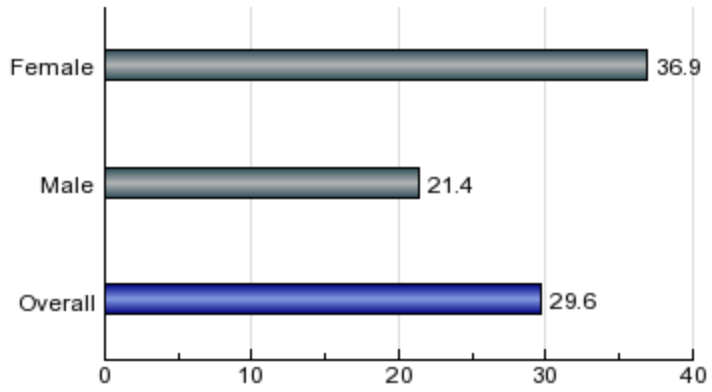


Figure 11. Adult Fruit and Vegetable Consumption by Gender

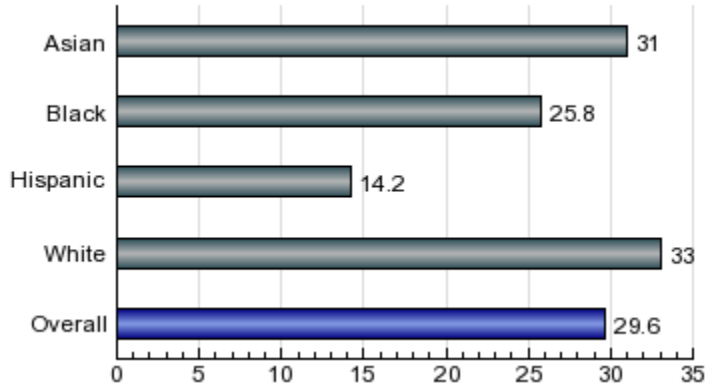


Figure 12. Adult Fruit and Vegetable Consumption by Race/Ethnicity

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

For the purposes of this report, 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/LHIContacts.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 complete Community Health Needs Assessment for Washington Adventist Hospital can be found on the hospital's website:

http://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital

Approach/Methodology

Establishing Infrastructure and Selecting Priorities

Washington Adventist Hospital is a member of Adventist HealthCare, which formed a Community Benefit Council (CBC) to guide and lead its community benefit activities, including conducting the Community Health Needs Assessment. The Council is being led by Ismael Gama, Associate Vice President of Mission Integration & Pastoral Care Services. As a starting point, the CBC researched topics in alignment with Montgomery County's Healthy Montgomery Focus Areas of cancer, cardiovascular disease, diabetes, maternal and infant health, behavioral health, and obesity. The CBC also decided to research additional topics of interest to the hospital including general rehabilitation, brain injury, spinal cord injury, asthma, influenza, HIV/AIDS, senior health, income and poverty, access to care/health insurance coverage, food access, housing quality, education, and transportation.

All of the topics included in this Community Health Needs Assessment were reviewed, discussed and approved by the Community Benefit Advisory Board. The Advisory Board was established in 2006 to help guide our efforts to reduce and eliminate health disparities, to identify community needs, and to help assess and direct our responses to those needs. The Advisory Board is comprised of both internal and external (community) leaders which include clinicians, researchers, administrators and other hospital staff, community-based organizations, local and state health departments, the University of Maryland, the National Institutes of Health (specifically, the National Institute of Minority Health and Health Disparities), and other public health stakeholder organizations. This active process began in November 2011 with a preliminary meeting of the Community Benefit Advisory Board. Washington Adventist Hospital's Community Health Needs Assessment was reviewed and approved by the Adventist HealthCare Board of Trustees on April 18, 2013. Washington Adventist Hospital's President's Council also reviewed the findings of the hospital's 2013 Community Health Needs Assessment. After discussion and consideration of community input, the President's Council came to a consensus to focus on two areas: behavioral health (i.e., mental health and substance abuse) and influenza in Washington Adventist Hospital's service area. Washington Adventist Hospital's Board of Trustees, consisting of leaders from community-based organizations, local safety net clinics, physicians, and health care leaders, reviewed and approved the hospital's CHNA Implementation Strategy.

Collecting and Analyzing Data

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

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

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

Healthy Montgomery

Locally, we worked with Montgomery County's Health and Human Services, Community Health Improvement Process (CHIP), to review the State of Maryland's State Health Improvement Process' (SHIP) 39 health indicators. Adventist HealthCare has representation on the Healthy Montgomery Steering Committee.

The health improvement process has three goals: (1) Improve access to health and social services; (2) Achieve health equity for all residents; and (3) Enhance the physical and social environment to support optimal health and well-being. The four objectives: (1) To identify and prioritize health needs in the County as a whole and in the diverse communities within the County; (2) To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporate a wide

variety of county and sub-county information resources and utilize methods appropriate to their collection, analysis and application; (3) To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and (4) To coordinate and leverage resources to support the *Healthy Montgomery* infrastructure and improvement projects

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

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

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

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

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

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

Washington Adventist Hospital gave $12,500 in grants to the Urban Institute in 2009 and in 2010 to provide support for the Healthy Montgomery work. In 2011 and in 2012 Washington Adventist Hospital increased its funding to $25,000. This included coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Department of Health and Mental Hygiene) and needs assessments and improvement plans from organizations in Montgomery County, support of the effort to select the 100 indicators to include in the Healthy Montgomery Website, preparation of indicators and maps that show the social determinants of health for the County as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the Needs Assessment document.

Other Available Data

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

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

Partnerships

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

prenatal services in 2006 by partnering with the Montgomery County Department of Health and Human Services in its Maternal Partnerships Program, a referral program that collaborates with hospitals to provide obstetric and gynecologic services for uninsured women in Montgomery County.

We also provide health services for women in the community with breast cancer through partnerships with the Susan G. Komen Foundation, the Women's Cancer Control Program of Montgomery County, the Health Initiative Foundation, and the American Breast Cancer Foundation. In addition, Adventist HealthCare and the Center on Health Disparities have ongoing collaborations with Sinai Hospital of Baltimore, the University of Maryland School of Public Health, and the Primary Care Coalition of Montgomery County. Public Health experts from these and other partner organizations provide Washington Adventist Hospital with important input on the needs affecting the health of the communities we serve.

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

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

- National Institute on Minority Health and Health Disparities, Office of Innovation and Program Coordination
- Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities
- Asian American Health Initiative, Montgomery County Department of Health and Human Services
- Latino Health Initiative, Montgomery County Department of Health and Human Services
- Primary Care Coalition of Montgomery County
- Mercy Health Clinic
- University of Maryland College Park, School of Public Health
- Cook Ross, Inc.
- Association of Clinicians for the Underserved
- Adventist Rehabilitation Hospital of Maryland
- Shady Grove Adventist Hospital
- Washington Adventist Hospital

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

Primary Data Collection

The community's perspective was obtained through a Community Health Needs Assessment Survey offered to the public through postings on this organization's Facebook pages, newsletters, email list serves, and meetings with community leaders. A 25-item survey, available online through surveymonkey.com, asked community members and community leaders alike to identify their socio-demographic information, health needs, problems affecting the health of the community, barriers to accessing care, and strengths/resources in the community.

Respondents to Adventist HealthCare's Community Health Needs Assessment Survey were asked to assist in identifying and prioritizing community health concerns, as well as community assets. A total of 90 people responded to the survey from August 2012 through February 2013: 46 lived within Washington Adventist Hospital's CBSA, 28 lived within Shady Grove Adventist Hospital's Community Benefit Service Area (CBSA), 15 lived in an area where the two hospital's CBSAs overlap, and 29 lived outside of the CBSA of either hospital. Many of the respondents were community leaders working within the CBSA of SGAH and/or WAH and serving community members within the CBSA, so their responses are included even though they may not personally live within the CBSA.

Key Takeaways from Survey:

- The greatest problems affecting the health of this community are chronic diseases, and factors that may contribute to chronic diseases, such as high stress, poor nutrition, heavy traffic and pollution, and lack of affordable access to health care.
- This community has many strengths, including strong community bonds/networks and involvement, numerous community resources/centers/activities, positive attributes of the physical environment, numerous health care facilities, and the high education level/socio-economic status of much of the population.
- Many people seek reliable health information from a doctor, the internet, nurses, or family and friends.

For complete survey results, please see Washington Adventist Hospital's 2013 Community Health Needs Assessment:
http://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital

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.

The complete CHNA Implementation Strategy Report for Washington Adventist Hospital can be found on the hospital's website:

http://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital

Implementation Strategy Development and Adoption

Washington Adventist Hospital's Community Health Needs Assessment was reviewed and approved by the Adventist HealthCare Board of Trustees on April 18, 2013. Washington Adventist Hospital's President's Council also reviewed the findings of the hospital's 2013 Community Health Needs Assessment. After discussion and consideration of community input, the President's Council came to a consensus to focus on two areas: behavioral health (including mental health and substance abuse), and influenza among the population served by Washington Adventist Hospital. Washington Adventist Hospital's Board of Trustees, consisting of leaders from community-based organizations, local safety net clinics, physicians, and health care leaders, reviewed and approved this CHNA Implementation Strategy.

Why These Priority Areas Were Chosen

Based on findings from its Community Health Needs Assessment, Washington Adventist Hospital's President's Council decided to focus on the following two areas:

Behavioral Health:
- The rate of hospital discharges for bipolar disorder has increased for Montgomery County adults; there was a two-fold increase in readmissions in the past decade.
- In Washington Adventist Hospital's service area, the ZIP code with the highest Emergency Room rate and hospitalization rate due to alcohol abuse was 20912.

Influenza:
- In Washington Adventist Hospital's service area, the ZIP codes with the highest Emergency Room rates due to immunization preventable influenza and pneumonia included 20901, 20904, and 20912.

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. 04/18/2013 (mm/dd/yy)

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

http://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital

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.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X_Yes
___ No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the

CB process and provide additional information if necessary):

i. ***Senior Leadership***

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

ii. Clinical Leadership

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

iii. Community Benefit Department/Team

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

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

Spreadsheet	___X__yes	_____no
Narrative	__X___yes	_____no

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

Spreadsheet	____X_yes	_____no
Narrative	___X__yes	_____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

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

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

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

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

Initiative #1 – Help Stop the Flu

Identified Need	Influenza – persons most at risk include the elderly, the very young, and the immune-compromised. The ZIP code in which Washington Adventist Hospital is located, 20912, had an immunization-preventable pneumonia and influenza rate of 12.1 ER visits/10,000 population (2009-2011), which is relatively high compared to 50% of Maryland counties, which have rates <8.9 ER visits/10,000 population. Although influenza vaccines (i.e., "flu shots") are widely available in Montgomery County, there are still many at-risk people who are not getting vaccinated due to income, cultural barriers, and access to clinics.
Hospital Initiative*	"Help Stop the Flu"
Primary Objective of the Initiative	The primary objective of Washington Adventist Hospital's "Help Stop the Flu" initiative is to provide flu vaccines for community members, regardless of the ability to pay, in various easily accessible locations including: senior centers, low-income and senior apartment complexes, schools, and faith-based communities, as well as the hospital. Washington Adventist Hospital's goal for 2012 was to provide flu shots to community members who normally would not be able to afford a flu shot. Another objective is to provide health education on cold and flu prevention to community members
Single or Multi-Year Initiative Time Period	Multi-year from 2008 – present year
Key Partners and/or Hospitals in initiative development and/or implementation	• WTOP 103.5 Radio Station • M & T Bank • Long Branch Community Center • Mid-County Community Center • Longwood Community Center • The Oaks at Four Corners Senior Living • Marilyn Praisner Community Center • Takoma Park Community Center • First United Methodist Church • Inwood House • Brinklow Seventh Day Adventist Church • Springvale Terrace Senior Living • Takoma Park Seventh Day Adventist Church • Casa de Maryland • Easter Seals • The Elternhaus Assisted Living • Greenbelt Community Center • Riverdale Presbyterian

	• Hillandale Baptist Church • Langley Park Community Center
Evaluation Dates	Evaluation completed at the end of each flu shot clinic
Outcome (Process & Impact Measures)	*Process:* Staff conduct a debrief/process evaluation at the end of each flu shot clinic to make adjustments and improvements for future flu shot clinics. *Impact:* • Washington Adventist Hospital provided a total of 730 flu shots for the community in 2012, with an average of 30 to 35 vaccines provided at each clinic. • Washington Adventist Hospital provided 50 free flu shots at Langley Park Community Center, where the majority of participants reported that they had never received a flu shot due to cost. • The hospital also provided supplies and nurses to administer flu vaccine to 83 community members at a flu shot clinic at the Cambodian Buddhist Temple in Silver Spring. • Additional flu shot clinic sites included senior centers, low-income housing complexes, Washington Adventist Hospital, and local congregations. • In addition to flu shot clinics, health education on cold and flu prevention was provided at a variety of community locations.
Continuation of Initiative	Washington Adventist Hospital plans to continue this program.
Cost of Initiative for Current FY	The total cost of the "Help Stop the Flu" initiative is approximately: $19,780 Cost of vaccine: $9,900 Approximate cost of salaries (including nurses): $8,120 Cost of supplies: $1,460 Miscellaneous costs: $300

* Evidence-Based:

The following citations show evidence of the effectiveness of vaccination against influenza in healthy adults, among high-risk populations, and the effectiveness of increasing influenza vaccination rates at inner-city health centers.

Citations:

Nichol, K., Lind, A., Margolis, K., Murdoch, M., McFadden, R., Hauge, M., Magnan, S., & Drake, M. (1995). The effectiveness of vaccination against influenza in healthy, working adults. *The New England Journal of Medicine*, 333(14), 889-93. doi: 10.1056/NEJM199510053331401.

Bond, T. (2010). Influenza vaccination in a high-risk population: An evidence-based approach to public health practice. (Doctoral dissertation), Available from *Emory University's Electronic Thesis and Dissertation Repository*. Retrieved from http://pid.emory.edu/ark:/25593/7v34t.

Nowalk, M., Zimmerman, R., Lin, C., Raymund, M., Tabbarah, M., Wilson, S., McGaffey, A., Wahrenberger, J., Block, B., Hall DG., Fox DE., & Ricci EM. (2008). Raising adult vaccination rates over 4 years among racially diverse patients at inner-city health centers. *Journal of the American Geriatrics Society*, 56(7), 1177-1182. doi: 10.1111/j.1532-5415.2008.01769.x.

Initiative #2 – Navigate to Health: Rapid Referral Program (Mammography)

Identified Need	Breast Cancer Screening for Low-Income Women According to the National Cancer Institute, the death rate for breast cancer in Prince George's County is 14% higher than the average in Maryland, and 23.5% higher than the national average. In both Montgomery and Prince George's Counties, the breast cancer mortality rate for black women (28.8% and 33.6%, respectively) is a great deal higher than for white women (19.9% and 25.3%, respectively). According to Healthy Montgomery's Community Dashboard, the breast cancer incidence rate in Montgomery County is in the highest quartile among all U.S. counties, at 127.5 cases/ 100,000 population (counties in the lowest 50th percentile have less than <115.6 cases/ 100,000 population). Although the age-adjusted death rate due to breast cancer is relatively low in Montgomery County, great disparities exist among racial/ethnic groups (30.3/100,000 breast cancer deaths among blacks compared to 19.9/100,000 deaths overall).
Hospital Initiative*	Navigate to Health: Rapid Referral Program (Mammography)
Primary Objective of the Initiative	The goal of Navigate to Health: Rapid Referral Program is to provide comprehensive breast care services to bridge the gap to medically underserved, low-income, and minority women in Montgomery County. This initiative aims to expand and enhance breast care services while providing a rapid and continuous process between referral and screening and the diagnosis and treatment for all patients served.
Single or Multi-Year Initiative Time Period	Multi-year/ ongoing
Key Partners and/or Hospitals in initiative development and/or implementation	• Primary Care Coalition • Mary's Center • Mobile Medical Care, Inc. • Muslim Community Clinic • Spanish Catholic Center • Women's Cancer Control Program of Montgomery County • Susan G. Komen Foundation • Maryland Breast and Cervical Cancer Diagnosis and Treatment (BCCDT) Program • American Breast Cancer Foundation • Health Initiative Foundation
Evaluation Dates	Ongoing process evaluation & monthly quality improvement meetings

Outcome (Process & Impact Measures)	*Process:* Ongoing process evaluations are conducted to determine the effectiveness of this program. Monthly Quality Improvement meetings take place with key partners to discuss successes and what works with the collaboration, as well as challenges and identification of program gaps. The average time from safety net clinic referral to screening is less than 21 days. The average time from diagnosis to treatment is 30-45 days. *Impact:* In 2012, Washington Adventist Hospital provided breast cancer services and education to 793 patients, provided 645 screening mammograms, 65 diagnostic mammograms, and 42 sonograms for free to low-income women.
Continuation of Initiative	Washington Adventist Hospital's breast cancer screening program has grown and expanded since its initial implementation in 1993, and the hospital intends to continue this program in future years.
Cost of Initiative for Current FY	The total annual cost of the Navigate to Health: Rapid Referral Program (Mammography) is approximately $286,118. [$175,178 (from grants) + $110,940 (WAH's cost) = $286,118 total] Adventist HealthCare receives an annual grant of $229,250 from the Susan G. Komen Foundation with the funds distributed between the Rapid Referral Mammography Programs at Shady Grove Adventist Hospital and at Washington Adventist Hospital. Of the total funding, approximately $67,748 is spent on salaries of personnel and $48,055 is spent on mammograms at Washington Adventist Hospital. Additional funding for this initiative comes from the following sources: American Breast Cancer Foundation funds $5,250 for 150 mammograms Health Initiative Foundation funds $19,125 for 225 mammograms Women's Cancer Control Program of Montgomery County funds: $10,000 for expanded services, and $25,000 for mammograms for women in their 40s and 50s. The cost to Washington Adventist Hospital of screening mammograms that are not covered by grant funding is approximately $110,940.

* Evidence-Based:

This initiative involves breast cancer screening and navigation for an underserved, mostly minority, population. There is evidence that patient navigation programs increase rates of cancer screening, particularly among minority populations:

Citations:

Percac-Lima S, Grant RW, Green AR, Ashburner JM, Gamba G, Oo S, Richter JM, Atlas SJ. (2009). A culturally tailored navigator program for colorectal cancer screening in a community health center: a randomized, controlled trial. *Journal of General Internal Medicine.* 24 (2), 211-217.

Robinson-White 2010 – Robinson-White S, Conroy B, Slavish KH, Rosenzweig M. Patient navigation in breast cancer: A systematic review. *Cancer Nursing*. 2010; 33(2):127-40

Phillips 2010 – Phillips CE, Rothstein JD, Beaver K, et al. Patient navigation to increase mammography screening among inner city women. *Journal of General Internal Medicine*. 2010; 26(2):123-9

Donaldson 2012 – Donaldson EA, Holtgrave DR, Duffin RA, et al. Patient navigation for breast and colorectal cancer in 3 community hospital settings: An economic evaluation. *Cancer*. 2012; 118(19):4851-9.

Glick 2012 – Glick SB, Clarke AR, Blanchard A, Whitaker AK. Cervical cancer screening, diagnosis and treatment interventions for racial and ethnic minorities: A systematic review. *Journal of General Internal Medicine*. 2012;27(8):1016-32.

Naylor 2012 – Naylor K, Ward J, Polite BN. Interventions to improve care related to colorectal cancer among racial and ethnic minorities: A systematic review. *Journal of General Internal Medicine*. 2012; 27(8):1033-46.

Jandorf 2005 – Jandorf L, Gutierrez Y, Lopez J, Christie J, Itzkowitz SH. Use of a patient navigator to increase colorectal cancer screening in an urban neighborhood health clinic. *Journal of Urban Health*. 2005; 82(2):216-24.

Initiative #3 – Cancer Screening

Identified Need	*Washington Adventist Hospital's Top Four cancers are Breast, Prostate, Lung, and Colorectal.* Blacks are diagnosed with and die from prostate cancer nearly 30% more often than whites; the death rate due to prostate cancer for Prince George's County is 117% higher than that of Montgomery County, 46% higher than the Maryland state average, and 65% higher than the national average. The death rate for breast cancer in Prince George's County is 14% higher than the average in Maryland, and 23.5% higher than the national average, and there are large disparities in breast cancer death rates among racial groups in both Montgomery and Prince George's Counties. Colorectal Cancer mortality rates were much higher for blacks than whites or other races in 2007. Lung Cancer is the leading cause of cancer-related death among men and women in Maryland. (Sources: Healthy Montgomery, 2012; MD DHMH Cancer Report, 2010; NCI State Cancer Profiles, 2012; Shady Grove Adventist Hospital Thoracic Program's Lung Cancer Annual Report Study, 2012)
Hospital Initiative	Annual Cancer Screening Day – March 2013
Primary Objective of the Initiative	Provide free cancer screenings for Prostate, Skin, Breast, Oral, Thyroid, and Colorectal Cancers to improve access to screenings for low income and disadvantaged populations. As a Commission on Cancer accredited cancer program, Washington Adventist Hospital provides a screening event each year, but because of the identified need, Washington Adventist Hospital screens for 6 different cancer types at our annual screening event.
Single or Multi-Year Initiative Time Period	Multi-Year/ Ongoing: This annual program began in 1998 to give community members access to free cancer screenings.
Key Partners and/or Hospitals in initiative development and/or implementation	• Washington Adventist Hospital Cancer Committee • Montgomery County Cancer Crusade • Washington Adventist Hospital's physicians
Evaluation Dates	The evaluation of the overall program is conducted following this event to improve the program for the next year. Results for all screenings, except Prostate Specific Antigen (PSA) and Colorectal exams, are given on the day of the screening. PSA results are emailed 1 week out. Colorectal Fecal Occult Blood Tests are collected for two months. Results are sent out one

	week from receipt of FOBT kit. Washington Adventist Hospital follows up with patients that had an abnormal result 3-6 months after the screening via phone call.
Outcome (Process & Impact Measures)	*Process:* The process evaluation of the overall program is conducted among staff following this event to improve the program for the following year. Results are reported out at Cancer Committee; phone calls are made, and referrals are made to those with abnormal results. DECO (an insurance eligibility management services company) helps Cancer Screening Day participants who are uninsured to obtain health insurance. Some participants return each year to receive these free cancer screenings and assistance is provided to ensure follow up with physicians or safety net clinics, as needed. *Impact:* At the Annual Cancer Screening Day (2013), Washington Adventist Hospital provided cancer screenings to a total of 65 participants: 222 cancer screenings were conducted with 206 normal results and 16 abnormal results.
Continuation of Initiative	Washington Adventist Hospital plans to continue providing an Annual Cancer Screening Day as a free service to community members.
Cost of Initiative for Current FY	The overall cost of the Cancer Screening Day program at Washington Adventist Hospital is approximately $2,780. Cost of Supplies: $1,020 Staff Salaries: $1,760 Additionally, more than 20 physicians, physician assistants and nurses volunteered their time.

* Evidence-Based:

There is evidence regarding the effectiveness of screening in early cancer detection:

Citation:

Smith, R. A., von Eschenbach, A. C., Wender, R., Levin, B., Byers, T., Rothenberger, D., Brooks, D., Creasman, W., Cohen, C., Runowicz, C., Saslow, D., Cokkinides, V. and Eyre, H. (2001), American Cancer Society Guidelines for the Early Detection of Cancer: Update of Early Detection Guidelines for Prostate, Colorectal, and Endometrial Cancers: ALSO: Update 2001—Testing for Early Lung Cancer Detection. *CA: A Cancer Journal for Clinicians*, 51: 38–75. doi: 10.3322/canjclin.51.1.38.

Initiative #4 – Diabetes Prevention

Identified Need	Diabetes affects an estimated 25.8 million people in the U.S. and of this amount 7 million to no have this 7th leading cause of death. In Maryland the number of people diagnosed has grown from 6.8% in 1999 to 9.5 % in 2012. In Prince Georges County 8.9 % of residents have been diagnosed with diabetes. The ZIP codes in the WAH CBSA area with the highest age-adjusted hospitalization rates due to diabetes are 20912, 20866, and 20903. Diabetes disproportionally affects minority populations and the elderly making this a growing health concern. Prediabetes is a condition in which blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. Prediabetes is also called impaired glucose tolerance (IGT) or impaired fasting glucose (IFG), depending on the test used to measure blood glucose levels. Having prediabetes puts one at higher risk for developing type 2 diabetes. People with prediabetes are also at increased risk for developing cardiovascular disease. Prediabetes is becoming more common in the United States. The U.S. Department of Health and Human Services estimates that about one in four U.S. adults aged 20 years or older—or 57 million people—had prediabetes in 2007. Those with prediabetes are likely to develop type 2 diabetes within 10 years, unless they take steps to prevent or delay diabetes
Hospital Initiative*	*Diabetes Prevention*: Pre-Diabetes Classes; community health screenings and education; and Project BEAT IT!
Primary Objective of the Initiative	The overall goal of this multi-faceted initiative is to provide education and awareness of diabetes and the steps that can be taken to prevent the disease. The Pre-diabetes Class at Washington Adventist Hospital focuses on lifestyle interventions to reverse pre-diabetes and to prevent the onset of type 2 diabetes. Class participants will gain knowledge about healthy eating choices, nutrition and food labels, so that they can make better nutrition choices when purchasing groceries. Information is provided to encourage participants to exercise more. Long-term goals of the class include increased overall health, improved quality of life, and weight loss due to healthy eating and exercise. The primary objective of community screenings and education is to provide low-income or underserved members of the community with diabetes-related health screenings and information that may not otherwise be able to access. The primary objective of Project BEAT IT! (Becoming Empowered Africans Through Improved Treatment of Diabetes, HIV/AIDS, and Hepatitis B) was to pilot newly-developed curricula designed to improve disease management and health outcomes of African immigrants with type 2 diabetes, hepatitis B, and/or HIV/AIDS. Separate curricula were developed for providers and for African patients with the target diseases.
Single or Multi-Year Initiative Time Period	This is a multi-year and multi-faceted initiative.
Key Partners and/or Hospitals in initiative	Key partners for diabetes education include: Diabetes Educators and Nutritionists from both Washington Adventist and Shady Grove Adventist Hospitals, partnering faith-based organizations that are addressing diabetes prevention, community organizations

development and/or implementation	such as senior centers and apartment complexes, and the Center for Health Equity and Wellness at Adventist HealthCare. Key partners for Project BEAT IT! included: Office of Minority Health, Immanuel's Church, Montgomery County Department of Health and Human Services, Prince George's County Department of Health, and D.C. Mayor's Office on African Affairs.
Evaluation Dates	Evaluations are conducted after each pre-diabetes class, and these classes are provided throughout the year. Evaluations are also conducted after each health education/screening program in the community, which also takes place year-round. Evaluation of Project BEAT IT!: Participants completed both a pre-test and a post-test on the day of the training. Participants were also asked to complete a follow-up questionnaire via Survey Monkey approximately four months after the training.
Outcome (Process & Impact Measures)	Washington Adventist Hospital Pre-diabetes Class Outcomes in FY 2013: A total of 15 people attended these two-part classes. The evaluations are conducted by a post class survey/evaluation. Program evaluations indicated that participants were strongly satisfied with the instruction received, as well as with the materials and handouts. They particularly liked the smaller class sizes, as it gave the opportunity to ask more questions. Evaluation comments indicated that all the participants were eager to learn more even after the classes ended. Pre-diabetes-related Health Screenings and Education conducted in the community – Outcomes: *Process* – health screening and education events are evaluated by staff after each event to make improvements for future events. *Impact* – Diabetes information was provided to approximately 500 people at 12 health fairs; 80 community members were provided body-mass-index (BMI) screenings at diabetes-related events; and 6 diabetes lectures were provided to a total of 95 participants (locations included: Cambodian Buddhist Temple in Silver Spring, First Baptist Church of Silver Spring (primarily African American and African immigrants), and community centers. The BEAT IT Outcomes: More than 1000 persons attended the trainings, including community trainings, trainings at Shady Grove Adventist Hospital and Washington Adventist Hospital, webinars, and Grand Rounds at both hospitals. Participants (providers) demonstrated an increased knowledge of the cultural barriers that (African) patients may face with diabetes prevention/management, and also models/techniques that can be used to improve patient-provider communication.
Continuation of Initiative	Washington Adventist Hospital's Pre-diabetes Classes will continue and will expand. Washington Adventist Hospital will continue to educate the community through health events, including health screenings and education in the community. Project BEAT IT! was grant funded and will not continue at this time.
Cost of Initiative for Current FY	Cost of Pre-Diabetes Classes: Staff Salaries: $3,000 + Supplies $75.00 = $3,075 total Cost of diabetes-related health education and screenings in the community: Estimated Staff Salaries: $5,000 Cost of Project BEAT IT! (Grant funded from Office of Minority Health): this 20-month project was funded with a $200,000 grant.

* Evidence-Based:

There is evidence regarding the effectiveness of diabetes prevention and community diabetes self-management programs:

Citations:

Vojta, D., Koehler, T., Longjohn, M., Lever, J., & Caputo, N. (2013). A coordinated national model for diabetes prevention: linking health systems to an evidence-based community program. *American Journal of Preventive Medicine.* doi: 10.1016/j.amepre.2012.12.018

Klug C, Toobert DJ, Fogerty M,. Healthy Changes for living with diabetes: an evidence-based community diabetes self-management program. *Diabetes Education*. 2008 Nov-Dec; 34(6):1053-61.

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

Areas of Need Not Directly Addressed by Washington Adventist Hospital & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
Asthma	Rates of ER visits for asthma were lower for Montgomery and Prince George's Counties than for the state of Maryland; however, black residents of both Montgomery and Prince George's Counties had asthma ER visit rates about 5 times higher than white residents, and hospitalization rates showed a similar trend.	Provide community members with resources on asthma through community outreach.	WAH is in the process of hiring a new pulmonologist to help address this identified need. Montgomery County has established The Asthma Management Program, which focuses on reaching out to Latino Children. This program provides education, support and follow-up care. Additionally, the following organizations provide the community with asthma resources: American Lung Association of Maryland, Asthma and Allergy Foundation of America (Maryland Chapter), and the Maryland Asthma Control Program.	WAH does not currently provide community outreach and educational programs specifically for asthma because asthma prevalence and rates of ER visits in Montgomery County and Prince George's County are below rates statewide, and because there are other asthma resources available in the County. WAH will continue to monitor trends in asthma to determine whether future reallocation of resources is needed to provide asthma-related community programs.

Areas of Need Not Directly Addressed by Washington Adventist Hospital & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
HIV/AIDS	Prince George's County has the 2nd highest rate of HIV/AIDS prevalence in the region (after D.C.); nearly 88% of people living with HIV/AIDS in Prince George's County are black. Black residents represent about 16% of Montgomery County's population, yet 71% of HIV cases diagnosed in 2008 were black residents. While HIV-related deaths in Montgomery County have greatly decreased in the past decade, black residents account for almost 4 out of 5 HIV-related deaths, and had a death rate that was nearly 10 times higher than whites.	Continue to support other organizations that provide services related to HIV and AIDS.	Treatment and support of those with HIV or AIDS is provided by both private and public health care providers. The safety net clinics serving Montgomery County provide diagnostic services and treatment. Montgomery County Health Department provides HIV Case Management (including dental care, counseling, support groups, home care services, education and outreach to at-risk populations), clinical services, lab tests, and diagnostic evaluations. Prince George's County Health Department provides testing in locations throughout the County, as well as health assessments, physical exams, lab tests, and case management services. Whitman Walker Clinic offers a variety of services. Maryland AIDS Administration educates	WAH does not currently provide community outreach and educational programs for HIV/AIDS due to limited financial resources, and because many HIV/AIDS services are provided by other local organizations. Adventist HealthCare's Center on Health Disparities led an initiative called Project BEAT IT! (Becoming Empowered Africans Through Improved Treatment of type 2 diabetes, HIV/AIDS, and hepatitis B), which was a grant-funded initiative from U.S. DHHS Office of Minority Health that provided culturally appropriate health education classes to health care providers and the African immigrant community to improve health outcomes related to these chronic and

Areas of Need Not Directly Addressed by Washington Adventist Hospital & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
			public and health care professionals.	infectious diseases. The 20-month grant funded project ended in September 2013.
Social Determinants of Health • **Food Access** • **Housing Quality** • **Education** • **Transportation**	**Food Access** – Montgomery County performs better than state and national baselines with regard to food deserts, while Prince George's County performs worse than state and national baselines. **Housing Quality** – 50.8 percent of renters in Montgomery County spend 30% or more of household income on rent. In the area served by WAH, shelters, transitional housing, and motel placements served nearly 8,000 residents (FY2008). **Education** – The percentage of children who enter kindergarten ready to learn in Montgomery	Partner with and support other organizations in the community that specialize in addressing needs related to food access, housing quality, education, transportation, and other social determinants of health.	**Food Access** – Manna Food Center is a central food bank in Montgomery County that provides direct food assistance at 14 locations, assisting approximately 5% of Montgomery County residents. In Prince George's County, Community Support System's pantry serves over 7,000 people each year. **Housing Quality** – WAH supports and partners with a local non-profit organization called Interfaith Works, which provides shelter to approximately 744 homeless men and women each night, and has served 135,000 meals through its Homeless Service programs. Additionally, the Montgomery County Coalition for the Homeless	WAH does not directly address many of the social determinants of health because those are not specialty areas of the hospital and WAH does not have the resources or expertise to meet many of these needs. Instead, WAH partners with and supports other organizations in the community that specialize in addressing needs related to food access, housing quality, education, transportation, and other social determinants of health.

Areas of Need Not Directly Addressed by Washington Adventist Hospital & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	County (74%) and in Prince George's County (79%) is lower than the state of Maryland baseline (81%). The percentage of students who graduate high school in 4 years is also lower in Prince George's County (73.3%) than in the state (80.7%). **Transportation** – Montgomery County ranks in the top quartile of longest commute times among all U.S. counties. The rate of pedestrian injuries on public roads in Montgomery County (44.2/100,000) is higher than the state of Maryland baseline (39.0/100,000).		has shelters and emergency housing as well as programs to provide permanent housing for families. This organization also assists with applying for Medicaid, food stamps, and other entitlement programs, as well as transportation, education completion, and vocational assistance. The Housing Initiative Partnership in Prince George's County helps low-income residents buy homes, prevents foreclosure, and helps people stay in their homes through tax assistance and loan modification programs. **Education** – The Housing Initiative Partnership sponsors a 'Reading is Fundamental' program encouraging families to read together, has a free library, sponsors summer reading programs, and offers an	

Areas of Need Not Directly Addressed by Washington Adventist Hospital & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
			English as a Second Language (ESL) program for adults. Local community colleges offer low-cost higher education opportunities. The Interagency Coalition to Prevent Adolescent Pregnancy works to reduce teen pregnancy – a common reason teenagers drop out of school. **Transportation** – For community members relying on public transportation, there is a Ride On bus stop located right next to WAH and Ride On Bus 17 will drop off passengers directly at the main entrance to the hospital. WAH also helps to arrange transportation home for many patients upon discharge.	

* For complete CHNA findings and sources, please refer to the Washington Adventist Hospital Community Health Needs Assessment (2013-2016)

PHYSICIANS

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

Washington Adventist Hospital is committed to addressing access to care and has noted an increase in the number of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our service area. According to the Maryland Hospital Association Maryland Physician Workforce Study,[10] Maryland has statewide shortages in Primary Care, Dermatology, Hematology/Oncology, Psychiatry, Anesthesiology, Emergency Medicine, Thoracic Surgery, and Vascular Surgery. Maryland also has only a borderline supply of orthopedic surgeons. These shortages are predicted to increase through 2015.

The 2012 County Health Rankings shows that the primary care physician-to-patient ratio in Prince George's County is 1,304:1 compared with the state average of 824:1 and the national benchmark of 631:1. Prince George's County has Healthcare Provider Shortage Areas (HPSA) in primary medical care, dental care, and mental health care, according to HRSA.gov. One of the HPSA's for primary medical care is in the Greenbelt/Langley Park/College Park area where there is a large Medicaid population; this is one of the primary service areas for Washington Adventist Hospital. Washington Adventist Hospital partners with local safety net clinics including Mobile Medical Care, Inc. and Mary's Center as well as individual physician practices to narrow the gap in availability of specialist providers to serve the uninsured cared for by the hospital.

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

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

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

- Anesthesia
- Emergency Physicians
- Radiologists

[10] Maryland Hospital Association Maryland Physician Workforce Study. Accessed 2013: http://www.mhaonline.org/workforce/physicians.

Non-Resident house staff and hospitalists:

- OB-Gyn
- Internal Medicine
- Psychiatry

Coverage of Emergency Department On-Call:

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

Physician recruitment to meet community need:

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

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

In FY 2013, Washington Adventist Hospital paid subsidies to physicians in the following service areas:

Physician Category	**Amount**
Emergency Department On-Call	$1,589,291.00
Non-Resident House Staff and Hospitalist	$8,303,439.00
Recruitment of Physicians to meet community need	$4,420,785.86
Total:	**15,030,126**

APPENDICES

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

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

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

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

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

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

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

Appendix I

Financial Assistance Policy Description

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

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

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

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

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

(Formerly known as Charity Care Policy)

Effective Date	01/08	Policy No:	AHC 3.19.0
Cross Referenced:	Financial Assistance - Decision Rules/Application (see Master Policy 3.19 Financial Assistance)	Origin:	PFS
Reviewed:	02/09, 06/15/10, 9/19/13	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13	Page:	1 of 12

DECISION RULES:

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

1. Once a patient qualifies for Charity Care under this policy the patient or any immediate family member of the patient living in the same household shall be eligible for Charity Care at the same level for medically necessary care when seeking subsequent care at the same hospital during the 12 month period from the initial date of service.
2. When the patient is a minor, an immediate family member is defined as; mother, father, unmarried minor natural or adopted siblings, natural or adopted children residing in the same household.
3. When the patient is not a minor, an immediate family member is defined as: spouse, minor natural or adopted siblings, natural or adopted children residing in the same household.

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

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

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

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

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

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

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

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

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

ADVENTIST HEALTH CARE, INC.

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NOTICE TO BE POSTED IN THE ADMISSIONS OFFICE, BUSINESS OFFICE AND THE EMERGENCY DEPARTMENT

ADVENTIST HEALTHCARE
NOTICE OF AVAILIBILITY OF CHARITY CARE

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

Size of Family Unit	Guideline
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,610
8	$39,630

Note: The guidelines increase **$4,020** for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660.

Revised July 2013

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

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ADVENTIST HEALTHCARE

Patient Financial Services, 820 West Diamond Ave, Suite 500, Gaithersburg, MD 20878

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

CHARITY CARE APPLICATION- DEMOGRAPHICS

Date: _____Account Number(s)_____

Patient Name: _____ Birth Date: _____

Address: _____ Sex: _____

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

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

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application_____

Dependents Listed on Tax Form:

Name: _____ Age: ____Relationship:_____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Name: _____ Age: ____Relationship: _____

Employment: Patient employer **Spouse employer**

Name: _____ Name:_____

Address: _____ Address: _____

Telephone #: _____ Telephone #:_____

Social Security #: _____ Social Security #: _____

How long employed: _____ How long employed: _____

TOTAL FAMILY INCOME $_____

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

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

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CHARITY CARE APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _____

Food _____

Transportation _____

Utilities _____

Health Insurance premiums _____

Medical expenses not covered by insurance _____

Doctor: _____

_____

_____

Hospital: _____

_____

TOTAL: _____

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

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

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

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

Applicant Signature: _____ Date: _____

Return Application To: Adventist HealthCare
Patient Financial Services

ADVENTIST HEALTH CARE, INC.

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Attn: Customer Service Manager
820 West Diamond Avenue. Suite 500
Gaithersburg, MD 20878

COMMUNITY CHARITY CARE APPLICATION- OFFICIAL DETERMINATION ONLY

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

The reason for Denial:

What additional information is needed?:

Approval Details:

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

Approval Letter was sent on _____

AUTHORIZED SIGNATURES:

_____
CS/COLLECTION MANAGER
UP TO $1500.00

_____
Sr. ASSISTANT DIRECTOR
UP TO $2500.00

_____
REGIONAL DIRECTOR
UP TO $25,000.00

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

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

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Revised July 2013

2013 POVERTY GUIDELINES

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	$11,490	100%	0%
2	100%	$15,510	100%	0%
3	100%	$19,530	100%	0%
4	100%	$23,550	100%	0%
5	100%	$27,570	100%	0%
6	100%	$31,590	100%	0%
7	100%	$35,610	100%	0%
8	100%	$39,630	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	125%	$14,363	100%	0%
2	125%	$19,388	100%	0%
3	125%	$24,413	100%	0%
4	125%	$29,438	100%	0%
5	125%	$34,463	100%	0%
6	125%	$39,488	100%	0%
7	125%	$44,513	100%	0%
8	125%	$49,538	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	150%	$17,235	100%	0%
2	150%	$23,265	100%	0%
3	150%	$29,295	100%	0%
4	150%	$35,325	100%	0%
5	150%	$41,355	100%	0%

6	150%	$47,385	100%	0%
7	150%	$53,415	100%	0%
8	150%	$59,445	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	175%	$20,108	100%	0%
2	175%	$27,143	100%	0%
3	175%	$34,178	100%	0%
4	175%	$41,213	100%	0%
5	175%	$48,248	100%	0%
6	175%	$55,283	100%	0%
7	175%	$62,318	100%	0%
8	175%	$69,353	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	200%	$22,980	100%	0%
2	200%	$31,020	100%	0%
3	200%	$39,060	100%	0%
4	200%	$47,100	100%	0%
5	200%	$55,140	100%	0%
6	200%	$63,180	100%	0%
7	200%	$71,220	100%	0%
8	200%	$79,260	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	225%	$25,853	90%	10%
2	225%	$34,898	90%	10%
3	225%	$43,943	90%	10%
4	225%	$52,988	90%	10%
5	225%	$62,033	90%	10%
6	225%	$71,078	90%	10%
7	225%	$80,123	90%	10%
8	225%	$89,168	90%	10%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	$28,725	80%	20%
2	250%	$38,775	80%	20%
3	250%	$48,825	80%	20%
4	250%	$58,875	80%	20%
5	250%	$68,925	80%	20%
6	250%	$78,975	80%	20%
7	250%	$89,025	80%	20%
8	250%	$99,075	80%	20%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	275%	$31,598	70%	30%
2	275%	$42,653	70%	30%
3	275%	$53,708	70%	30%
4	275%	$64,763	70%	30%
5	275%	$75,818	70%	30%
6	275%	$86,873	70%	30%
7	275%	$97,928	70%	30%
8	275%	$108,983	70%	30%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	300%	$34,470	60%	40%
2	300%	$46,530	60%	40%
3	300%	$58,590	60%	40%
4	300%	$70,650	60%	40%
5	300%	$82,710	60%	40%
6	300%	$94,770	60%	40%
7	300%	$106,830	60%	40%
8	300%	$118,890	60%	40%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**

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1	350%	$40,215	50%	50%
2	350%	$54,285	50%	50%
3	350%	$68,355	50%	50%
4	350%	$82,425	50%	50%
5	350%	$96,495	50%	50%
6	350%	$110,565	50%	50%
7	350%	$124,635	50%	50%
8	350%	$138,705	50%	50%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	400%	$45,960	40%	60%
2	400%	$62,040	40%	60%
3	400%	$78,120	40%	60%
4	400%	$94,200	40%	60%
5	400%	$110,280	40%	60%
6	400%	$126,360	40%	60%
7	400%	$142,440	40%	60%
8	400%	$158,520	40%	60%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	450%	$51,705	30%	70%
2	450%	$69,795	30%	70%
3	450%	$87,885	30%	70%
4	450%	$105,975	30%	70%
5	450%	$124,065	30%	70%
6	450%	$142,155	30%	70%
7	450%	$160,245	30%	70%
8	450%	$178,335	30%	70%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	500%	$57,450	20%	80%
2	500%	$77,550	20%	80%
3	500%	$97,650	20%	80%

4	500%	$117,750	20%	80%
5	500%	$137,850	20%	80%
6	500%	$157,950	20%	80%
7	500%	$178,050	20%	80%
8	500%	$198,150	20%	80%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	550%	$78,994	10%	90%
2	550%	$106,631	10%	90%
3	550%	$134,269	10%	90%
4	550%	$161,906	10%	90%
5	550%	$189,544	10%	90%
6	550%	$217,181	10%	90%
7	550%	$244,819	10%	90%
8	550%	$272,456	10%	90%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	600%	$103,410	5%	95%
2	600%	$139,590	5%	95%
3	600%	$175,770	5%	95%
4	600%	$211,950	5%	95%
5	600%	$248,130	5%	95%
6	600%	$284,310	5%	95%
7	600%	$320,490	5%	95%
8	600%	$356,670	5%	95%

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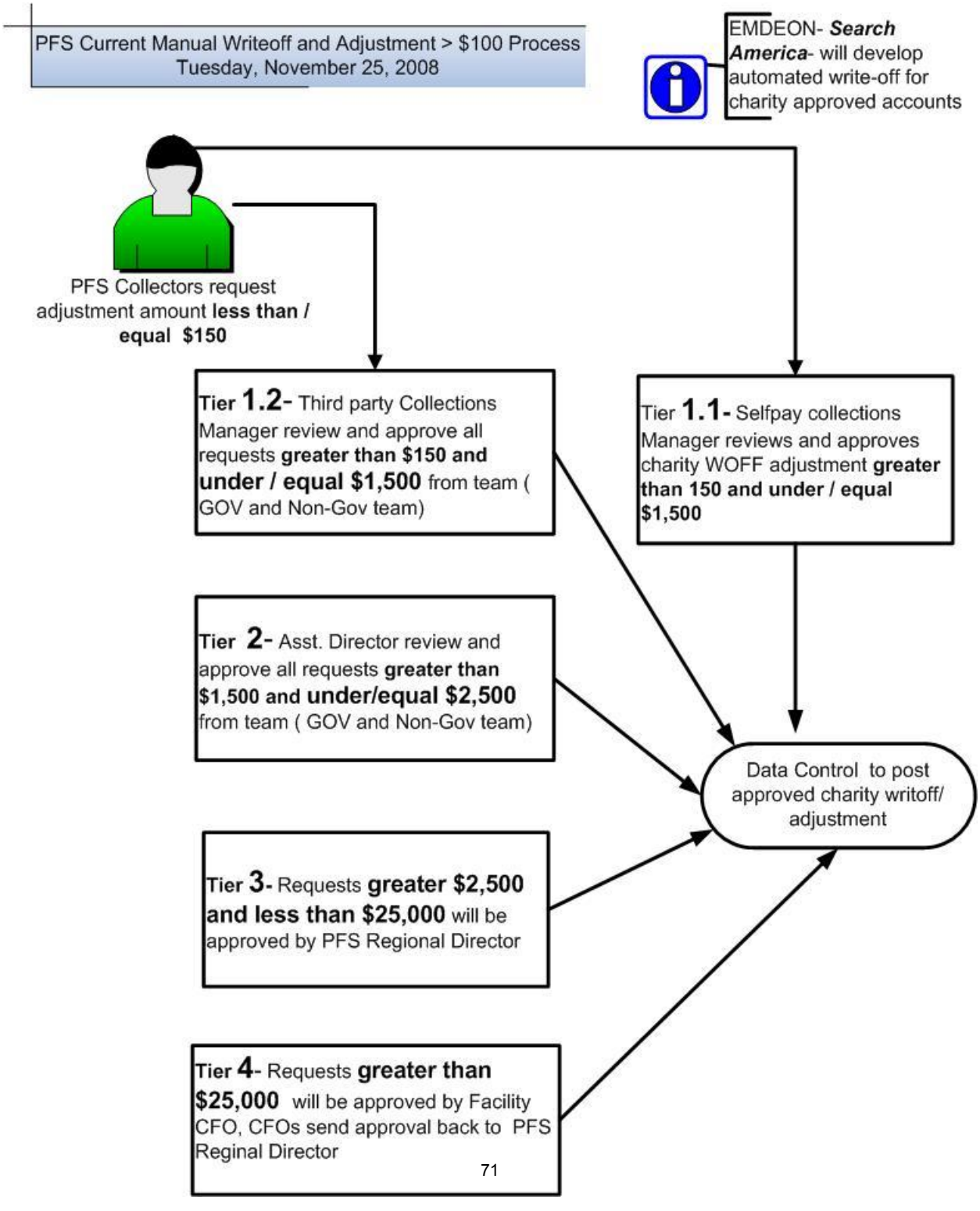

Appendix III

Washington Adventist Hospital
A Member of Adventist HealthCare

Public Notice of Financial Assistance & Charity Care

Application Form

Download Charity Care Application Form (en Español)

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

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

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

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

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

Aviso Publico Sobre Ayuda Financiera

El Hospital de Washington Adventist esta comprometido a acomodar las necesidades de asistencia medica de su comunidad a través de un servicio de curación física, mental y espiritual. Todos los pacientes, sin tener en cuenta su raza, religión, sexo, edad, origen nacional o estado financiero, pueden solicitar ayuda financiera al Hospital de Washington Adventist.

Cada aplicación para Ayuda Financiera será evaluada de acuerdo a la necesidad del paciente y/o familia, sus ingresos o recursos financieros.

Parte de la misión de Hospital de Washington Adventist es proporcionar ayuda financiera a aquellos que no pueden pagar por el cuidado medico recibido. Esta póliza requiere que los pacientes cooperen y se eduquen ellos mismos acerca de todos los programas disponibles (incluyendo ayuda medica, Medicaid, compensación de trabajo y otros programas estatales y locales) que podrían proporcionar la cobertura para servicios médicos.

Una determinación de elegibilidad puede ser hecha inmediatamente si servicios médicos ya han sido proporcionados o dentro de dos días laborales después de la entrega de la solicitud donde esta incluida suficiente información financiera.

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

Appendix III

Usted también puede recoger una aplicación para la Ayuda Financiera en el hospital en el Departamento de Admisión ubicado en el primer piso o el Departamento de Emergencia en el LL1.

Appendix IV

Mission & Values

Mission

We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing.

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

Values

Adventist HealthCare has identified five core values that we use as a guide in carrying out our day-to-day activities:

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

2. **Integrity:** We are above reproach in everything we do.

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

4. **Excellence:** We provide world class clinical outcomes in an environment that is safe for both our patients and care givers.

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