Adventist HealthCare
Washington Adventist Hospital

COMMUNITY BENEFIT NARRATIVE
Effective for FY2015 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

December 15, 2015

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 acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

Table I

Bed Designation:	**Inpatient Admissions** *(CY2014)*:	**Primary Service Area Zip Codes:**	**All other Maryland Hospitals Sharing Primary Service Area:**	**Percentage of Uninsured Patients, by County** *(CY2014)*:	**Percentage of Patients who are Medicaid Recipients, by County** *(CY2014)*:
232	13,159	20783 20912 20782 20903 20904 20901 20910 20906 20740 20902	**Holy Cross Silver Spring** 20783, 20912, 20782, 20903, 20904, 20901, 20910, 20902, 20906 **Montgomery General** 20906, 20904 **Suburban** 20906, 20902 **Laurel Regional Hospital** 20740 **Adventist HealthCare Physical Health & Rehabilitation** 20783, 20904, 20901,20910, 20902, 20740, 20906 **Adventist HealthCare Behavioral Health & Wellness Services** 20904, 20901, 20910, 20902, 20906 **Hospital Brook Lane** 20906	**Prince George's County:** 8.6% **Montgomery County:** 6.75%	**Prince George's County:** 12.34% **Montgomery County:** 12.14%

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. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Adventist HealthCare 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 Adventist HealthCare Washington Adventist Hospital:

County	Percentage
Prince George's County	48%
Montgomery County	40%
District of Columbia	6%
Other	6%

Figure 1. Adventist HealthCare Washington Adventist Hospital Discharges by County, 2014

Approximately 85 percent of discharges come from our Total Service Area, which is considered Adventist HealthCare Washington Adventist Hospital's Community Benefit Service Area "CBSA" (see Figure 2).

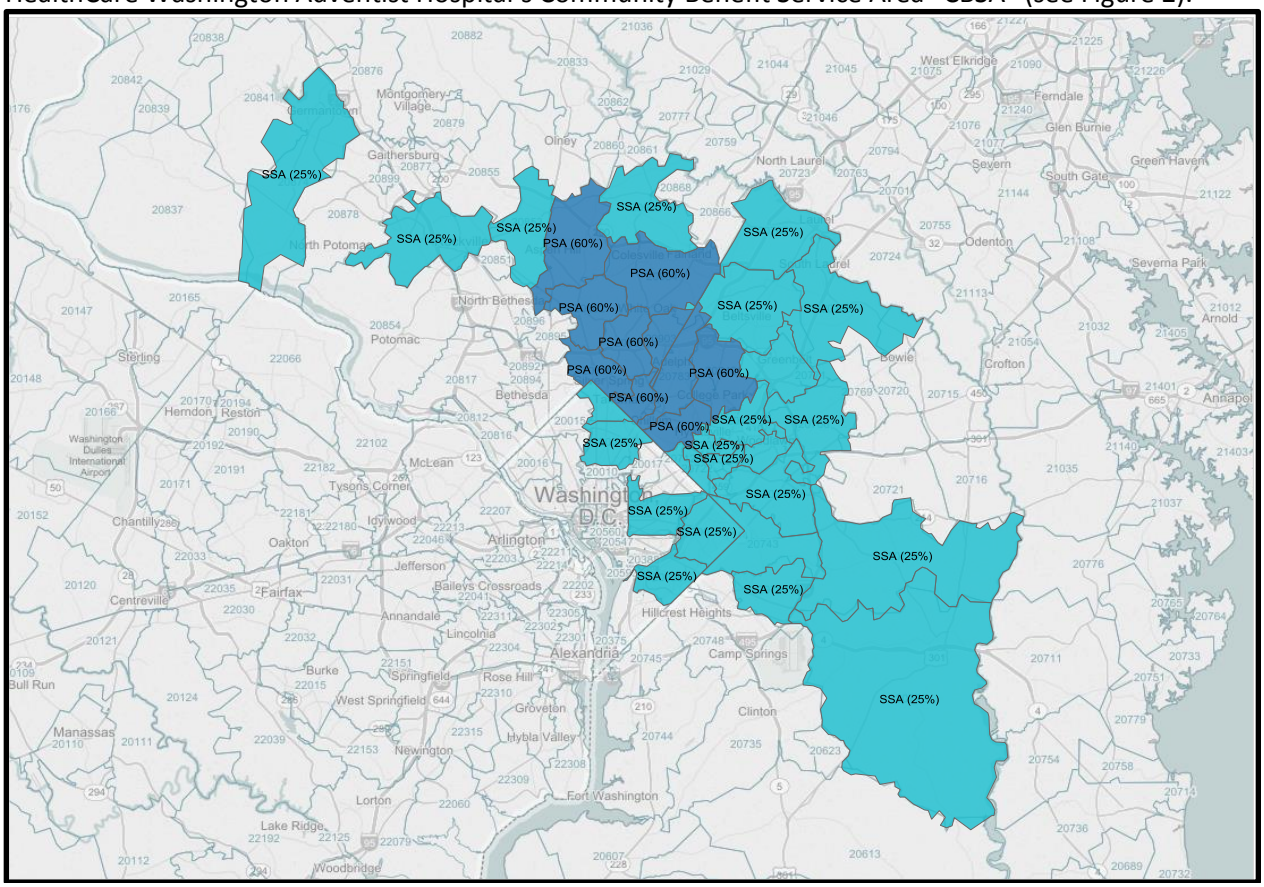

Figure 2. Map of Adventist HealthCare Washington Adventist Hospital's Primary (navy) and Secondary (teal) Service Areas based on 2014 inpatient discharges

Within that area, 60 percent of discharges are from the Primary Service Area including the following zip codes/cities:

College Park (20740); Hyattsville (20783, 20782); Silver Spring (20903, 20901, 20904, 20910, 20902, 20906); Takoma Park (20912).

We draw 25 percent of discharges from our Secondary Service Area including the following zip codes/cities:

Riverdale (20902); Beltsville (20705); Hyattsville (20784, 20781, 20785); Lanham (20706); Greenbelt (20770); Washington, DC (20011, 20012, 20020, 20019, 20002); Laurel (20708, 20707); Mount Rainier (20712); Upper Marlboro (20774; 20772); Capitol Heights (20743); Bladensburg (20710); Brentwood (20722); Rockville (20850; 20853); Germantown (20874); District Heights (20747); Silver Spring (20905).

Our Community Benefit Service Area (CBSA), covering approximately 85 percent of discharges, includes 1,264,909 people (see Figure 3).

	2014 Estimates							
	White	**Black/AF American**	**American Indian / Alaska Native**	**Asian**	**Native HI/PI**	**Other Race**	**2+ Races**	**Hispanic / Latino**
Community Benefit Service Area (CBSA)	366,922	625,029	6,952	85,685	981	131,017	48,363	250,469
	29%	49.41%	0.55%	6.77%	0.08%	10.36%	3.82%	19.80%
Primary Service Area (PSA)	164,762	118,278	3,100	35,740	446	65,964	19,467	124,766
	40.41%	29.01%	0.76%	8.77%	0.11%	16.18%	4.77%	30.60%
Secondary Service Area (SSA)	202,120	506,751	3,852	49,945	535	65,053	28,896	125,703
	23.58%	59.1%	0.45%	5.83%	0.06%	7.59%	3.37%	14.67%

Figure 3. Population Estimates (2014) by Race/Ethnicity for Washington Adventist Hospital's Community Benefit Service Area (85% of discharges), Primary Service Area (60% of discharges) and Secondary Service Area (25% 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 by 2010, making it the third most populated jurisdiction in the Washington metropolitan area[1]. The 2014 population estimate for Prince

[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

George's County has reached 904,430 residents (Census.gov, Quick Facts, accessed 2015). 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, 20.2 percent of the county's residents are foreign-born (Census.gov, Quick Facts, accessed 2015). One fifth of the county's households speak a language other than English at home. Spanish is the most frequently spoken language other than English, and among Spanish-speaking homes, about half speak English less than "very well" (2014 American Community Survey, 1-Year Estimates).

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 just over one million residents (Census.gov, Quick Facts, accessed 2014). Racial and ethnic diversity has concurrently increased with this drastic increase in population numbers. Non-Hispanic whites now comprise only 46 percent of the population of Montgomery County, a decrease of more than 20 percent over the last two decades (U.S. Census Bureau, 2014 Population Estimate). 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 (18.7 percent) is more than double the percentage of Hispanics or Latinos in the state of Maryland (9.3 percent), and within the county, it outnumbers all populations other than non-Hispanic whites (Census.gov, Quick Facts – 2014 estimate, accessed 2015).

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 gone 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.

b) In Table II, describe the population within the CBSA, including 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.

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

[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

(Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II

Median Household Income within the CBSA

Median Household Income

Prince George's County: $73,623
Montgomery County: $98,221
Source: U.S. Census Bureau, State and County Quick Facts, 2009-2013

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 served by Adventist HealthCare Washington Adventist Hospital (Montgomery & Prince George's Counties), across racial and ethnic groups, non-Hispanic whites have the highest median household income, while blacks and Hispanics have the lowest (see Figure 4). However, when looking at the state of Maryland as a whole, Asians have the highest median income.

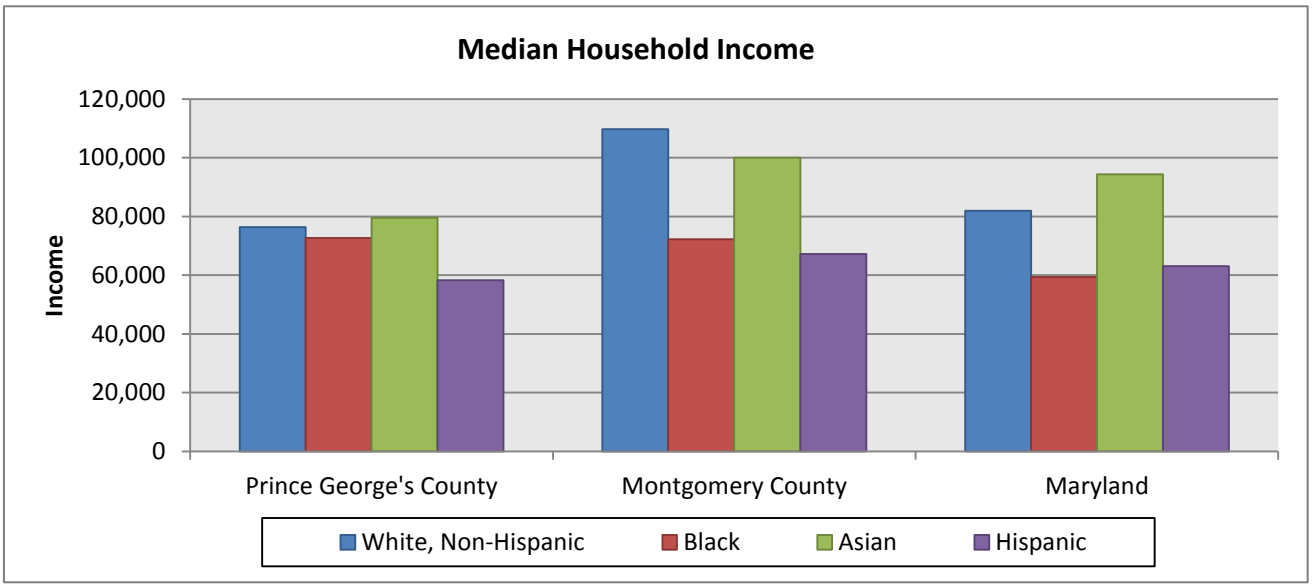

Figure 4. Median Household Income, Prince George's County, Montgomery County and Maryland by Race and Ethnicity 2014 (US Census Bureau, 2014 1-Year ACS Estimates)

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

From 2009-2013, Montgomery County experienced poverty levels lower than that of the state of Maryland overall. According to the U.S. Census Bureau, 7 percent of Montgomery County residents and 9.9 percent of Prince George's County residents were living in poverty compared to 10.1 percent of Maryland residents.

Despite lower rates of poverty in Montgomery County compared to the state, racial disparities are still evident. Poverty levels among whites were the lowest at 3.80 percent and highest among Blacks at 11.5 percent and Hispanics at 10.5 percent (see Figure 5).

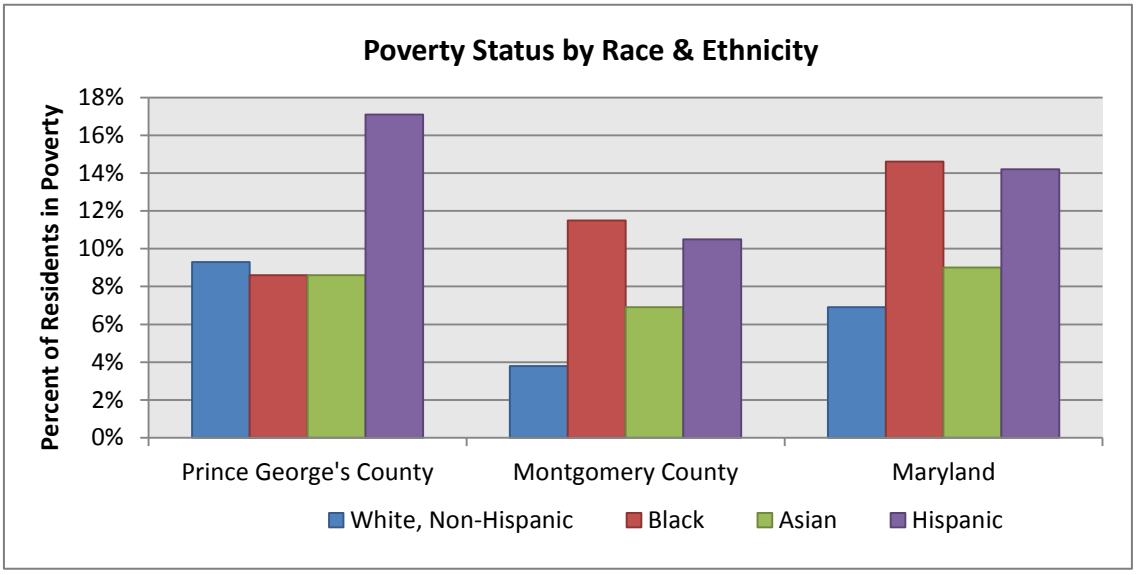

Figure 5. Poverty Status by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland 2014 (US Census Bureau, 2014 1-Year ACS Estimates)

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

Approximately 9.65 percent of all civilian non-institutionalized Montgomery County residents and 13 percent of Prince George's County residents are uninsured (U.S. Census Bureau, ACS 1-Year Estimate, 2014). This number is compared to 7.87 percent of Maryland residents and 11.68 percent of U.S. residents (U.S. Census Bureau, ACS 1-Year Estimate, 2014).

Across Montgomery County, Prince George's County, and Maryland, Hispanics are uninsured at rates significantly higher than whites, blacks, and Asians. Nearly 39 percent of Hispanics are uninsured in Prince George's County, compared to 25 percent in Montgomery County and 26.6 percent in Maryland (see Figure 6). Whites are least likely to be uninsured across Prince George's County, Montgomery County, and Maryland.

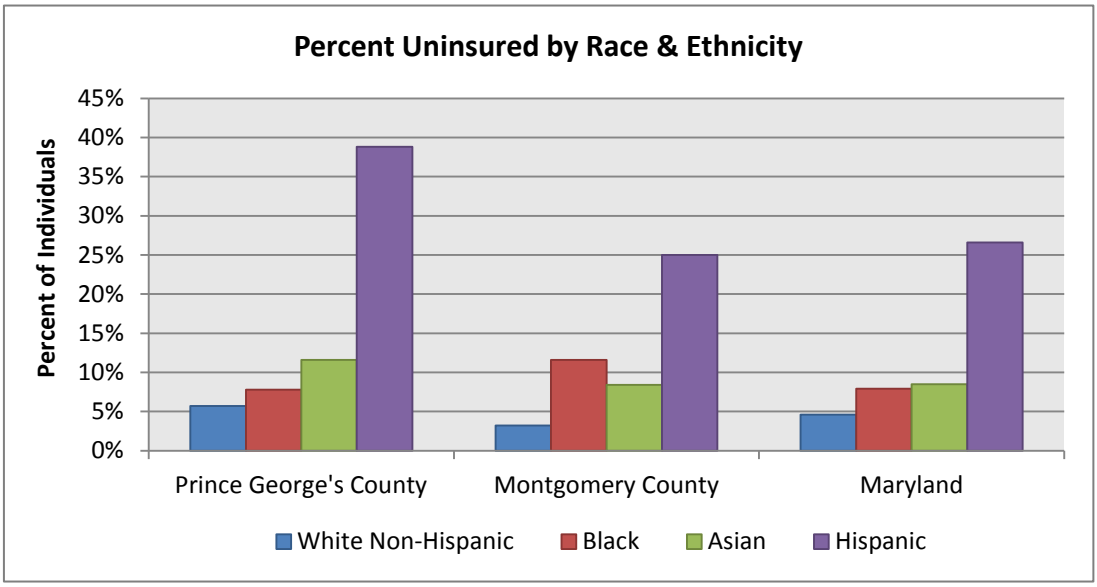

Figure 6. Percent Uninsured by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2014 (US Census Bureau, 2014 1-Year ACS Estimates)

Percentage of Medicaid recipients by County within the CBSA.

Percentage of Medicaid Recipients by County within the CBSA

Montgomery County: 13.31% (136,035)

Prince George's County: 19.62% (176,184)

Source: U.S. Census Bureau, American Community Survey 1-Year Estimate, 2014

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

According to the 2013 Maryland State Health Improvement Process, the overall life expectancy for Montgomery County is 84.3 years, 4.7 years greater than that of Maryland (79.6) and 4.5 years greater than the Maryland 2017 target of 79.8 years (see Figure 7). However, when stratifying by race, a significant gap can be seen between black and white residents. The life expectancy for white residents of Montgomery County is 84.3 years and for black residents is 82.4 years (see Figure 7). In Prince George's County, the overall life expectancy is 79.6 years, which is the same as that of Maryland. When stratifying by race, the life expectancy for white residents is 80.6 years, compared to only 78.9 years among black residents of Prince George's County.

County	SHIP Objective	SHIP 2012 County Baseline	SHIP 2013 County Update	SHIP 2013 County Update (Race/ Ethnicity)	SHIP 2013 Maryland Update	SHIP 2013 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Increase life expectancy in Maryland	79.2	79.6	Black – 78.9 White – 80.6	79.6	Black – 77.2 White – 80.3	79.8
Montgomery		84.1	84.3	Black – 82.4 White – 84.3			

Figure 7. Life Expectancy at Birth, Prince George's and Montgomery Counties
(Maryland SHIP County Profile, 2013)

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

Crude Mortality Rates

The mortality rate in Montgomery County is 573.2 per 100,000 population, and the mortality rate in Prince George's County is 597.1 per 100,000 population. These rates are lower than the mortality rate for the state of Maryland overall, at 766.5 per 100,000 population (see Figure 8). The highest mortality rates in Montgomery County, Prince George's County, and Maryland are seen among white residents and the lowest among Hispanic residents.

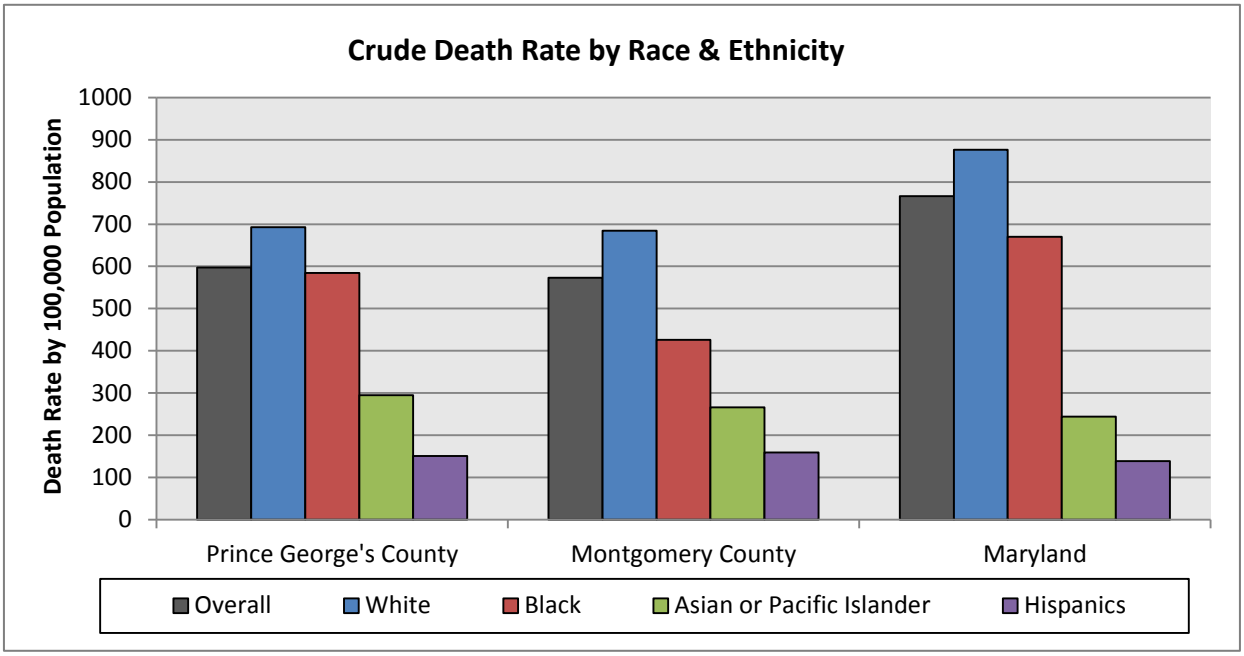

Figure 8. Crude Death Rate by Race and Ethnicity for Prince George's County, Montgomery County, and Maryland 2013 (Maryland Department of Health and Mental Hygiene, Maryland *Vital Statistics Annual Report, 2013.* Accessed: http://dhmh.maryland.gov/vsa/Documents/13annual.pdf)

Infant Mortality

Although Montgomery County has met and surpassed the Maryland SHIP 2017 target for infant mortality, black residents continue to experience higher rates of infant mortality than other racial and ethnic groups. In Prince George's County, which has a majority African American/Black population, the rate of infant mortality (10.6 per 1,000 live births) is significantly higher than that of the state of Maryland (6.6 per 1,000 live births) (see Figure 9).

County	SHIP Objective	SHIP 2012 County Baseline	SHIP 2013 County Update	SHIP 2013 County Update (Race/ Ethnicity)	SHIP 2013 Maryland Update	SHIP 2013 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Reduce Infant Deaths	8.6	7.8	NH Black -10.6 Hispanic - 4.7 NH White - 5.1	6.6	NH Black -10.6 Hispanic--4.7 NH White--4.6	6.3
Montgomery		5.1	4.7	NH Black - 9.9 Hispanic - 2.6 NH White -3.5			

Figure 9. Infant Mortality Rate (per 1,000 Live Births), by Race/Ethnicity, Prince George's and Montgomery Counties (Maryland SHIP County Profile, 2013)

Access to Healthy Food

Healthy Eating Behaviors

In Montgomery County, 66.7 percent of the adult population consumes less than five servings of fruits and vegetables daily. This proportion is lower than the Prince George's County average of 70.7 percent or Maryland's average of 72.4 percent (see Figure 10).

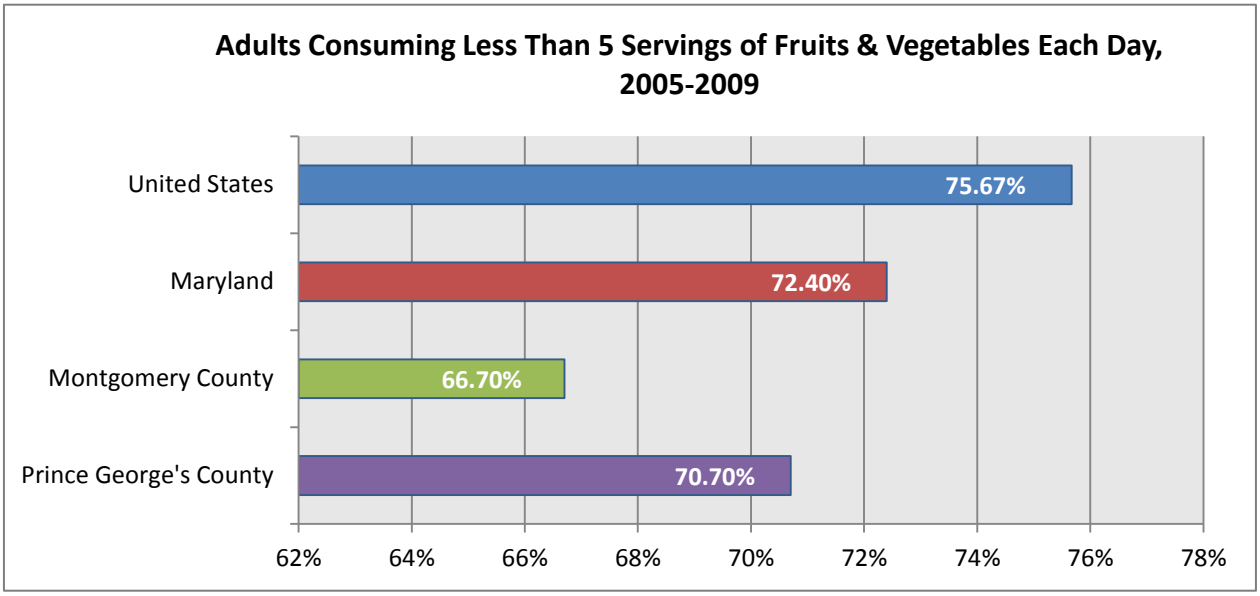

Figure 10. Adults Consuming Less Than 5 Servings of Fruits & Vegetables Each Day
(Community Commons. *Community Health Needs Assessment,* 2013.
http://assessment.communitycommons.org/CHNA/report?page=3&id=404)

In Montgomery County, there are differences in fruit and vegetable consumption among racial and ethnic groups. A higher percentage of white (33%) and Asian (31%) residents consume five or more servings of fruits and vegetables daily, compared to the county as a whole (29.6 %). However, only 14.2 percent of the Hispanic residents in the county consume the recommended number of fruit and vegetable servings (see Figure 11).

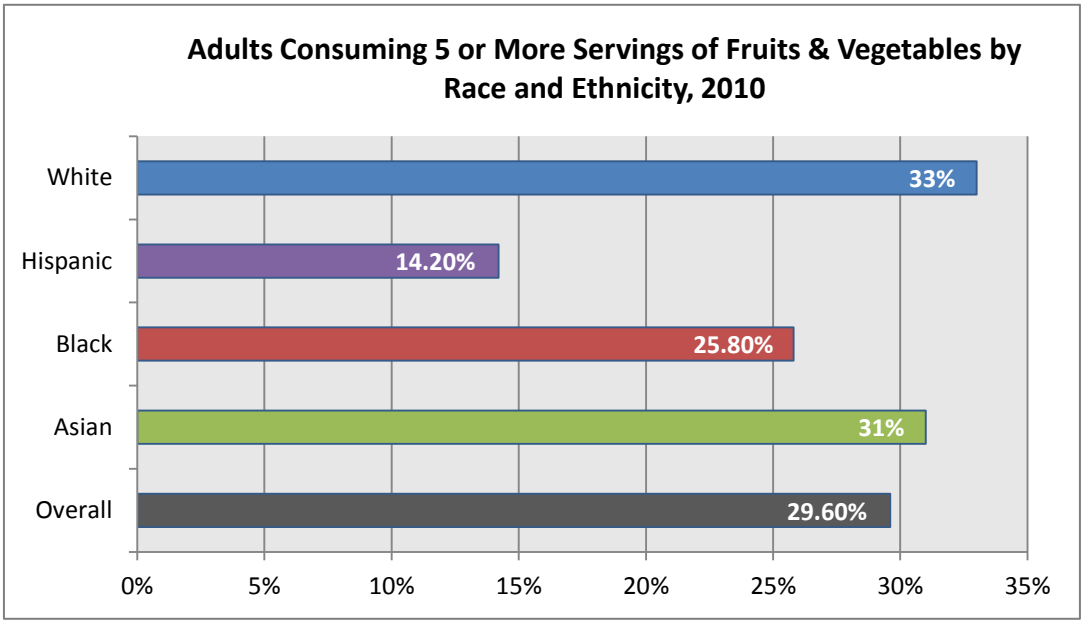

Figure 11. Fruit and Vegetable Consumption by Race and Ethnicity, Montgomery County, 2010 (http://www.healthymontgomery.org/)

Food Environment

Food insecurity is defined by the USDA as lack of access to enough food for a healthy life and limited or uncertain availability of adequately nutritious foods (feedingamerica.org). In 2013, 7.9 percent of the Montgomery County population experienced food insecurity, compared to 12.8 percent of the Maryland population and 15.8 percent of the country's population. Prince George's County had a higher rate of food insecurity at 14.8 percent (see Figure 12).

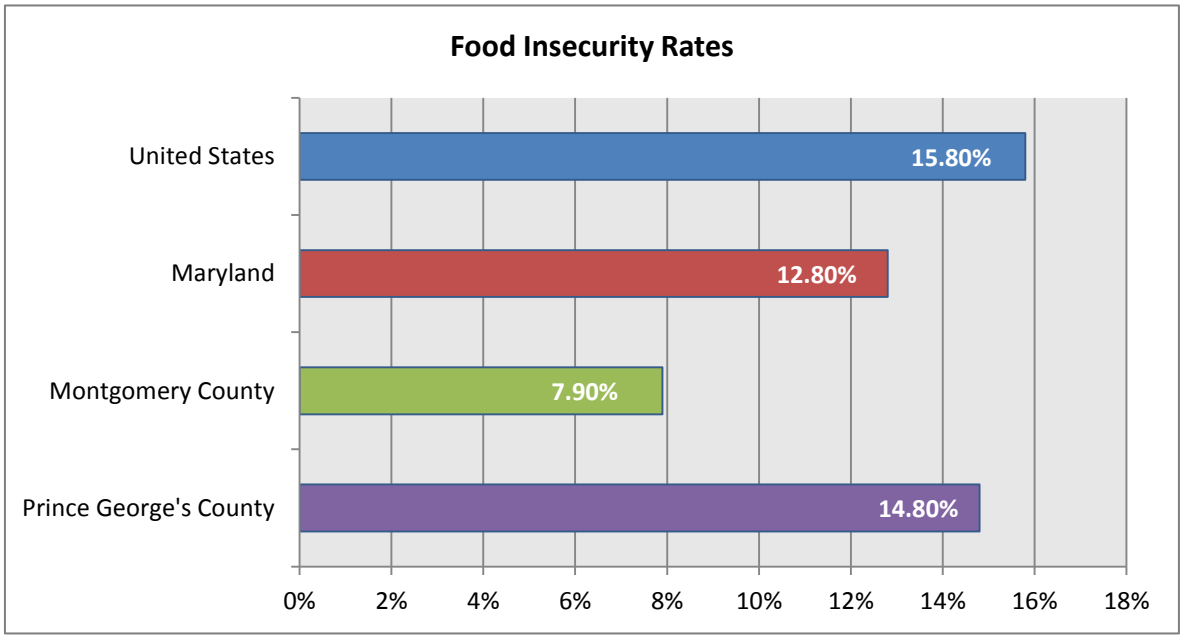

Figure 12. Percent of Food Insecure Population.
(Feeding America. *Map the Meal Gap,* 2013. Accessed: map.feedingamerica.org)

One measure of healthy food access and environmental influence on healthy behavior is access to grocery stores. The Community Commons defines grocery stores as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. In Montgomery County there are 21.1 grocery stores per 100,000 population, a rate very similar to that of Maryland (21.5 per 100,000 population) and the U.S. (21.2 per 100,000). However, in Prince George's County, there are only 18.42 grocery stores per 100,000 population (see Figure 13).

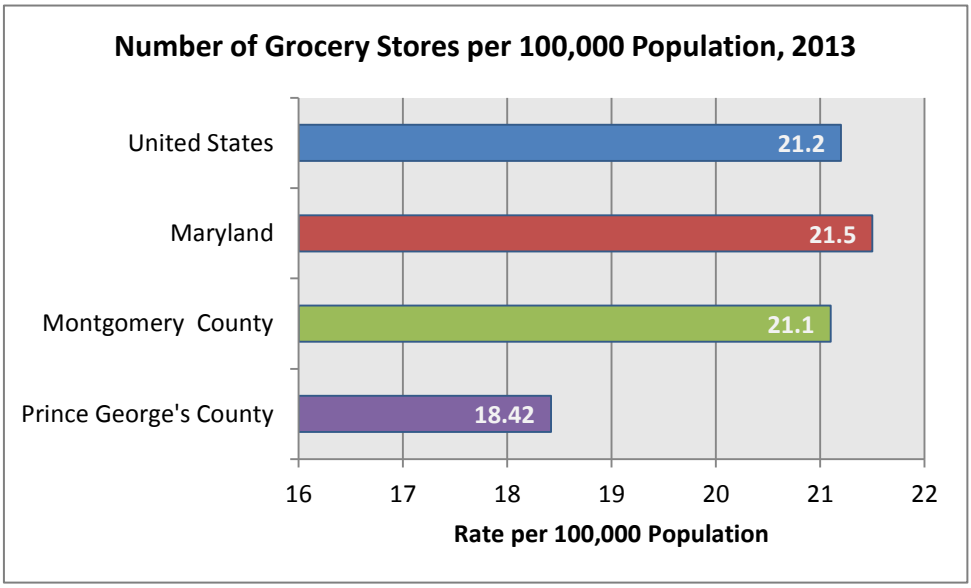

Figure 13. Number of Grocery Stores per 100,000 Population.
(Community Commons. *Community Health Needs Assessment,* 2013.
http://assessment.communitycommons.org/CHNA/report?page=3&id=404)

Fast food restaurant access has been on the rise over the past several years at the local and national levels. From 2009 to 2013, the rate in Maryland has increased from 85.77 to 86.6 per 100,000 population.[5] In Prince George's County, residents have access to fast food restaurants at a rate of 87.21 per 100,000 population, a rate higher than Montgomery County (81.6 establishments per 100,000 population), and higher than that of the country overall (72.7 per 100,000 population), but slightly less than that of Maryland (86.6 per 100,000 population)(see Figure 14).

[5] Community Commons. *Community Health Needs Assessment*. (2013). Accessed: http://assessment.communitycommons.org/CHNA/)

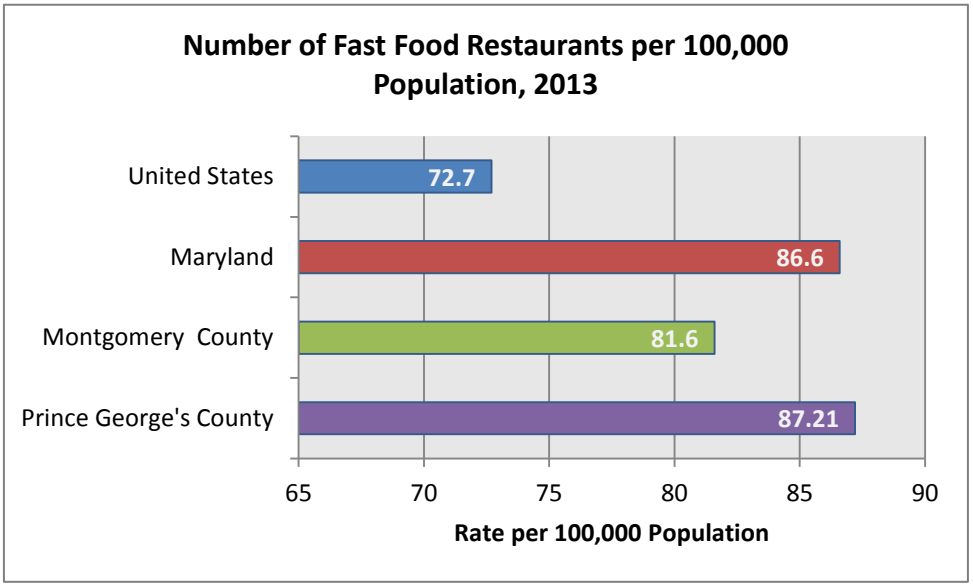

Figure 14. Number of Fast Food Restaurants per 100,000 Population.
(Community Commons. *Community Health Needs Assessment,* 2013.
http://assessment.communitycommons.org/CHNA/report?page=3&id=404)

Transportation

Commuting

The majority of both Prince George's (67.50 percent) and Montgomery County (64.10 percent) residents drive to work alone or utilize public transportation (16 percent) (see Figure 15).

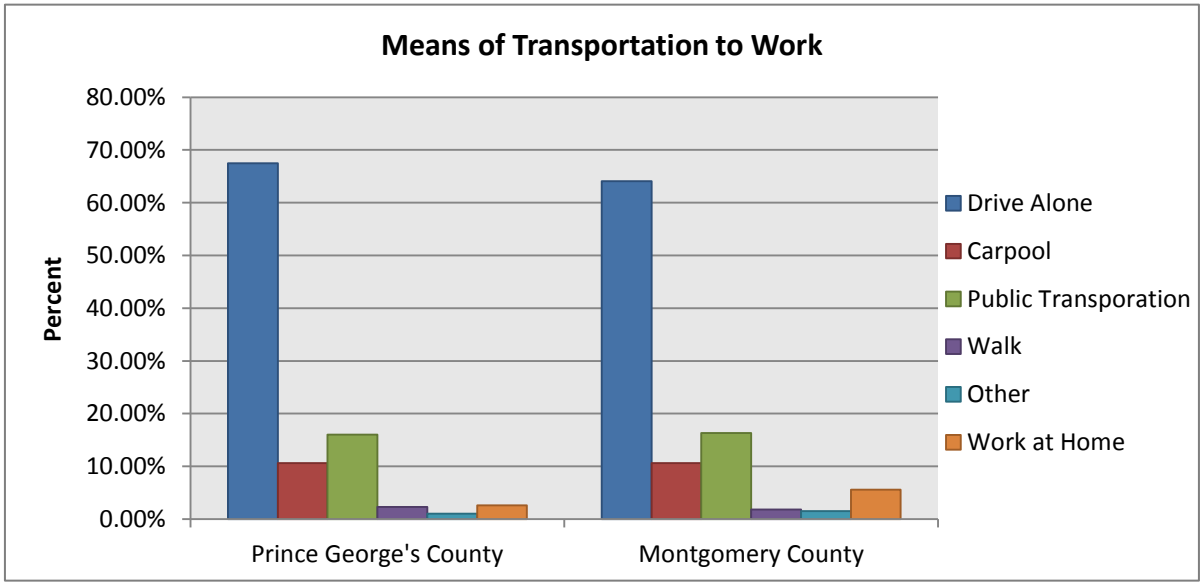

Figure 15. Means of Transportation to Work.
(US Census Bureau, 2014 ACS 1-Year Estimates)

The mean travel time to work for Montgomery County is 34.2 minutes; whereas the mean travel time for Prince George's County is 35.8 minutes (see Figure 16).

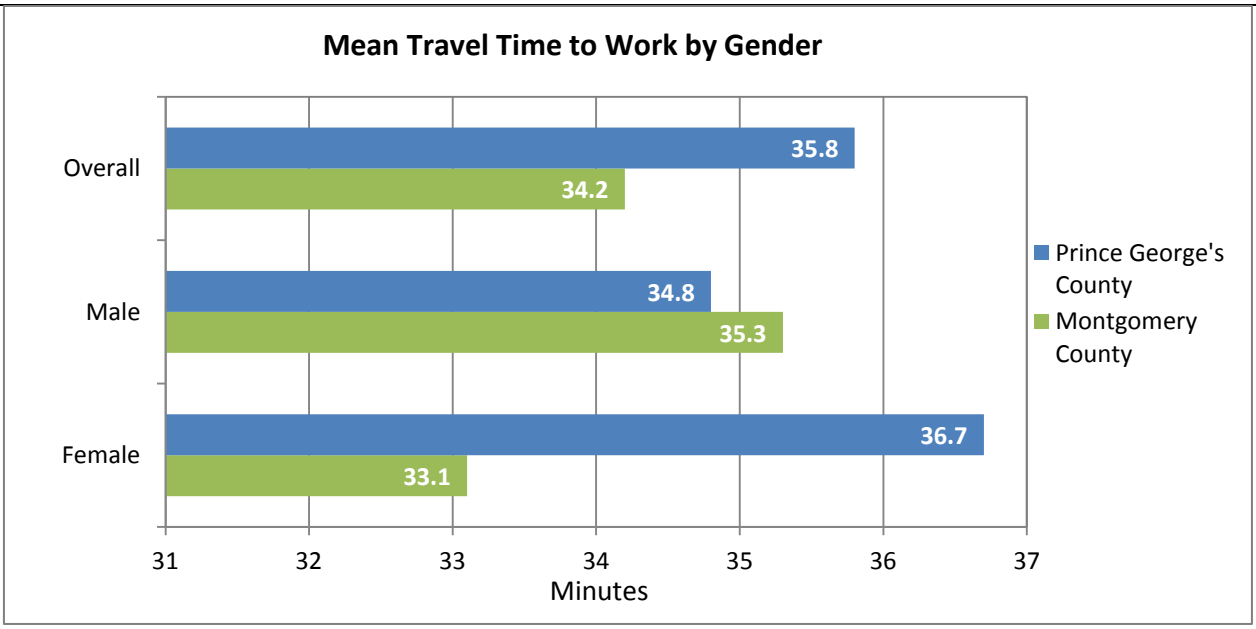

Figure 16. Mean Travel Time to Work by Gender for Prince George's County and Montgomery County (Healthy Montgomery, 2009-2013; PGC Health Zone, 2009-2013)

Pedestrian Safety

The rate of pedestrian injuries on public roads in Montgomery County (41.3 per 100,000 population) is nearly equivalent to that of the state (42.5 per 100,000 population), whereas the rate in Prince George's County is slightly lower at 39.6 per 100,000 population. The rates have increased since the 2013 County measures and they remain higher than the SHIP 2017 target of 35.6 per 100,000 population (see Figure 17).

County	SHIP Objective	SHIP 2012 County Measure	SHIP 2013 County Measure	SHIP 2014 County Update	SHIP 2014 Maryland Update	Maryland SHIP 2017 Target
Prince George's	Reduce rate of pedestrian injuries	35.4	37.2	39.6	42.5	35.6
Montgomery		38.9	35.6	41.3		

Figure 17. Rate of Pedestrian Injuries per 100,000 Population, Prince George's and Montgomery Counties, 2014 (Maryland SHIP, 2014)

The pedestrian death rate in Montgomery County at 1.2 deaths per 100,000 population, is lower than that of Maryland (1.82 per 100,000 population)[6] and the Healthy People 2020 target of 1.4 deaths per 100,000 population; however, the pedestrian death rate in Prince George's County at 1.7 deaths per 100,000 population is higher than both state and national rates[7].

From 2009 to 2012 in Montgomery County, white non-Hispanic individuals experienced the highest number of traffic

[6] Traffic Safety Facts 2013 Data. U.S. Department of Transportation National Highway Traffic Safety Administration. February 2015. Accessed from: http://www-nrd.nhtsa.dot.gov/Pubs/812124.pdf

[7] Prince George's County Health Zone, 2013.

fatalities among both vehicle occupants and non-occupants (see Figure 18 -A).

Montgomery County Traffic Fatalities					
Person Type by Race/Hispanic Origin		2009	2010	2011	2012
Occupants (All Vehicle Types)	Hispanic	4	4	0	2
	White Non-Hispanic	14	14	9	11
	Black, Non-Hispanic	3	8	1	7
	Asian, Non-Hispanic/Unknown	1	0	0	0
	All Other Non-Hispanic or Race	5	3	1	3
	Unknown Race and Unknown Hispanic	1	3	19	7
	Total	28	32	30	30
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	0	1	0	0
	White Non-Hispanic	9	7	2	4
	Black, Non-Hispanic	1	0	1	2
	Asian, Non-Hispanic/Unknown	0	0	0	0
	All Other Non-Hispanic or Race	1	2	0	0
	Unknown Race and Unknown Hispanic	0	5	7	1
	Total	11	15	10	7
Total	Hispanic	4	5	0	2
	White Non-Hispanic	23	21	11	15
	Black, Non-Hispanic	4	8	2	9
	Asian, Non-Hispanic/Unknown	1	0	0	0
	All Other Non-Hispanic or Race	6	5	1	3
	Unknown Race and Unknown Hispanic	1	8	26	8
	Total	39	47	40	37

Figure 18-A. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2009-2013
(National Highway Traffic Safety Administration, Traffic Safety Facts, 2013. Retrieved: http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/24_MD/2013/Counties/Maryland_Montgomery%20County_2013.HTM)

From 2009 to 2012 in Prince George's County, black non-Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants. It is notable that there was a high percentage of traffic fatalities listed as having an unknown race and ethnicity; particularly in 2011 (see Figure 18-B).

Prince George's County Traffic Fatalities					
Person Type by Race/Hispanic Origin		2009	2010	2011	2012
Occupants (All Vehicle Types)	Hispanic	3	4	3	5
	White Non-Hispanic	13	16	13	7
	Black, Non-Hispanic	49	38	26	36
	Asian, Non-Hispanic/Unknown	0	0	0	0
	All Other Non-Hispanic or Race	0	1	1	0
	Unknown Race and Unknown Hispanic	9	9	31	15
	Total	74	68	74	63
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	1	1	2	1
	White Non-Hispanic	2	4	5	4
	Black, Non-Hispanic	15	9	9	14
	Asian, Non-Hispanic/Unknown	0	1	0	0
	All Other Non-Hispanic or Race	1	1	0	0
	Unknown Race and Unknown Hispanic	5	8	15	5
	Total	24	24	31	24
Total	Hispanic	4	5	5	6
	White Non-Hispanic	15	20	18	11
	Black, Non-Hispanic	64	47	35	50
	Asian, Non-Hispanic/Unknown	0	1	0	0
	All Other Non-Hispanic or Race	1	2	1	0
	Unknown Race and Unknown Hispanic	14	17	46	20
	Total	98	92	105	87

Figure 18-B. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2009-2013
(National Highway Traffic Safety Administration, Traffic Safety Facts, 2013. Retrieved: http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/24_MD/2013/Counties/Maryland_Prince%20Georges_2013.HTM)

Education

Graduation and Educational Attainment

In 2014, 89.69 percent of Montgomery County students graduated high school within 4 years. The 4 year graduation rate for the county is higher than that of the state (86.39 percent) and surpasses the Healthy People 2020 goal of 82.4 percent, but falls short of the Maryland SHIP target of 95 percent (www.mdreportcard.org). However, the 4-year high school graduation rate of Prince George's County students at 76.59 percent falls below both the state average and targeted goals (www.mdreportcard.org).

While the overall 4 year graduation rate in Montgomery County has exceeded national targets, disparities are present among racial and ethnic groups. Asian and White students in Montgomery County have the highest graduation rates,

exceeding 95 percent, while Hispanic students have the lowest rates at 80.03 percent. A similar trend among race/ethnicities can be seen in Prince George's County as well (see Figure 19).

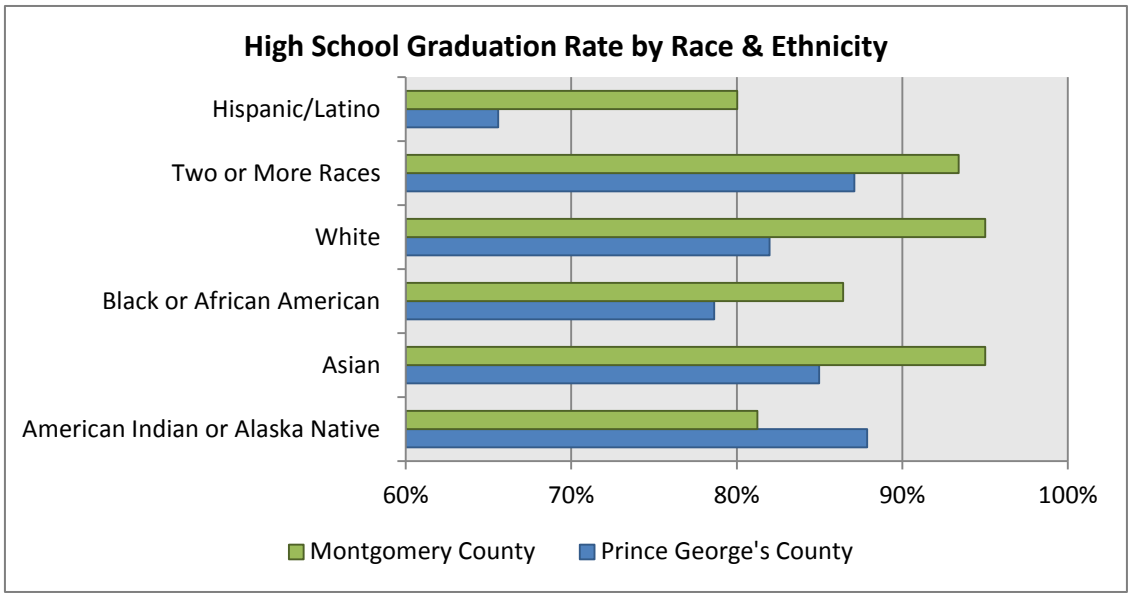

Figure 19. High School Graduation Rates by Race and Ethnicity
(www.mdreportcard.org)

Disparities in education by race and ethnicity become even more apparent at the college level. The overall percentage of adults 25+ in Montgomery County with a bachelor's degree or higher is 58.46 percent. However, when stratified, the percentage goes as high as 66.29 among Whites and as low as 25.8 among Hispanics (see Figure 20). In Prince George's County, the overall percentage of adults 25+ with a bachelor's degree is much lower at only 31 percent. When stratified by race and ethnicity, there are large disparities in Prince George's County as well, with 58.23 percent of Asians obtaining a bachelor's degree compared with 9.65 percent of Hispanics (see Figure 20).

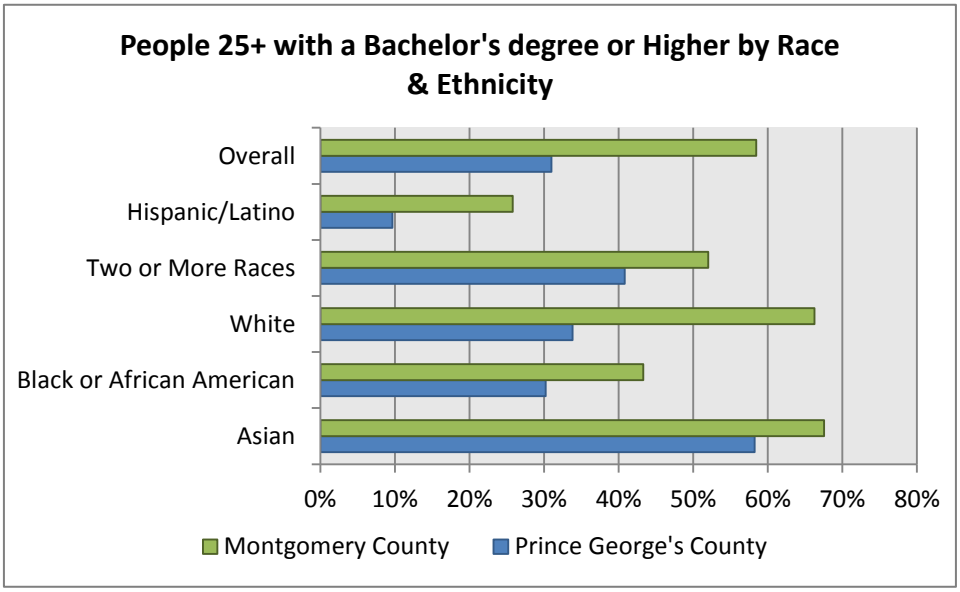

Figure 20. People 25 and over with a Bachelor's Degree or Higher by Race and Ethnicity
(US Census Bureau, 2014 1-Year ACS Estimates)

Reading & Math Proficiency

Based on student scores on the Maryland School Assessment, approximately 94 percent of white and Asian 8th graders are proficient in reading compared to 73 percent of Hispanic and 75 percent of Black students in Montgomery County. In Prince George's County, there are also disparities in reading proficiency among 8th graders of different races and ethnicities, with Asian 8th graders testing highest at 87.3 percent and Hispanic students testing at 63.3 percent proficient (see Figure 21).

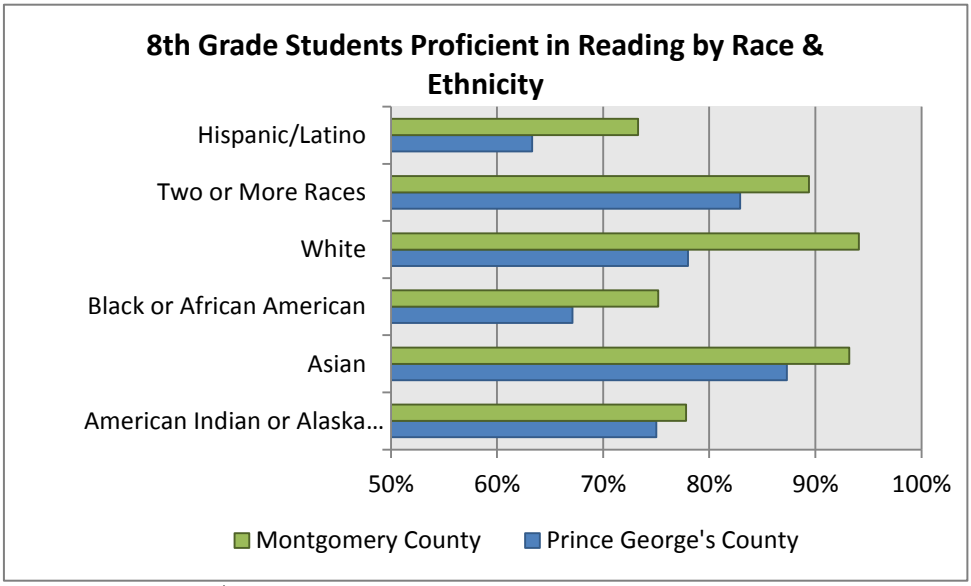

Figure 21. 8th Grade Students Proficiency in Reading by Race and Ethnicity (www.mdreportcard.org)

The same trend can be seen for math proficiency. In Montgomery County, approximately 87 percent of white and Asian 8th graders are proficient in math compared to only 49 percent of black and Hispanic students. In Prince George's County, 75.7 percent of Asian students are proficient in math compared to 39.3 percent of black and 38.7 percent of Hispanic students testing the lowest (see Figure 22).

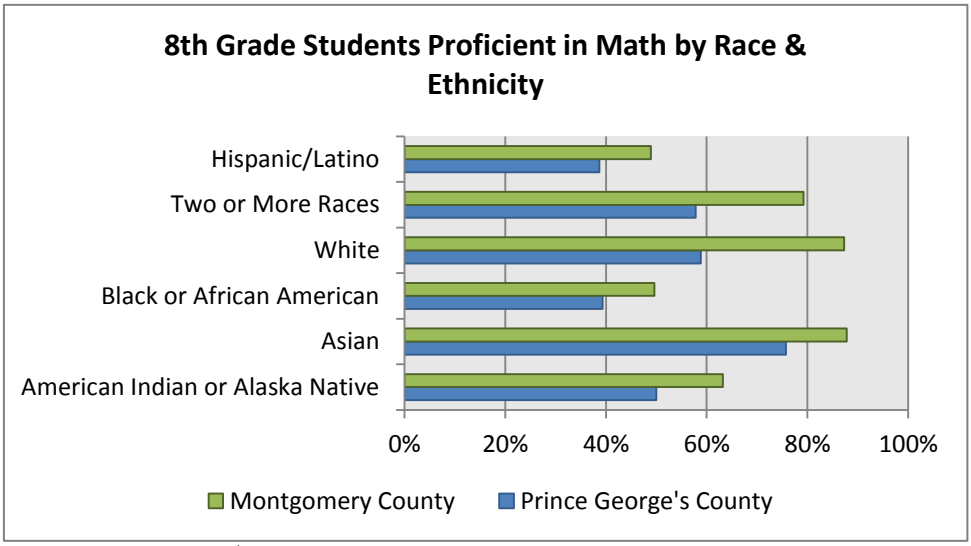

Figure 22. 8th Grade Students Proficiency in Math by Race and Ethnicity (www.mdreportcard.org)

Readiness for Kindergarten

The percentage of children who enter kindergarten ready to learn in Montgomery County rose in 2013 but remained lower than that of the state overall. Hispanic children were among those least likely to be prepared for kindergarten (71 percent). White (90 percent) and Asian (87 percent) children were among those most prepared to enter Kindergarten in Montgomery County (see Figure 23).

The percentage of children who enter kindergarten ready to learn in Prince George's County increased in 2013 to 80 percent but remained lower than that of the state overall (83 percent). Hispanic children were the least likely to be prepared for kindergarten at 72 percent, while Asian and white children were among those most prepared to enter Kindergarten in Prince George's County at 84 percent and 83 percent, respectively (see Figure 23).

County	SHIP Measure	County 2012-2013 Measure	SHIP 2013-2014 County Update	SHIP 2013-2014 County Update (Race & Ethnicity)	SHIP 2013-2014 Maryland Update	Maryland Target 2017
Prince George's County	Percentage of children who enter kindergarten ready to learn	73%	80%	Asian–84%; AA-83% Hispanic-72% White-83%	83%	85.5%
Montgomery County		80%	81%	Asian–87%; AA-78% Hispanic-71% White-90%		

Figure 23. Percentage of Children Entering Kindergarten Ready to Learn, Prince George's and Montgomery Counties (Maryland SHIP, 2014)

Housing Quality

Housing Quality

A person's living situation – the condition of their homes and neighborhoods – is a crucial determinant of health status. Across the United States, a disproportionate percentage of minority households are affected by moderate and severe housing problems (see Figure 24).

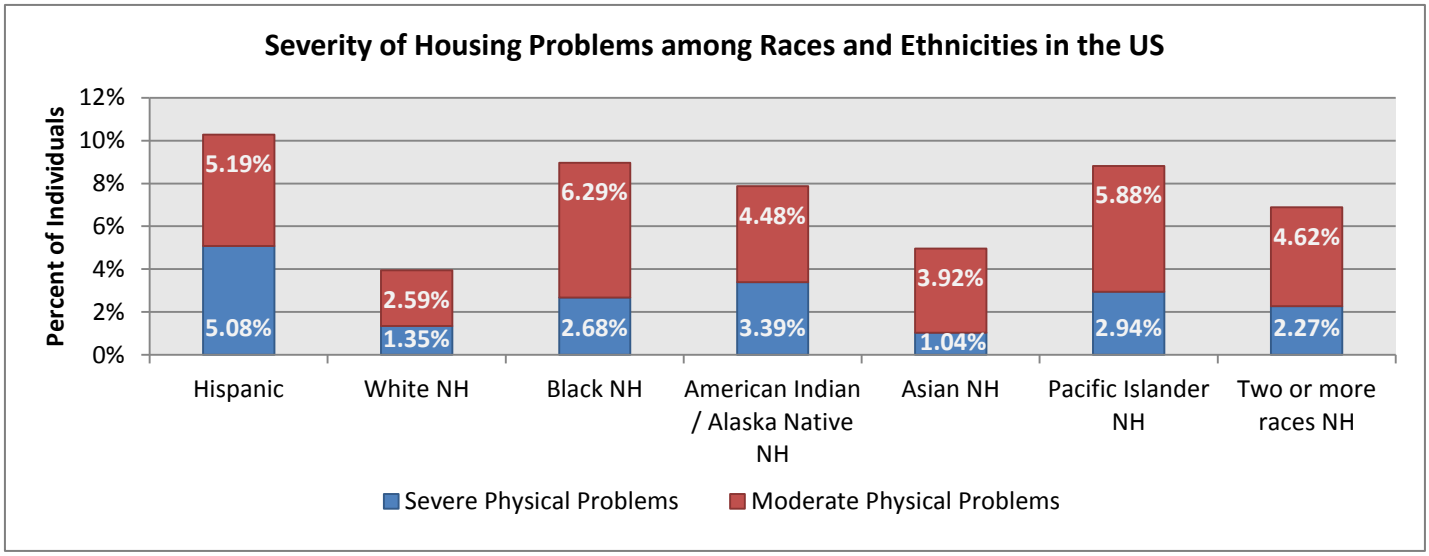

Figure 24. Severity of Housing Problems among Races and Ethnicities in the US, 2013

Note: Physical problems include plumbing, heating, electrical, and upkeep

(US Census Bureau, American Housing Survey, 2013)

At the local level, 17 percent of households in Maryland, 18 percent of households in Montgomery County, and 21

percent of households in Prince George's County were identified as having at least 1 of 4 severe housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities (www.CountyHealthRankings.org, 2007-2011).

Montgomery County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 51.6 percent
- Homeowner vacancy rate: 1.1
- Housing units in multi-unit structures: 33.7 percent
  (Source: U.S. Census, ACS, 1-YearEstimate, 2014)
- Housing units: 385,721 (2014)
- Homeownership rate: 67.3 percent (2009-2013)
- Median value of owner-occupied housing units: $446,300 (2009-2013)
- Households: 360,563 (2009-2013)
- Persons per household: 2.72 (2009-2013)
  (Source: U.S. Census, State and County Quick Facts)

Prince George's County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 52.8 percent
- Homeowner vacancy rate: 0.05
- Housing units in multi-unit structures: 33.2 percent
  (Source: U.S. Census, ACS, 1-YearEstimate, 2014)
- Housing units: 330,516 (2014)
- Homeownership rate: 62.5 percent (2009-2013)
- Median value of owner-occupied housing units: $269,800 (2009-2013)
- Households: 303,441 (2009-2013)
- Persons per household: 2.81 (2009-2013)
  (Source: U.S. Census, State and County Quick Facts)

Spotlight on Homelessness

Perhaps the most extreme case of living situation having a negative impact on health is that of homelessness. Homelessness amplifies the threat of various health conditions and introduces new risks, such as exposure to extreme temperatures. People who experience homelessness have multidimensional health problems and often report unmet health needs, even if they have a usual source of care.

In January 2015, a Point-In-Time Enumeration survey found there has been an increase in the homeless population in Montgomery County, whereas there has been a decrease in the homeless population in Prince George's County (see Figure 25)[8].

[8] Homelessness in Metropolitan Washington. May 2015. Accessed: https://www.mwcog.org/uploads/pub-documents/v15bWlk20150514094353.pdf

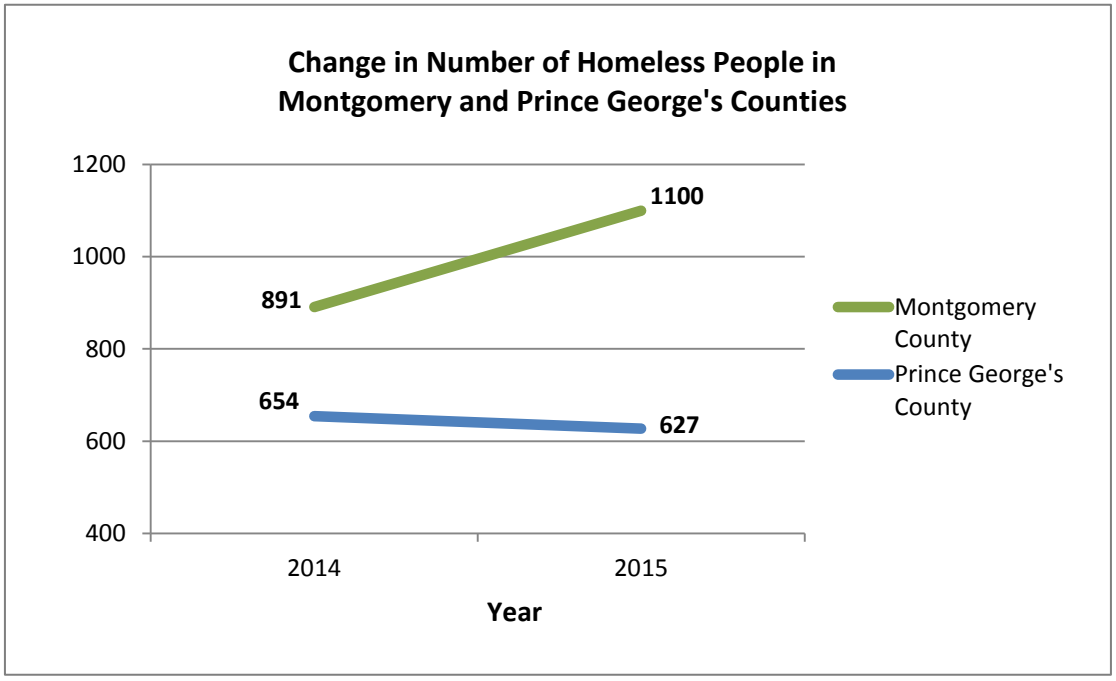

Figure 25. Change in Number of Homeless People in Montgomery County and Prince George's County from 2014 to 2015

In Montgomery County, the homeless population included 598 individuals and 159 homeless family units, made up of 184 adults and 318 children. Prince George's County's homeless population was made up of 60 individuals and 112 family units, which included 359 adults, and eight children (see Figure 26).

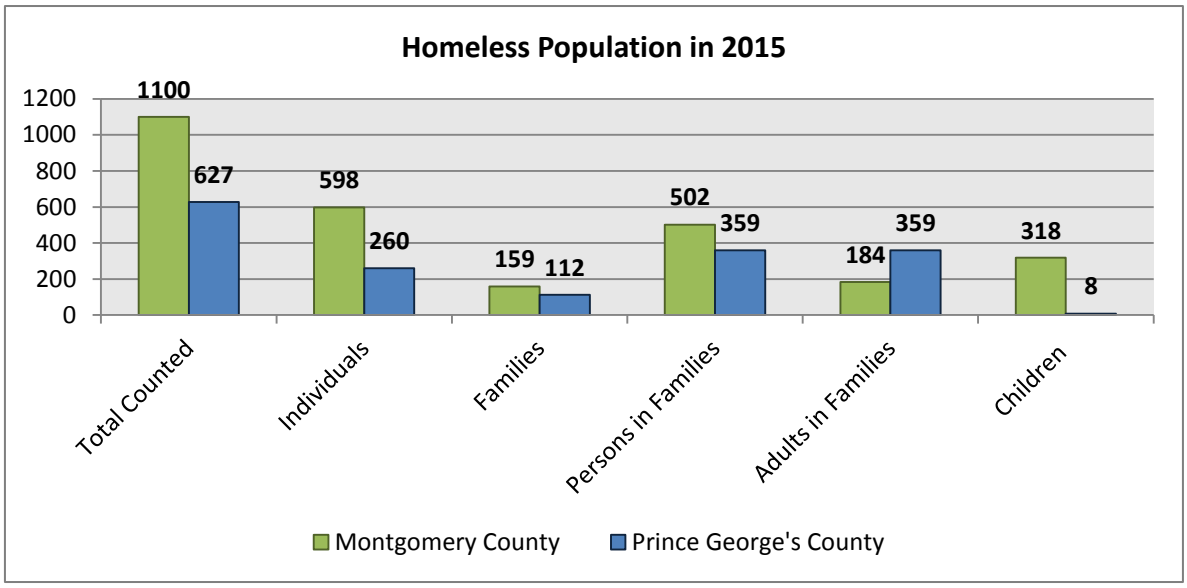

Figure 26. Homeless Populations in Montgomery County and Prince George's County, 2015 (Metropolitan Washington Council on Governments Point-In-Time Survey, 2015. Accessed: https://www.mwcog.org/uploads/pub-documents/v15bWlk20150514094353.pdf)

Among the homeless populations, numerous individuals reported various health, mental, and physical issues. In Montgomery County, 162 individuals were chronically homeless, 24 were US veterans, 291 were victims of domestic violence, 144 were suffering from co-occurring disorders (mental and substance abuse), 80 were physically disabled,

and 15 were living with HIV/AIDS. Similar issues were found among the Prince George's County homeless population (see Figure 27).

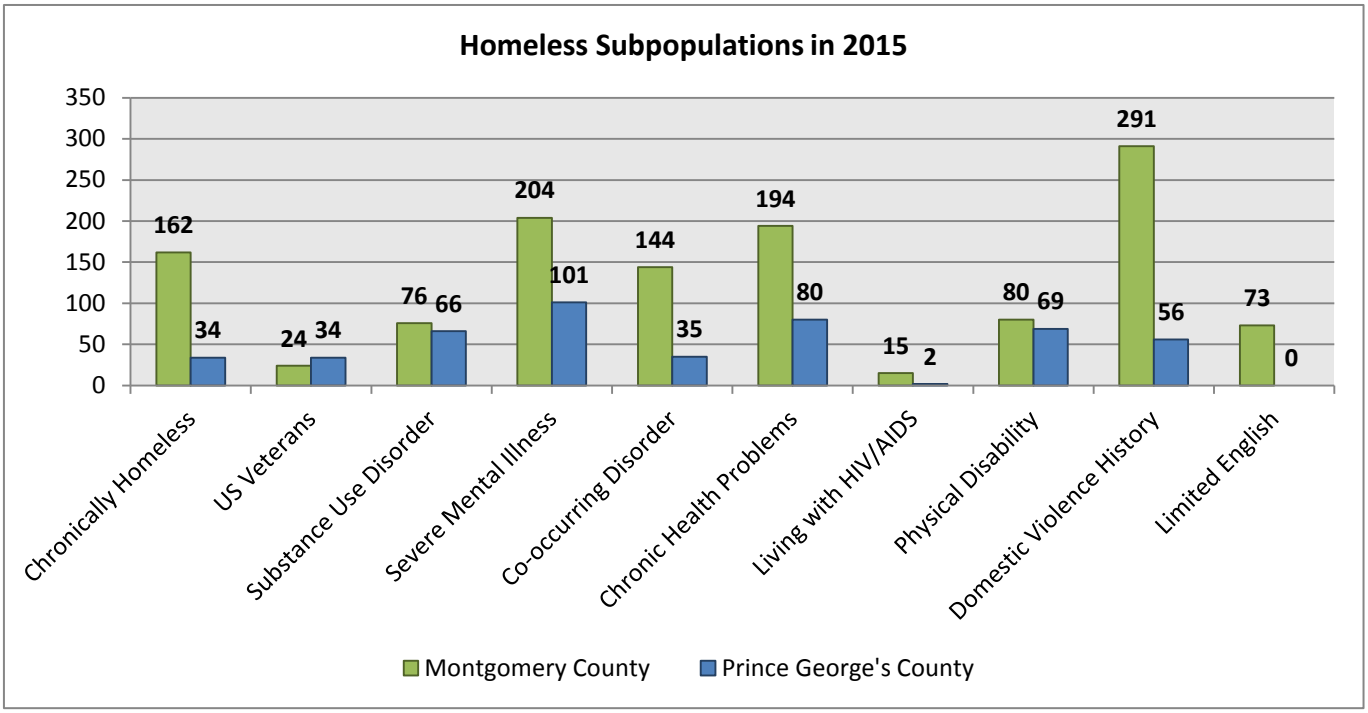

Figure 27. Homeless Subpopulations in Montgomery County and Prince George's County in 2015 (Metropolitan Washington Council on Governments Point-In-Time Survey, 2015. Accessed: https://www.mwcog.org/uploads/pub-documents/v15bWlk20150514094353.pdf)

Exposure to Environmental Factors that Negatively Affect Health Status

Air Pollution

Air pollution, measured by ozone levels, poses a serious threat in both Montgomery and Prince George's Counties. Ozone is an extremely dangerous gas that attacks lung tissues when breathed in. Based on the number of days its ozone levels surpass the US standards in three years, Montgomery County received a grade of D from the American Lung Association (healthymontgomery.com); Prince George's County received a grade of F (pgchealthzone.com). Prince George's County also has a high quantity (684lbs) of carcinogens released into the air.

Available detail on race, ethnicity, and language within CBSA ***See SHIP County profiles for demographic information of Maryland jurisdictions.***			
Demographics	**Prince George's County**	**Montgomery County**	**Maryland**
Total Population*	904,430	1,030,477	5,976,407
Age, %*			
Under 5 Years	6.7%	6.5%	6.2%
Under 18 Years	22.7%	23.5%	22.6%
65 Years and Older	11.2%	13.7%	13.8%
Race/Ethnicity, %*			
White	26.9%	62.0%	60.1%
Black or African American	64.7%	18.8%	30.3%
Native American & Alaskan Native	1.0%	0.7%	0.6%
Asian	4.6%	15.2%	6.4%
Native Hawaiian & Other Pacific Islander	0.2%	0.1%	0.1%
Hispanic	16.9%	18.7%	9.3%
Language Other than English Spoken at Home, % age 5+**	20.8%	39.1%	16.7%
Median Household Income**	$73,623	$98,221	$73,538
Persons below Poverty Level, %**	9.9%	7.0%	10.1%
Pop. 25+ Without H.S. Diploma, %**	14.5%	8.8%	11.3%
Pop. 25+ With Bachelor's Degree or Above, %**	29.8%	57.1%	36.8%
*Sources: *U.S. Census Bureau, State and County Quick Facts, 2014 Estimates* ***U.S. Census Bureau, State and County Quick Facts, 2009-2013 Estimates*			

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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. (Please note: this may be the same document used in the prior year report).
   http://www.adventisthealthcare.com/app/files/public/3167/2013-CHNA-WAH.pdf

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

   _X_Yes Enter date approved by governing body here (mm/dd/yy): 10/23/2013
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://www.adventisthealthcare.com/app/files/public/3338/2013-CHNA-WAH-ImplementationStrategy.pdf

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?** *(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)*

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

      _✓_Yes
      ___No

      If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

      Community Benefit is integrated throughout Adventist HealthCare Washington Adventist's strategic plan. Three guiding principles are listed on the strategic plan from which the strategies, objectives and initiatives directly stem. These guiding principles are the mission, vision, and values of the organization. AHC's mission is to demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing. The values which include respect, integrity, service, excellence and stewardship, exemplify the ideals strived for in fulfilling the mission. Specific strategies listed on the strategic plan include providing population based care and enhancing access to care. Specific objectives include improving the health status of the community through health, medical and chronic disease management and creating and sustaining a viable and valued community presence.

Values (R.I.S.E.S):
Our underlying principles. Answer the question,
"What motivates us?"

Respect:	We recognize the infinite worth of the individual and care for each one as a whole person.
Integrity:	We are above reproach in everything we do.
Service:	We provide compassionate and attentive care in a manner that inspires confidence.
Excellence:	We provide world class clinical outcomes in an environment that is safe for both our patients and caregivers.
Stewardship:	We take personal responsibility for the efficient and effective accomplishment of our mission.

Mission:
The reason we exist. Answers the question, "Why?"
We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing.

Vision:
Keeps us relevant. Answers the question, "Who are we?"
Adventist HealthCare 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.

2013 to 2015 Strategies

Provide Population-based Care
5.0 Improve the Health Status of the Community Through Health, Medical and Chronic Disease Management

Expand Access to Care:
7.0 Create and Sustain a Viable and Valued Community Presence

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 describe the role each plays in the planning process (additional positions may be added as necessary)*

i. **Senior Leadership**

1. **_✓_CEO**
2. **_✓_CFO**
3. **_✓_Other (please specify:** president's council)

Describe the role of Senior Leadership.
The senior leaders listed above as well as the other members of the president's council play a role in the community benefit planning for Washington Adventist Hospital. The president's council played a lead role in completing the prioritization of needs process and provided input and approval on the implementation strategy prior to board approval. The Director of Population Health Management acted as a champion for the initiatives and served on the AHC Community Benefit Council on behalf of Washington Adventist Hospital. The CFO works closely with finance and provides final approval of financials submitted.

ii. Clinical Leadership

1. **_✓_Physician (**Chief Medical Officer)
2. **___Nurse**
3. **___Social Worker**
4. **_✓_Other (please specify:** Director of Case Management**)**

Describe the role of Clinical Leadership
The Chief Medical Officer acted as a champion for the flu initiative. He also serves on the AHC Community Benefit Council on behalf of Washington Adventist Hospital. The Director of Case Management assists with planning and implementation of community benefit activities and plays a large role in community building as well.

iii. Community Benefit Operations

1. **___Individual (please specify FTE)**
2. **_✓_Committee (please list members:** Adventist HealthCare Community Benefit Council - members listed below**)**
3. **___Department (please list staff)**
4. **___Task Force (please list members)**
5. **___Other (please describe)**

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

Adventist HealthCare has a Community Benefit Council with representatives from each of the 5 hospital entities in addition to key departments from the corporate office. The Council meets every other month and takes part in the planning, execution, and monitoring of the community benefit activities taking place at their entities and across AHC. They also play a large role in the development of each hospital's CHNA, Implementation Strategy, and Community Benefit Reports. Members of the council include:

- Executive Director, Center for Health Equity and Wellness (AHC) - CHAIR
- Project Manager for Community Benefit (AHC)
- Manager of Community Health and Outreach (AHC)
- VP of Operations of Shady Grove Medical Center
- Director of Case Management for SGMC and Washington Adventist (WAH)
- Director of Population Health (AHC)
- Chief Medical Officer at WAH
- AVP, Rehabilitation at Physical Health & Rehabilitation
- Cultural Diversity Liaison at Physical Health & Rehabilitation
- Manager, Business Development at Behavioral Health and Wellness Rockville
- Director of Clinical Services at Behavioral Health and Wellness Eastern Shore
- Project Accountant, AHC
- Senior Tax Accountant, AHC
- Financial Services Project Manager, AHC
- PR Marketing Coordinator, AHC

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

Spreadsheet	**__✓_yes**	**____no**
Narrative	**____yes**	**__✓_no**

If yes, describe the details of the audit/review process *(Who does the review? Who signs off on the review?)*
Prior to finalizing the spreadsheet, the finance team meets in person with the CFO to go over the spreadsheet in detail. The narrative is not formally audited; however, it is put together and reviewed in partnership with key hospital staff and leadership.

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

Spreadsheet	**_____yes**	**__✓_no**
Narrative	**_____yes**	**__✓_no**

If no, please explain why.
The hospital's Board reviewed and approved the Community Health Needs Assessment and Implementation Strategy. The Adventist HealthCare Board of Trustees only meets twice per year so they have not yet had a chance to review this report, but they will review this Community Benefit report when they next meet in Q1 2016.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

__✓__ Other hospital organizations
__✓__Local Health Department
__✓__ Local health improvement coalitions (LHICs)
__✓__ Schools
_____ Behavioral health organizations
__✓__ Faith based community organizations
__✓__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	**Healthy Montgomery**
Name of Key Collaborator	Healthy Montgomery Steering Committee Co-Chairs: • Mr. George Leventhal, Council Member, Montgomery County Council • Ms. Sharon London, Vice President, ICF International Additional Committee Members can be found here: http://www.healthymontgomery.org/index.php?module=htmlpages&func=display&pid=5000
Title	*See previous row*
Collaboration Description	Washington Adventist Hospital collaborates with Healthy Montgomery (HM), which serves as the Local Health Improvement Coalition in Montgomery County. WAH contributes $25,000 annually to support the infrastructure of HM. WAH worked with HM to complete a 2011 Community Health Needs Assessment, which helped to inform our CHNA, and the website maintained by HM provides current data which was utilized by WAH to identify needs and set priorities. WAH was also represented on the HM Steering Committee, which sets the direction for the group, and the Data Project subcommittee, which selected core measure indicators in the identified priority areas.

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

_____yes __✓__no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

__✓__yes _____no

Dr. Deidre Washington, Research Associate at the Adventist HealthCare Center for Health Equity & Wellness is a member of the Healthy Montgomery Steering Committee on behalf of Shady Grove Medical Center, Washington Adventist Hospital, Behavioral Health & Wellness Services Rockville, and Physical Health & Rehabilitation. Dr. Washington, as well as Gina Maxham, MPH (Project Manager of Community Benefit, at the Center for Health Equity and Wellness) are also members of the Healthy Montgomery Community

Health Needs Assessment Committee on behalf of Shady Grove Medical Center, Washington Adventist Hospital, Behavioral Health & Wellness Services, and Physical Health & Rehabilitation.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. **Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.**

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

   a. *1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.*
   2. Please indicate whether the need was identified through the most recent CHNA process.

   b. *Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)*
   (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

   c. *Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?*

   d. *Total number of people reached by the initiative (how many people in the target population were served by the initiative)?*

   e. *Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.*

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

   g. *Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.*

   h. *Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.*

      - *What were the measurable results of the initiative?*
      - *For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.*

i. *Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.*

j. *Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?*

k. *Expense:*
A. 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.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

Table III

Identified Need Was this identified through the CHNA process?	Persons most at risk for contracting influenza include the elderly, the very young, and the immune-compromised. The ZIP code in which Adventist HealthCare 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. In Adventist HealthCare 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, with rates of 11.3, 11.2 and 12.1 ER visits/10,000 population, respectively (Healthy Montgomery, 2009-2011). A racial disparity exists within the population: the age-adjusted ER rate due to immunization-preventable pneumonia and influenza in Montgomery County was 17.5/10,000 among black residents compared to only 5.8/10,000 among white residents (Healthy Montgomery, 2009-2011). 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 barriers such as income, cultural barriers, and access to clinics. This need was identified in the 2013 CHNA.
Hospital Initiative	Help Stop the Flu
Total Number of People Within the Target Population	Adventist HealthCare Washington Adventist Hospital targeted the zip codes with the highest ER rates due to influenza. According to the 2014 U.S. Census data, the total population for the three ZIP codes (20901, 20904, and 20912) was 117,696.
Total Number of People Reached by the Initiative Within the Target Population	**Total People Reached: 762** • 198 individuals were immunized directly • Vaccine for an additional 371 individuals was provided to Care for your Health and Community Clinic Inc. • 193 individuals were educated about flu and/or received a glo germ screening
Primary Objective of the Initiative	The primary objective of this initiative is to implement strategies to address high influenza-related Emergency Room rates in the population served by Adventist HealthCare Washington Adventist Hospital. Adventist HealthCare Washington Adventist Hospital's "Help Stop the Flu" initiative aims to provide flu vaccines for community members in various easily accessible locations including: senior centers, low-income and senior apartment complexes, and faith-based communities, as well as the hospital. In addition to the flu shots themselves, we also provide health education on cold and flu prevention to community members. Strategies for this initiative include: • Partnering with Community Clinic, Inc. (a local FQHC located in ZIP code 20912 serving

	uninsured patients), Mobile Medical Care, Inc. (a safety net clinic serving uninsured patients at multiple locations within the hospital's primary service area), and community organizations to provide free flu shots to residents with a greater need in ZIP codes with the highest ER rates due to immunization preventable influenza (20912, 20901, and 20904). • Partnering with Care for Your Health (Dr. Anna Maria Izquierdo-Porrerra) to provide vaccine for micropractice patients. ○ Practice located in ZIP code 20904; secondary practice area to be covered includes 20901 and 20912. The patient population served by the Care for Your Health micropractice is 75% Hispanic, 12% Black, 5% White, 4% Asian, and 4% other. The majority of patients are Spanish-speaking. • Partnering with community organizations, places of worship, senior centers, community centers, low-income housing complexes, and county health departments in Montgomery and Prince George's Counties to provide free or low cost vaccinations to residents with the greatest need.
Single or Multi-Year Initiative Time Period	**Multi-Year**: This initiative has taken place every year since 2008, with extra emphasis on targeted ZIP codes in response to CHNA findings in the years 2014, 2015, and 2016.
Key Collaborators in Delivery of the Initiative	**Flu shots and/or flu education were provided at the following locations in 2015:** • Care For Your Health Micropractice (Dr. Anna Maria Izquierda-Porrera) • Community Clinic, Inc. (FQHC) • Long Branch Community Center • Takoma Park Community Center • Takoma Park Seventh Day Adventist Church • Burnt Mills Seventh Day Adventist Church • Adventist HealthCare Washington Adventist Hospital • Greenwood Terrace Apartments (low-income housing) • Westfield Wheaton Mall • Community Crossroads Farmers Market • Greenbelt Community Center • Avondale Park Apartments • CentroNía **Additional Collaborators and Funders Include:** • WTOP • M&T Bank

Impact/Outcome of Hospital Initiative	In 2015, Adventist HealthCare Washington Adventist Hospital provided a total of **569 free** flu vaccines for the community through partnerships with Community Clinic, Inc., Care for Your Health, and numerous outreach flu shot clinic events at a variety of community locations.
	• Thus far, 198 flu shots (185 regular, 12 high-dose, and 1 preservative free) have been provided through 5 flu clinics at community locations throughout the hospital's service area.
	  ○ 3 of the 5 flu clinics took place in the target ZIP codes of 20901, 20904, and 20912. The additional 2 clinics took place at a commonly frequented mall and a farmers market, both adjacent to the target ZIP codes.
	  ○ Of the 198 flu shots administered, 23 were provided to residents of ZIP code 20912, 11 were provided to residents of ZIP code 20904, and 18 were provided to

<table>
<tr><td></td><td colspan="2">residents of ZIP code 20901.
○ Community flu shot clinic sites included senior centers, low-income housing complexes, a local mall, farmers market, and a local micropractice.
• 119 free flu shots (regular) were provided to the micropractice Care for Your Health (Dr. Anna Maria Izquierda-Porrera) located in ZIP code 20904.
• An additional free 252 flu shots will be provided to the community (201 regular, 31 high-dose, 10 pediatric, 7 preservative free, and 3 intradermal).
○ These flu shots will be provided at an additional two flu clinics scheduled for December 8th and 9th, at a local low-income housing complex (20912) and the hospital (20912).
○ The remaining vaccine will be provided to local safety net clinics such as Community Clinic, Inc. (an FQHC serving uninsured patients) located in ZIP code 20912.

In addition to flu shot clinics, health education on cold and flu prevention was provided at 4 community locations within the target ZIP codes of 20901, 20904 and 20912. Education included presentations, trivia, and glo germ demonstrations/screenings. There were approximately 126 encounters for these events. Education and screenings were provided at an additional 3 locations outside of but adjacent to the target zip codes. There were approximately 67 encounters for these events.</td></tr>
<tr><td>Evaluation of Outcomes</td><td colspan="2">Maryland SHIP indicators show that the percentage of Montgomery County adults vaccinated has increased from 43.1% in 2012 to 48.7% in 2013; in Prince George's County, the percentage has steadily increased from 31.1% in 2011 to 36.9% in 2013. The state of Maryland has set a SHIP target of 49.1% vaccinations for 2017, while Healthy People 2020 set 70% as the target percentage of adults who are annually vaccinated against seasonal influenza. This CHNA implementation strategy initiative, Help Stop the Flu, has been targeting at-risk people in high risk areas to decrease the high rate of ER visits due to immunization-preventable pneumonia and influenza and to increase the percentage of adults annually vaccinated.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">Adventist HealthCare Washington Adventist Hospital will continue to provide flu shots to residents of targeted ZIP codes in response to CHNA findings in 2016.</td></tr>
<tr><td>A. Total Cost of Initiative for Current Calendar Year
B. What amount is from Restricted Grants/ Direct offsetting revenue</td><td>A. Total Cost of Initiative

Total Estimated Costs: $8,749</td><td>B. Direct offsetting revenue from Restricted Grants

Offsetting Funding: $5,000</td></tr>
</table>

Identified Need Was this identified through the CHNA process?	In Adventist HealthCare Washington Adventist Hospital's service area, ZIP code 20912 had, by far, the highest Emergency Room rate due to alcohol abuse (121.2 compared to an average of 20.3 per 10,000 residents in CBSA) and hospitalization rate due to alcohol abuse (20.7 compared to an average of 6.6 per 10,000 residents in CBSA) (Healthy Montgomery, 2013). In Montgomery County, more men reported binge drinking (17.2%) than women (11.5%), and White adults (at 15.8%) were more likely than adults of other racial/ethnic groups to report engaging in binge drinking (BRFSS, 2010; accessed via Montgomery County Behavioral Health Profile, 2012). Nearly 40% of Montgomery County Medicaid recipients between 14-20 years of age received inpatient, outpatient, and/or professional services for substance abuse in 2011, and patients receiving these services were more likely to be Black (41.0%) than other groups (34% White, 18% Hispanic) (Montgomery County Behavioral Health Profile, 2012). In particular at Victory Tower, a low-income senior housing complex in ZIP code 20912, there is a great need for behavioral and mental health services. Management and staff at the housing complex have reported that significant numbers of residents struggle with one or more of the following: clinical depression, clinical anxiety, alcohol use, cannabis use, hoarding, and psychosis. This need was identified both through the latest CHNA as well as through an ongoing partnership with Victory Tower.
Hospital Initiative	Victory Tower Wellness Partnership
Total Number of People Within the Target Population	There are approximately 211 residents in the Victory Tower housing complex.
Total Number of People Reached by the Initiative Within the Target Population	Because identifying information is not collected for each of the activities as part of this initiative, it is difficult to get an exact number of unique individuals reached. The number of encounters is provided below for each of the activities. When available, the number of unique individuals reached is listed. • 12 individuals in the wellness group, 147 encounters • 120 encounters for monthly blood pressure screenings • 82 individuals participated in the health fair • 47 encounters for the Live Well lecture series **Total encounters:** 396
Primary Objective of the Initiative	The primary objective of this initiative is to enhance the health, wellness, and quality of life of the residents of Victory Tower, a low income senior housing complex in Takoma Park. In particular, Adventist HealthCare Washington Adventist Hospital has been working to address the mental and behavioral health needs of the residents. Hospital staff has engaged in regular contact with staff and management at Victory Tower in order to ensure that specific health needs and interests of residents are being addressed, and in order to evaluate progress and outcomes.

	Strategies for this initiative include:
	• A weekly wellness circle organized by a certified substance abuse counselor. Weekly sessions are approximately 1.5 hours in length. The purpose of the wellness circle is to enhance quality of life and assist participants with sobriety and mental health maintenance. Weekly discussions focus on The Substance Abuse and Mental Health Services Administration's (SAMHSA) 8 Dimensions of Wellness, adapted from their Wellness Initiative:
	  ○ Emotional: coping effectively with life and creating satisfying relationships
	  ○ Financial: satisfaction with current and future financial situations
	  ○ Spiritual: expanding a sense of purpose and meaning in life
	  ○ Occupational: personal satisfaction and enrichment derived from one's work
	  ○ Physical: recognizing the need for physical activity, diet, sleep, and nutrition
	  ○ Intellectual: recognizing creative abilities and finding ways to expand knowledge and skills
	  ○ Environmental: good health by occupying pleasant, stimulating environments that support well-being
	• Provision of regular screening, health education, and resources. By maintaining a regular presence at Victory Tower, hospital staff has been able to build both rapport and trust among the residents.
	  ○ Monthly blood pressure screenings and heart health education.
	  ○ Health fairs including screenings, education, and lectures
	  ○ LiveWell lecture series

Single or Multi-Year Initiative Time Period	This is a multi-year initiative that began in 2014.
Key Collaborators in Delivery of the Initiative	**Key collaborators involved in this initiative include:** • Victory Tower, low-income senior housing complex

Impact/Outcome of Hospital Initiative	**Weekly Wellness Circle**
	• Approximately 12 individuals have taken part in the wellness circle sessions with an average of 3-7 participants at each session
	• As of the first week of December, there have been a total of 147 encounters
	• Positive results have been seen among the residents, both via self-report and through feedback provided by Victory Tower management
	  ○ 11 of 12 residents have reported less depression, anxiety, drinking, and a reduction in hoarding behavior
	  ○ 2 members have been referred for additional substance abuse services
	  ○ Those members in the group who had been being processed for eviction have since been removed from that list
	
	Blood Pressure Screenings
	• 11 blood pressure screenings have been held thus far this year. An additional monthly screening is scheduled for December 18th.
	• There have been 120 encounters thus far (January-November)
	  ○ Systolic readings (January-October):
	  ▪ 26.32% have been normal
	  ▪ 42.11% have been in the prehypertension range

	▪ 24.56% have been in the stage 1 hypertension range ▪ 6.14% have been in the stage 2 hypertension range ▪ 0.88% have been in the hypertensive crisis range ○ Diastolic readings (January-October): ▪ 61.4% have been normal ▪ 25.44% have been in the prehypertension range ▪ 13.16% have been in the stage 1 hypertension range **Health Fairs** • "Spring into Health at Victory Tower" was held on April 23rd, 2015. The health fair included screenings, education, and demonstrations. • A total of 82 individuals participated in the health fair. • The following screenings and corresponding health education were provided ○ 62 blood pressure ○ 41 body fat percentage and BMI ○ 24 bone density ○ 39 carbon monoxide ○ 50 dermascan ○ 51 grip strength • Two health lectures took place ○ Nutrition & Diabetes - with approximately 50 attendees ○ Mental Health, Alzheimer's and Dementia – Approximately 60 attendees • A cooking and nutrition demonstration took place as well which had approximately 75 attendees **LiveWell Lecture Series** • A total of three lectures took place in 2015 as a part of this series. Topics and participants are listed below. ○ Colorectal cancer: 14 participants ○ Skin Cancer: 18 participants ○ Role of the caregiver – helping a loved one with mental health conditions and depression during the holidays: approximately 15 participants
Evaluation of Outcomes	Healthy People 2020 set a goal to reduce binge drinking to 24.4% and excessive drinking to 25.4% for adults aged 18 and over. Data collected between 2010 and 2012 shows that 21.7% of Montgomery County residents aged 18 and over engaged in binge drinking, whereas data from 2009 to 2013 shows 4.8% of adults aged 21 and older in Maryland heavily abused alcohol, compared to 6.8% nationally[9]. From 2010 to 2014, the rate of intoxication deaths was 4.9 deaths per 100,000 population in Montgomery County[10]. Additionally, Healthy Montgomery shows an increasing trend in depression for the Medicare population. However, in 2014, seniors aged 65 and over comprised only 1.1% of the population served by the Maryland state mental health authority. Adventist HealthCare Washington Adventist Hospital partnered with Victory Tower Senior Apartments to provide the underserved senior population with a wellness program targeting substance abuse, mental health, and general health needs. The residents' substance abuse and mental health needs were addressed through the Weekly Wellness Circle,

[9] Substance Abuse and Mental Health Administration: Behavioral Health Barometer, 2014. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-MD.pdf

[10] Maryland Behavioral Health Administration, 2014. http://bha.dhmh.maryland.gov/Documents/Age-Adjusted%20Death%20Rates1,2%20for%20Total%20Intoxication%20Deaths%20by%20Place%20of%20Residence,%20Maryland,%202010-2014.pdf

	while their general health needs were addressed through free health education and screenings.	
Continuation of Initiative	This initiative will be continuing into 2016 based on the positive outcomes that have been achieved thus far. Feedback from Victory Tower management and residents has been incredibly positive as well. In 2016 a survey will be distributed among residents to gauge if there are any additional health needs, concerns, or interests that they would like additional support around. This information will be used to help guide future screenings, education, and resources provided to residents.	
C. Total Cost of Initiative for Current Calendar Year D. What amount is from Restricted Grants/ Direct offsetting revenue	**C. Total Cost of Initiative** Total estimated cost of initiative: $6,796.10	**D. Direct offsetting revenue from Restricted Grants** There is no offsetting revenue for this initiative

Identified Need Was this identified through the CHNA process?	Breast cancer is the leading cause of cancer death for women in the United States, with 1 in 8 women developing breast cancer at some point in their lifetime and about 1 in 36 dying from it[11]. Age, genetic disposition, obesity, and alcohol use are risk factors for breast cancer. The rates have declined in the past two decades due to early detection and advanced treatment. In Montgomery County, the breast cancer incidence rate is 126.6 per 100,000 women[12], whereas Prince George's County's incidence rate is 121 per 100,000[13]. A disproportionately high breast cancer death rate exists in the African American population. The Black age-adjusted breast cancer death rate in Montgomery County is 27.1 per 100,000, which is significantly higher than the White rate of 18.4; in Prince George's County, the black age-adjusted death rate due to cancer is similarly disproportionate for Blacks (30.6) compared to whites (22.6)[14]. Lack of medical coverage, late detection and screening, and unequal access to advanced cancer treatments may contribute to the lower survival rates for African American women[15]. Lack of health insurance is the main barrier to breast cancer screening in the United States[16]. Thirty-two percent of women ages 40 and older with no health insurance had a mammogram within the past two years, which is less than half of the 71 percent of women with insurance. The need was identified prior to the CHNA but was reinforced by the 2013 CHNA findings.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Breast Cancer Screening and Support Program
Total Number of People Within the Target Population	According to the US Census Bureau, Montgomery County has a population of 269,065 women over the age of 40; Prince George's County has 221,799 women over the age of 40. The Breast Cancer Screening and Support Program specifically targets uninsured or underinsured women within these population.
Total Number of People Reached by the Initiative Within the Target Population	**Total People Reached: 552** • 537 individuals were screened through the Breast Cancer Screening Program • 15 individuals participated in Look Good Feel Better
Primary Objective of the Initiative	The primary objectives of the initiative are: • To implement strategies that address breast cancer needs in the uninsured or underinsured population served by Adventist HealthCare Washington Adventist Hospital. • To reduce the incidence, prevalence, and mortality rates of breast cancer in Montgomery County and Prince George's County by increasing access to preventive breast care and follow-up treatment for uninsured or underinsured women over 40.

[11] Healthy Montgomery. (2015). Age-Adjusted Death Rate due to Breast Cancer. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18904705
[12] Healthy Montgomery. (2015). Breast Cancer Incidence Rate. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18855415
[13] PGC Health Zone (2015). Breast Cancer Incidence Rate. http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18855417
[14] PGC Health Zone (2015). Age-Adjusted Death Rate due to Breast Cancer. Retrieved from http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18904707
[15] National Cancer Institute. (2008). Cancer Health Disparities. Retrieved from http://www.cancer.gov/about-nci/organization/crchd/cancer-health-disparities-fact-sheet#q6
[16] Susan G. Komen Foundation. (2015). Disparities in breast cancer screening. Retrieved from http://ww5.komen.org/BreastCancer/DisparitiesInBreastCancerScreening.html

	• To decrease the intervals between screening, diagnosis and treatment through cancer navigation. Adventist HealthCare Washington Adventist Hospital has implemented the following strategies to address the breast cancer screening and support needs of the population it serves. **Breast Cancer Screening Program**: The Breast Cancer Screening Program provides free, comprehensive breast cancer services to women 40 years and over with limited or no health insurance in Montgomery County and Prince George's County. Patients are educated about the importance of breast health and given access to free mammograms and referrals to cancer treatment services. These services include mammograms, biopsies, ultrasounds, diagnostic and treatment services, and patient navigation to women in need. **Look Good Feel Better:** Through a partnership with the American Cancer Society, Adventist HealthCare offers Look Good Feel Better sessions to the community it serves. The program is aimed at improving self-image appearance through free group, individual, and self-help beauty sessions that create a sense of support, confidence, courage and community. The two-hour sessions are led by a certified cosmetologist who teaches make-up tips, turban use, wig care, and beauty-related information to women undergoing cancer treatment. Participants are also given a free makeup kit.
Single or Multi-Year Initiative Time Period	The implemented initiatives are multi-year initiatives.
Key Collaborators in Delivery of the Initiative	**Key partners involved in the outreach for, and implementation of, this initiative include:** • Muslim Community Clinic • Mary Center • Community Clinic, Inc. • Spanish Catholic Center • Mobile Med • Women's Cancer Control Program • American Cancer Society • Komen Foundation (Funder) • Avon Foundation (Funder) • Montgomery Cares Primary Care Coalition (Funder)

Impact/Outcome of Hospital Initiative	**Breast Cancer Screening Program (January-November 2015)**
	• A total of 745 breast cancer screening and diagnostic services were provided among 537 individuals
	  ○ Screening Mammograms: 404
	  ○ Diagnostic Services including Mammograms and Sonograms: 341
	• Demographics:
	  ○ Age
	  ▪ <40: 3.76%
	  ▪ 40-49: 41.48%
	  ▪ 50-64: 43.49%
	  ▪ 65 and over: 11.28%

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Race

White: 1.07%
Black: 32.75%
Asian: 5.64%
Other: 60.54%

Ethnicity

Hispanic: 59.19%
Non-Hispanic: 40.81%

Time to Follow-Up: Screening to Diagnostic Mammogram (January-September 2015)

The screening to diagnostic mammogram patient call back time frame has been on a downward trend this year, starting at 53.6 days in January and decreasing to 7 days in September.
Monthly Average for the year: 32 days
While the numbers have been improving consistently, and the American Society of Clinical Oncology standard of 15 days was met in both August and September, Washington Adventist Hospital continues to strive for improvement. The hospital will continue working to maintain this success as well as strive to achieve “world class” status (which is reached at 5 days) in order to provide participants with the highest quality of care.

Look Good, Feel Better

Look Good Feel Better was held 4 times in 2015.
There were a total of 15 participants for the year.

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<tr><td>Evaluation of Outcomes</td><td colspan="2">Healthy People 2020 set a target of 20.7 deaths per 100,000 females[17] for breast cancer. Montgomery County has met this target and has an even lower death rate due to breast cancer at 18.8 deaths per 100,000. According to the National Cancer Institute, recent trends show breast cancer rates in Montgomery County to be stable. The Breast Cancer Screening and Support Program at WAH has been targeting specific populations with health care access barriers and providing them with the necessary screenings and diagnostic services. Additionally, the breast cancer initiative at WAH has been navigating the patients in their cancer screening, diagnosis and follow-up processes in order to lower the call back rate to the 15-day standard set by the American Society of Clinical Oncology. In 2015 alone, this initiative at WAH not only met the 15-day standard, but lowered the call back rate from 53.6 days in January to 7 days in September.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">Yes, the program will continue into 2016. The need remains and positive results have been seen.</td></tr>
<tr><td>E. Total Cost of Initiative for Current Calendar Year
F. What amount is from Restricted</td><td>E. Total Cost of Initiative

Total Estimated Cost: $280,517.37</td><td>F. Direct offsetting revenue from Restricted Grants

Offsetting Funding: $99,003.18</td></tr>
</table>

[17] Healthy People 2020 (2015). Cancer. Accessed: http://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives

Grants/ Direct offsetting revenue		

Identified Need Was this identified through the CHNA process?	Infant Mortality – The Maryland SHIP 2017 target is to reduce the infant mortality rate in Maryland to 6.3 deaths per 1,000 live births. The Healthy People 2020 national health target infant mortality rate is 6 deaths per 1,000 live births. Montgomery County exceeds both these goals by far, with an infant mortality rate of 4.7 deaths per 1,000 live births. Although the overall infant mortality rate in Montgomery County is relatively low, a disproportionately high rate exists in the African American population. The Black, non-Hispanic infant mortality rate is 9.9, almost three times the Hispanic and non-Hispanic White rates (2.6 and 3.5 respectively)[18]. In contrast, Prince George's County has a high infant mortality rate, 7.8 deaths per 1,000 live births[19]. The Black, non-Hispanic infant mortality rate is 8.7 deaths per 1,000 live births, which is higher than the Hispanic and non-Hispanic White rates (6.9 and 5.1 respectively). Breastfeeding – According to the World Health Organization, exclusive breastfeeding reduces infant mortality caused by childhood illnesses and helps for faster recovery during illness[20]. Despite these recommendations, breastfeeding remains low in the Black community. In 2008, the percentage of Black babies who were ever breastfed was 59%, which is significantly lower than the 75.2% of White babies and 80% of Hispanic babies[21]. The need was identified prior to the CHNA but was reinforced by the 2013 CHNA findings.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Maternal and Child Education & Support
Total Number of People Within the Target Population	WAH primarily serves Montgomery and Prince George's Counties. Montgomery County has an estimated 204,161 women of childbearing age (15 to 44 years old). Prince George's County has an estimated 194,442 women of childbearing age[22].
Total Number of People Reached by the Initiative Within the Target Population	**Total people reached:** 418+ • 9 attendees and 16 encounters at Black Mothers Breastfeeding Club meetings • 267 individuals and 358 encounters on the Warm Line • 142 attendees at the conference • 35 encounters at Hecho de Pecho **Total encounters:** 551
Primary Objective of the Initiative	Adventist HealthCare Washington Adventist Hospital has implemented programs to address the maternal and child health needs of the community it serves by providing education, support, and resources to mothers and families. The primary objectives of the initiative are to: • Continue employing strategies that address maternal child health needs, particularly around breastfeeding and infant mortality, in the population served by Washington

[18] Healthy Montgomery. (2015). Infant Mortality Rate. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=65
[19] PGC Health Zone. (2015). Infant Mortality rate. Retrieved from http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=17507107
[20] World Health Organization. (2015). Nutrition. Retrieved from http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
[21] Centers for Disease Control and Prevention. (2013). Morbidity and Mortality Weekly Report. Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences – United States, 200-2008 Births. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm
[22] U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates

	Adventist Hospital • Increase access to breastfeeding support programs and services for mothers in Montgomery County • Reduce infant mortality rate disparities in Montgomery County, particularly among the Black population **Hecho de Pecho**: Through Hecho de Pecho, Adventist HealthCare Washington Adventist Hospital provides a free, weekly, peer-led breastfeeding support group for Spanish-speaking mothers. It is a safe space for mothers to share their experiences and connect with other mothers in a cordial and informative meeting to promote breastfeeding. Mothers are encouraged to bring their baby, older children, or a support person. **Black Mothers' Breastfeeding Club (BMBFC)**: Through the Black Mothers' Breastfeeding Club, Adventist HealthCare Washington Adventist Hospital and Shady Grove Medical Center provide a monthly community-based, peer-led, and culturally-tailored support group for expecting and new Black/African-American mothers in order to promote breastfeeding in the Black communities of Montgomery and Prince George's Counties. At each meeting participants are provided with a hot meal and have the opportunity to win door prizes. Children and partners are welcome to attend. **Warm Line**: Through the Warm Line, Adventist HealthCare Washington Adventist Hospital and Shady Grove Medical Center provide telephone assistance for breastfeeding questions and concerns, as well as evidence-based information for breastfeeding mothers and families. The Warm Line is staffed by an IBCLC (International Board Certified Lactation Consultant) and is available 7 days a week/365 days a year at (240) 826-6667. **"Before the Bough Breaks: Approaches to Reduce Disparities in Infant Mortality":** The ninth annual Adventist HealthCare Center for Health Equity and Wellness Conference was held on Thursday, October 8, 2015, at College Park Marriott Hotel and Conference Center. The conference brought healthcare professionals and community members together to engage in a lively discourse regarding ways to address the significant disparities in infant mortality. The learning objectives for the conference were as follows: • Review disparities in infant mortality rates to build awareness among health care professionals • Describe the impact of social determinants of health on infant mortality • Discuss the roles of public health and health care in reducing disparities in infant mortality, regionally (within the Washington, DC/Baltimore metropolitan areas) • Discuss strategies for health care professionals to improve care and outcome for mothers and infants across the maternal/child continuum • Discuss the roles of mothers and fathers in improving health outcomes for infants • Discuss clinical support options, specifically doulas and nurse midwives This conference was approved to provide continuing education credits for nurses, physicians, and social workers.
Single or Multi-Year Initiative	The warm line is an ongoing multi-year initiative. The conference takes place annually however, the topic varies each year. Hecho de Pecho is a new initiative that began in 2015 and will be an ongoing multi-year initiative. Black Mother's Breastfeeding Club is a one-year initiative

Time Period	beginning April 2015 and ending May 2016.
Key Collaborators in Delivery of the Initiative	**Key partners involved in the outreach for, and implementation of, this initiative include:** • Montgomery County Health Department • The Women's Center Program • African American Health Program (AAHP) • Black Mothers Breastfeeding Association (BMBFA) • The National Association of County and City Health Officials (NACCHO)

Impact/Outcome of Hospital Initiative	**Hecho de Pecho**
	• Hecho de Pecho was started on June 2, 2015 at Adventist HealthCare Washington Adventist Hospital.
	• Thus far there have been a total of 35 encounters over the course of 19 group meetings. Twenty of the encounters were mothers, ranging from 15 to 40 years of age. Additional participants included children, partners, and other family members.
	
	Black Mothers' Breastfeeding Club (BMBFC)*
	• BMBFC began on April 28, 2015 at Adventist HealthCare Washington Adventist Hospital. Each meeting is approximately 2 hours.
	• There have been 9 participants and 16 encounters over the course of 7 group meetings. An additional 5 meetings are planned for 2016.
	
	Warm Line*
	A total of 267 individuals have called into the warm line and received breastfeeding support from January through November of 2015. There have been a total of 358 calls/encounters.
	
	"Before the Bough Breaks: Approaches to Reduce Disparities in Infant Mortality" (Conference)*
	• There were a total of 142 attendees, with 82 attendees being from organizations other than Adventist HealthCare. The conference attendees were from various professional backgrounds, such as healthcare, academia, urban development and legislation.
	• Following the conference, attendees were asked to complete an evaluation. Of the 142 attendees, 83 completed the evaluation.
	  ○ 91% strongly agreed or agreed that the topics were relevant to their work
	  ○ 91- 100% strongly agreed or agreed that each of the conference objectives were met
	  ○ When asked what the most important topics presented during the conference were, most attendees mentioned the role of racism in infant mortality, epigenetics, preconception health, as well as the impact of stress on birth outcomes and over the life course.
	• Continuing education credits were provided for nurses, physicians, and social workers.
	
	******The BMBFC, Warm Line, and Conference are AHC programs that are joint efforts between Shady Grove Medical Center and Washington Adventist Hospital. The descriptions and outcomes for these programs have been listed on the reports for both hospitals. The costs and offsetting revenue for these programs has been split accordingly between the two reports.*

Evaluation of	Maryland SHIP measures show infant death rates have increased from 7.2 per 1,000 in 2010 to 9.9 per 1,000 in 2013 among black residents in Montgomery County. In Prince George's County,

Outcomes	infant mortality among black residents has fallen from 11.5 per 1,000 in 2010 to 8.7 per 1,000 in 2013. The SHIP measures also show that Hispanic residents in Montgomery County and Prince George's County experience higher rates of babies with low birth weight (approximately 10% and 11%, respectively) than their racial counterparts. The Maternal and Child Health initiatives at Adventist HealthCare Washington Adventist Hospital have been working towards the reduction of infant mortality and babies with low birth weight by targeting the specific populations most affected. To address the high infant mortality rates among black residents, Black Mothers' Breastfeeding Club met 7 times in 2015; there was also a conference specifically focusing on disparities in infant mortality.	
Continuation of Initiative	All of the programs described above will be continued into 2016. The BMBFC will continue only until May 2016. Despite the need in the community, participation rates have been a struggle thus far with the program. Efforts have been made to address low participation rates but have not been very successful. In addition to offering both meals and prizes, the location, day and time of the club meetings have been changed to improve access. Various promotional efforts have been put into place as well. Additional efforts will be continued in order to increase participation in 2016. Although this program will likely be ending in 2016, Washington Adventist Hospital and Shady Grove Medical Center will continue exploring evidence-based practices and programs to better reach and meet the needs of current and expectant African American mothers.	
G. Total Cost of Initiative for Current Calendar Year H. What amount is from Restricted Grants/ Direct offsetting revenue	**G. Total Cost of Initiative** **Total Estimated Costs:** $56,716.09	**H. Direct offsetting revenue from Restricted Grants** **Total offsetting revenue and restricted grant funding:** $27,089.93

Identified Need Was this identified through the CHNA process?	Cigarette smoking is the leading preventable cause of death in the United States, accounting for more than 480,000 premature deaths each year[23]. Studies show that smokers have a life expectancy 10 years shorter than nonsmokers. Cigarette smoke, including secondhand smoke, contains carcinogens and has been linked to several types of cancers, stroke, coronary heart disease, bronchitis, and asthma (SmokeFree.gov). Smoking is highly correlated with lung cancer, which kills more people than any other cancer. The 2013 smoking rate in Maryland is 16.4% (MDQuit.org). Beyond health issues, cigarette smoking has also been correlated with lower productivity and higher absenteeism in the work environment. Therefore, smoking is a significant public health issue that needs to be addressed. The need was identified prior to the CHNA but was reinforced by the 2013 CHNA findings.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Tobacco Cessation Program
Total Number of People Within the Target Population	Washington Adventist Hospital primarily serves Montgomery and Prince George's Counties. Montgomery County has an adult population of 788,132[24]. In 2013, it was found that 8.2% of adults, approximately 64,627 adults, in Montgomery County are tobacco users[25]. Prince George's County has an adult population of 699,350[26] , of which 14.4% are tobacco users. That is approximately 100,706 adults.
Total Number of People Reached by the Initiative Within the Target Population	**Total People Reached: 1,493** • 1,064 individuals received one-on-one tobacco cessation counseling • 60 individuals received tobacco cessation education and resources • 369 individuals were screened for carbon monoxide and were provided with tobacco cessation education and resources
Primary Objective of the Initiative	The primary objective of this initiative is to increase the number of current tobacco users who quit and stay quit and to reduce tobacco use among adults in Montgomery County and Prince George's County, primarily to prevent lung cancer. Additional objectives include: 1. Counseling all in-patients who want to make the decision to quit smoking tobacco. 2. Assisting patients' quit attempts by providing nicotine-replacement therapy to all in-patients who have made the decision to quit smoking tobacco. 3. Providing culturally competent tobacco-use prevention and cessation health education information to help smokers who want to quit. 4. Achieving a tobacco quit rate of 30 – 33 percent. The Tobacco Cessation Program works toward reducing lung, bronchial, and tracheal cancers as well as reducing premature deaths from smoking. The Program seeks to improve cancer, cardiovascular health, and other health outcomes, especially among underrepresented and underserved populations. The program consists of one-on-one tobacco cessation counseling as well as 1 year of follow-up phone counseling and free nicotine replacement therapy for those

[23] Center for Disease Control and Prevention. *Tobacco-Related Mortality.* 2015.
[24] U.S. Census Bureau, *State and County Quick Facts,* 2014 Estimates
[25] HealthyMontgomery.org, 2013 Measurement
[26] PGCHealthzone.org, 2013 Measurement

	who enroll in the free program.
	
	Strategies for this initiative include:
	• Initial tobacco cessation counseling
	  ○ Certified tobacco cessation counselors meet with all admitted patients who have been identified as having a history of tobacco use during intake. This includes anyone who currently uses tobacco products or has quit within the last 12 months. Counselors discuss with patients their tobacco use history, assess their readiness to quit, and advise tobacco users to quit. This counseling takes place while the patient is in the hospital or over the telephone if a known tobacco user is discharged before receiving counseling.
	  ○ Following the initial counseling session, patients are given the opportunity to enroll in the 1-year follow-up program.
	• Outpatient follow-up support for one year
	  ○ For those individuals who enroll in the 1 year program, tobacco cessation counselors make follow-up calls at 1-week, 3 months, 6 months, 9months, and 12 months post enrollment. The counselors will use these telephone calls to provide additional counseling and determine the participants' needs and whether they have stayed quit.
	• Nicotine Replacement Therapy (NRT)
	  ○ Program participants are provided with nicotine replacement aids such as nicotine patches, gums, and/or lozenges to relieve nicotine cravings and reduce withdrawal symptoms. The NRT aids contain low doses of nicotine without the harmful toxins found in cigarette smoke. Multiple types and dosages of NRT are provided in order to best meet the needs of the program participants.
	• Community outreach and education
	  ○ In order to increase education and awareness in the community, tobacco cessation counselors complete additional outreach via presentations, lectures, health fairs, and screenings (carbon monoxide) in the community. At each of these events, certified counselors provide attendees with tobacco use prevention and cessation counseling as well as educational literature and resources (available in English, Spanish, and Korean). Attendees are also able to enroll in the 1-year tobacco cessation program to receive follow-up support calls and NRT.

Single or Multi-Year Initiative Time Period	**Multi-Year:** This initiative has been ongoing since it was initiated in 2002.
Key Collaborators in Delivery of the Initiative	**Key partners involved in this initiative include:** • Montgomery County Department of Health and Human Services
Impact/Outcome of Hospital Initiative	**Counseled Individuals:** This includes all individuals who were counseled, both those that did and did not enroll in the full 1-year program. • A total of 1,064 individuals received one-on-one tobacco cessation counseling. ○ Of the 1,064 individuals counseled, 76 enrolled in the full 1-year program. • There were an additional 60 individuals (family, friends, and caregivers) who were present during the initial one-on-one counseling and received tobacco cessation education and resources. **Enrolled Individuals Demographics:** Included below are demographic details for the 76

	individuals currently enrolled in the program.
	• Gender
	  ○ Female: 31.58% (24)
	  ○ Male: 67.11% (51)
	  ○ No Response: 1.32% (1)
	• Ethnicity
	  ○ Hispanic: 11.39% (9)
	  ○ Non-Hispanic: 82.28% (65)
	  ○ No Response: 6.33% (5)
	• Race
	  ○ White: 29.11% (23)
	  ○ Black: 44.30% (35)
	  ○ Asian: 2.53% (2)
	  ○ Other: 16.46% (13)
	  ○ No Response: 7.59% (6)
	
	Enrolled Individuals' Outcomes: Included below are outcome details for the 76 individuals currently enrolled in the program.
	• Reductions in Tobacco Use and Quit Rates (Self-Report)
	  ○ 1 Week: 62 individuals were reached for a follow-up call and provided a response
	  ▪ Quit Rate: 14.5% (9 individuals)
	  ▪ Decreased Tobacco Use: 64.5% (40 individuals)
	  ▪ No Change in Tobacco Use: 17.7% (11 individuals)
	  ▪ Increased Tobacco Use: 3.2% (2 individuals)
	  ○ 3 Month: 43 individuals were reached for a follow-up call and provided a response
	  ▪ Quit Rate: 44.2% (19 individuals)
	  ▪ Decreased Tobacco Use: 55.8%% (24individuals)
	  ▪ No Change in Tobacco Use: 0% (0 individuals)
	  ▪ Increased Tobacco Use: 0% (0 individuals)
	  ○ 6 Month: 26 individuals were reached for a follow-up call and provided a response
	  ▪ Quit Rate: 50% (13 individuals)
	  ▪ Decreased Tobacco Use: 50% (13 individuals)
	  ▪ No Change in Tobacco Use: 0% (0 individuals)
	  ▪ Increased Tobacco Use: 0% (0 individual)
	
	Community Outreach and Screenings (January-November)
	• A total of 369 individuals received a carbon monoxide screening and were provided with tobacco cessation education and resources at multiple community events. Carbon monoxide levels detected were as follows:
	  ○ Non-Smoker: 322 individuals (87.26%)
	  ○ Light smoker or exposed to second hand smoke: 38 individuals (10.3%)
	  ○ Smoker: 0 individuals
	  ○ Heavy Smoker: 9 individuals (2.44%)

Evaluation of Outcomes	According to the Maryland SHIP, the rate of Montgomery County adults who smoke fell from 11.3% in 2011 to 8.2% in 2013; in Prince George's County, the rate of adults who smoke fell from 17% in 2011 to 14.4% in 2013. The National Cancer Institute lists Montgomery and Prince George's Counties among the three Maryland counties with the lowest incidence rates of lung cancer (36.8/100,000 and 48.1/100,000, respectively) from 2008 to 2012. Recent trends show that the rate of lung cancer is still falling in Montgomery and Prince George's Counties.

	The Tobacco Cessation Program at WAH has been successfully addressing its community's health needs regarding the reduction of tobacco use. The program has provided evidence-based tobacco cessation counseling, free nicotine replacement therapy and a year-long follow-up to assist participants in reducing their tobacco use and quitting. The tobacco cessation initiative at WAH has seen reduction rates of 50-64.5% in tobacco use at 1 week, 3 months and 6 months and a quit rate of 50% at 6 months, which surpasses the goal set by the program (30 - 33%) and success rates of 25%[27] typically seen among individuals utilizing medication to aid in quitting.	

Continuation of Initiative	Adventist HealthCare Washington Adventist Hospital will continue to offer the Tobacco Cessation Program. The outcomes as described above have been very positive, which aided in driving the expansion of the program to Adventist HealthCare Shady Grove Medical Center in the spring of 2015. The program at Washington Adventist Hospital has received a number of accolades as well, including:
	• Being highlighted as a best practice at the February 2013 Maryland Million Hearts Symposium
	• Receiving a perfect score for a comprehensive tobacco cessation program when evaluated by Maryland Health Systems Change, Inc.
	• Being selected for two poster presentations (focused on the programs at both Washington Adventist and Shady Grove Medical Center)
	  ○ Completed: 2015 Maryland Chronic Disease Conference hosted by DHMH in September 2015
	  ○ Upcoming: 2016 Association for Community Health Improvement (ACHI) national conference in March of 2016	

I. Total Cost of Initiative for Current Calendar Year J. What amount is from Restricted Grants/ Direct offsetting revenue	**I. Total Cost of Initiative** ***Total Estimated Cost:*** *$68,834.00*	**J. Direct offsetting revenue from Restricted Grants** ***Total Offsetting Revenue:*** *$29,522.00*

[27] American Cancer Society (2015). Guide to Quitting Smoking. Accessed: http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-success-rates

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
Cancer: Lung, Prostate, Cervical, Skin, Oral, and Thyroid	**General** – Prince George's County has higher mortality rates than the state of Maryland for most cancers. **Lung cancer –** incidence and mortality rates among black residents of Montgomery County are higher than among white residents. In Prince George's County, white residents have highest lung cancer incidence and death rates. **Prostate cancer** – in Prince George's County, Black men are affected at significantly higher rates, with 88.93% higher incidence rates and 71.24% higher death rates than white men. In Montgomery County, 68.26% more black men died of prostate cancer than white men. **Cervical cancer** – incidence rate is greatest among Hispanic women (7.5 per 100,000), compared to black women (6.8 per 100,000) or white women (4.6 per 100,000) in Montgomery County. Similarly, the incidence rate in Prince George's County is highest for Hispanic women (9.0 per	Provide free cancer screenings to the community at the annual cancer screening days; provide educational lectures to target populations as well as education to patients at the hospital, and to the community at health fairs and various community locations.	WAH partners with physicians to provide free annual cancer screenings to the community, targeting: breast, prostate, colorectal, oral, skin and thyroid cancer. Additionally, bilingual Cancer Outreach Coordinators encourage prevention and early detection by providing educational presentations and materials to underserved and at-risk populations at community locations. WAH also provides tobacco cessation education and counseling as well as nicotine replacement therapy (NRT) at no cost to eligible patients.	Track and analyze numbers of: cancer screenings, abnormal findings, and treatment provided. Track number of participants encountered and educated through community outreach. **Cancer Screening Day** Nineteen (19) individuals participated in Adventist HealthCare Washington Adventist Hospital's Annual Cancer Screening Day in 2015. Of the 19 who completed an evaluation: • 63.2 percent were male & 36.8 percent were female • 42.1 percent were White, 26.3 percent were Black, 21.1 percent were Asian, and 10.5 percent were other A total of 40 screenings were completed (the majority of participants received more than 1 screening): • 12 Prostate (PSA) • 8 Rectal (DRE) • 2 Thyroid • 11 Oral • 7 Breast (CBE)

	100,000) in comparison to white women (8.0 per 100,000) or black women (7.5 per 100,000). **Oral Cancer** – Prince George's and Montgomery Counties have the lowest incidence rates among Maryland's counties. In Prince George's County, whites have the highest oral cancer incidence rates at 12.1 per 100,000 population. **Thyroid Cancer** – Montgomery County has a higher incidence rate (18.6 per 100,000) than the state average (14.3 per 100,000) for thyroid cancer. Prince George's County has the lower rate at 11.7 per 100,000.			
Diabetes	Diabetes is the 5th leading cause of death in Prince George's County and the 6th leading cause of death in Montgomery County. Diabetes disproportionately affects minority populations and the elderly. It is predicted to rise as these populations continue to increase in Montgomery and Prince George's Counties. The total health care related costs for the treatment of diabetes runs about $176 billion annually in the U.S., much of that is spent on	Encourage prevention of diabetes through community health education at health fairs, senior and community centers. Ensure that patients at WAH who are diagnosed with diabetes receive appropriate education on how to manage their disease.	WAH provides inpatient and outpatient services and education for diabetes, and its Center for Advanced Wound Care & Hyperbaric Medicine treats wounds due to complications of diabetes. Provide diabetic education classes. WAH encourages diabetes prevention through education at community health fairs and community locations.	Track and analyze numbers of participants encountered and educated through inpatient and outpatient diabetes education and through community outreach. Monitor rates of ER visits and hospitalizations due to diabetes. Free pre-diabetes classes are offered at Adventist HealthCare Washington Adventist Hospital every other month. Each class consists of two 2-hour sessions and is

	hospitalizations and medical care.			taught by a certified diabetes educator. In 2015, although the class was offered on 6 occasions, it only took place twice with 3 participants due to a lack of registrants.
Heart Disease and Stroke	**Heart Disease –** Heart disease was ranked as number one cause of death in U.S. by the CDC. The death rate from heart disease was higher in Prince George's County (180 per 100,000) than in Maryland (171.7 per 100,000). In Prince George's County, heart disease kills more blacks (190.5 per 100,000) and whites (185.1 per 100,000) than Asians (92.5 per 100,000) or Hispanics (82.3 per 100,000). Although on the decline in Maryland and Montgomery County due to improvements in treatment, it remains the leading cause of death in Montgomery County, killing blacks (132.9 per 100,000) at a higher rate than whites (122 per 100,000). **Stroke –** One of the top five leading causes of death in the U.S. Mortality rates in Montgomery County have met the HP 2020 target, but health disparities between racial/ethnic groups persist. Black residents have the	Provide free screenings related to cardiovascular health at annual "Love Your Heart" community health fair. Provide strong cardiovascular community outreach, to include the following screenings to community: Lipid Profile, Vertical Auto Profile, Homocysteine, HsCRP, blood pressure, glucose and A1C. Provide free cardiovascular educational materials, blood pressure screenings and body composition screenings (BMI, weight, % body fat, % muscle) at health fairs, churches, senior centers, and various community locations.	WAH will continue to hold its annual "Love Your Sweetheart" screening event to provide free screenings to community members for: blood pressure, cholesterol, glucose, waist circumference, BMI, body composition, and sleep apnea, as well as 1:1 counseling with a clinician. WAH will continue offering Lipid Profile, Vertical Auto Profile, Homocysteine, HsCRP, blood pressure, glucose and A1C screenings, as well as providing free educational lectures to the community.	Track and analyze numbers of screenings and findings from screenings. Track the number of participants encountered and educated through community outreach. **Love Your Sweetheart Event** The 2015 Love Your Sweetheart Event was held in February at White Oak Community Center in Silver Spring. Thirty-two (32) participants received free blood pressure screenings and 23 participants received body composition screenings. **Spring Into Better Health Event** In 2015, at the Spring Into Better Health event held at Adventist HealthCare Washington Adventist Hospital, 51 individuals received 153 free screenings. The screenings included: • 51 Ankle-brachial index • 51 Carotid artery disease

	highest stroke death rate in the County at 34.9/100,000 compared to whites at 28.3, Asian/Pacific Islanders at 26.9, and Hispanics at 23.2. Prince George's County, which has a stroke mortality rate of 40.4/100,000, has not met Healthy People 2020 goal. When stratified by race and ethnicity, whites have a high mortality rate at 39.4, followed by blacks at 39.2, Asians at 35.4, and Latinos at 28.4.			• 51 Abdominal aortic aneurysm
				
				Community Heart Health Screenings
				Adventist HealthCare Washington Adventist Hospital provides thousands of free heart health screenings at over 200 community events/activities each year. Heart health screenings include:
				• Blood pressure
				• Body Composition
				  ○ Body mass index (BMI)
				  ○ Body fat percent
				
				There were a total of 1,599 blood pressure screenings in the WAH CBSA (including those listed above):
				• 25.08% (401) systolic and 51.44% (822) diastolic readings were normal
				• 48.22% (771) systolic and 32.54% (520) diastolic readings were Pre-hypertension
				• 21.76% (348) systolic and 13.45% (215) diastolic readings were Stage 1

				• 4.63% (74) systolic and 2.57% (41) diastolic readings were Stage 2 • 0.31% (5) systolic and 0 diastolic readings were in hypertensive crisis There were 466 BMI screenings: • 1.93% (1) were underweight • 36.91% (172) were normal • 35.84% (167) were overweight • 25.32% (118) were obese There were 501 body fat percentage screenings: • 3.79% (19) had low body fat percentages • 34.53% (173) had normal body fat percentages • 32.53% (163) had high body fat percentages • 29.14% (146) had very high body fat percentages **Clinical/Blood Draw Heart Health Screenings** In addition to the free

				screenings offered in the community, Adventist HealthCare Washington Adventist Hospital also offers a Heart Health Community Screening Program. Through this program, individuals are able to register for an appointment or walk-in, and receive any of the following for a reasonable rate: • Vertical Auto profile • Lipid Profile • Homocysteine • HsCRP • Glucose • A1c • PSA Individuals are able to select individual screenings or a screening package. Free blood pressure screenings are also provided to participants. In 2015, there were 11 clinical/blood draw heart health screenings at Adventist HealthCare Washington Adventist Hospital.
Obesity	According to Healthy Montgomery, 17.9% of County resident adults are either overweight or obese, with Blacks (27.2%) and Hispanics (18.8%) being disproportionately more	Provide both individual (1:1) and group nutrition counseling, and health education related to exercise and nutrition to the community at a variety of community locations.	Provide 1:1 health education and group presentations about healthy nutrition and the importance of exercise at health fairs, senior and community centers, and faith-based organizations. Provide	Track the number of participants encountered and educated through community outreach. Monitor rates of obesity and overweight at the county level.

	obese than their racial counterparts. Twenty percent of high school students in Montgomery County are overweight, with Hispanic (29.7%) and Black (25.8%) teens being overweight at higher rates than other races/ethnicities. In Prince George's County, 34.5% of resident adults are overweight or obese, with Hispanics (44.9%) having the highest rate of obesity. Approximately 15% of adolescents ages 12 to 19 are overweight or obese.		affordable individual nutrition counseling to the community.	Adventist HealthCare Washington Adventist Hospital provides thousands of free weight related screenings at over 200 community events/activities each year. Relevant screenings include:
				• Body composition
				  ○ Body mass index (BMI)
				  ○ Body fat percent
				
				(See Heart Disease and Stroke above for outcomes)

Senior Health	According to the Maryland Department of Aging, the percentage of Maryland residents over the age of 60 is expected to increase from 18.6% in 2010 to 25.8% by 2030. In Montgomery County, 6.6% of seniors live below the poverty level, with higher percentages among minority seniors and women. Similarly, 6.8% of seniors in Prince George's County live below the poverty line, with higher percentages among minority seniors and women.	Continue to provide community health outreach programs, education and health screenings to seniors at a variety of locations in the community served by WAH.	WAH offers community health programs for seniors at: Long Branch Community Center, Takoma Park Community Center, Mid-County Community Center, Victory Towers, Springvale Terrace, as well as numerous other subsidized senior apartment complexes. WAH's community health education and outreach to seniors covers a variety of topics such as: heart health, cholesterol screenings, blood pressure screenings, healthy nutrition, fall prevention, summer safety, disease prevention, cancer screening education, brain health, osteoporosis screenings and bone health, flu and	Track the number of participants encountered and educated through community outreach. Continue to monitor and assess senior health status in Montgomery and Prince George's Counties to assure needs are being met and addressed. **Clinical/Blood Draw Heart Health Screenings** *(see heart disease and stroke section above for details)* This program is offered regularly at Adventist HealthCare Washington Adventist Hospital **Monthly Blood Pressure Screenings**

			pneumonia shots, education on the importance of exercise, lay person CPR and Basic First Aid instruction.	Free monthly blood pressure screenings are offered at various sites in the community such as: • Mid County Community Center • Long Branch Senior Center • Takoma Park Community Center • White Oak Community Recreation Center • Victory Tower Apartments • Seabury at Springvale Terrace • Adventist HealthCare Washington Adventist Hospital **Cardiovascular Support and Activity Groups** Groups meet at least monthly to promote both disease prevention and disease management. The groups at Adventist HealthCare Washington Adventist Hospital include Women and Hear Disease, as well as Mended Hearts.

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

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & 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 Montgomery County had ER visit rates about 3.4 times higher than white residents, while black residents of Prince George's County had asthma ER visit rates about 2.6 times higher than white residents. Hospitalization rates showed a similar trend.	Provide community members with resources on asthma through community outreach.	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.
HIV/AIDS	Prince George's County has the 3nd highest rate of HIV/AIDS prevalence in the region (after Baltimore City and D.C.); nearly 88% of people living with HIV/AIDS in Prince George's County in 2012 were black. Black	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	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.

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	residents represent about 18.8% of Montgomery County's population, yet 66.8% of HIV cases diagnosed in 2013 were black residents. While HIV-related deaths in Montgomery County have greatly decreased in the past decade, the death rate remains high among black residents at 9.7 HIV-related deaths per 100,000 population.		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 public and health care professionals.	
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 but better than national baselines. **Housing Quality** – 51.6 percent of renters in Montgomery County spend 30% or more of household income on rent. The rate in Prince George's County is	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	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,

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	similar with 52.8 percent of renters spending 30% or more of household income on rent. In 2015, an annual survey found there were 1100 homeless people in Montgomery County and 627 in Prince George's County. **Education** – The percentage of children who enter kindergarten ready to learn in Montgomery County (81%) and in Prince George's County (80%) is lower than the state of Maryland baseline (83%). The percentage of students who graduate high school in 4 years is also lower in Prince George's County (76.6%) than in the state (86.4%). **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 (41.3/100,000) is lower than that of the state (42.5/100,000) but remains higher than the SHIP 2017 target of 35.6/100,000 population. In Prince George's		local non-profit organization called Interfaith Works, which provided shelter to 824 homeless men, women, and children, while providing 13,073 income-qualified residents with free clothing and household goods in 2014 alone. Additionally, the Montgomery County Coalition for the Homeless 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	education, transportation, and other social determinants of health.

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	County, the rate of injuries on public roads is 39.6 per 100,000 population, a rate lower than the state, but higher than SHIP 2017 target.		library, sponsors summer reading programs, and offers an 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.	

3. **How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?** (see links below for more information on the State's various initiatives)

The State's initiatives for improvement in population health include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. Also, in the context of the State's unique all-payer rate setting model, hospitals are tasked with improving quality, including decreasing 30-day readmissions. Washington Adventist Hospital's community benefit operations/activities are aligned with many of these initiatives. For example, WAH's "Help Stop the Flu" initiative, in partnership with local safety-net clinics, senior centers, and faith-based communities, reached over 750 people with flu vaccinations and/or education about the flu, in order to address high rates of flu in the population, as evidenced by high flu-related emergency department visits. Also, in efforts to reduce cancer-related mortality and survival, WAH offers free cancer screenings to community members. Also, free cardiovascular screenings (e.g. blood pressure and body composition) are offered at various health fairs, houses of worship, senior centers, etc., to reach populations that may not otherwise have access to these kinds of services. The Breast Cancer Screening program, which provides free, comprehensive breast cancer services to women over 40 with limited or no insurance, serves many African American and Latino women from underserved areas. Patients at-risk for diabetes, or with a diagnosis of diabetes, may be referred to one of several free diabetes programs, including a pre-diabetes class, a 6-week diabetes self-management program, and an ongoing support group for persons wishing to adopt a healthier lifestyle to reduce their risk or improve management of chronic disease; these programs illustrate the integration of health care with various community resources, which, in turn, can lower readmission rates.

VI. 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.**

Adventist HealthCare 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. The lists included below in question VI.2 include physician specialties and services the hospital provides to ensure access to care for all in our community, including the uninsured.

Published reports by health care advocacy organizations have noted that the capital area, including Montgomery County and Prince George's County, has shortages in 8 of 30 physician specialty groups[28]. Shortages were identified among hematology/oncology, anesthesiology, diagnostic radiology, general surgery, and neurosurgery. A borderline physician supply was found in dermatology, physical medicine, radiation oncology, and vascular surgery. Across the state, medical specialists are projected to decrease from 40 per 100,000 state residents to 37 per 100,000 in 2015. However, the capital region is projected to be less significantly affected compared to other regions of the state due to lower retirement rates and higher rates of medical residents. Washington Adventist Hospital is augmenting this information by conducting a Medical Staff Development plan to determine physician specialty needs in the community and at the hospital.

Adventist HealthCare Washington Adventist Hospital partners with local safety net clinics including Community Clinic, Inc., 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. Washington Adventist Hospital has subsidized 4,000 visits to maternal-fetal specialists in 2014 to meet the needs of high-risk uninsured prenatal patients. The partnership with Community Clinic Inc. includes a Federally Qualified Health Center (FQHC) developed on the hospital's campus to serve uninsured patients.

[28] Maryland Hospital Association & MedChi the Maryland State Medical Society. 2008. Maryland Physician Workforce Study.

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 the Community Benefit report, would not be able to meet patient demand if they did not receive a subsidy from Adventist HealthCare Washington Adventist Hospital:

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

- Anesthesia
- Emergency physicians
- Radiologists
- Pathology
- Critical Care

Non-resident house staff and hospitalists:

- OB-Gyn
- Internal Medicine
- Infection control
- Pulmonary medicine
- Psychiatry

Coverage of emergency department on-call:

- G.I.
- Cardiology
- General surgery
- Plastic surgery
- Urology
- Thoracic and vascular surgery
- Psychiatry
- Neurology
- Neurosurgery
- Ophthalmology
- Orthopedic surgery
- Pulmonary Medicine

Physician recruitment to meet community need:

- Cardiology
- Primary Care
- OB/GYN
- Orthopedic surgery

The following table describes the physician subsidies that Adventist HealthCare Washington Adventist Hospital provided:

Physician Category	Amount
Emergency Department On-Call	$1,910,981.77
Non-Resident House Staff and Hospitalist	$10,244,935.11
Recruitment of Physicians to meet community need	$6,215,525.23
Total	**$18,351,442.11**

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

c. Include a copy of your hospital's FAP (label appendix III).

d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Appendix I

Financial Assistance Policy Description

Adventist HealthCare 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 is 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 reviewed for eligibility for Medical Assistance and 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 and assist with the application process. Patients must first apply for Medical Assistance before applying for financial assistance from the hospital.

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 patient that financial assistance 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 financial assistance application will be sent to them.

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

Appendix II

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

Adventist HealthCare 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 Adventist HealthCare 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 Adventist HealthCare 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.

The only change made to the financial assistance policy was the annual update to the Income Poverty Guidelines established by the Community Services Administration. It was not necessary to make any additional changes to the policy as the hospital considers Financial Assistance to any patient responsibility amount as long as the patient has followed our requirements.

Appendix III

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.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

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Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13	Page:	3 of 12

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 five time these amounts, you may qualify for Charity Care.

Size of Family Unit	Guideline
1	$11,670
2	$15,730
3	$19,790
4	$23,850
5	$27,910
6	$31,970
7	$36,030
8	$40,909

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. A written determination of your eligibility will be made two business days of the receipt of your completed application.

Revised 3/2015

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

(Formerly known as Charity Care Policy)

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Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

☐ 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.

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
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 SUPERVISOR
UP TO $5,000.00

_____
REGIONAL DIRECTOR
UP TO $25,000.00

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

Revised 3/2015

2015 POVERTY GUIDELINES

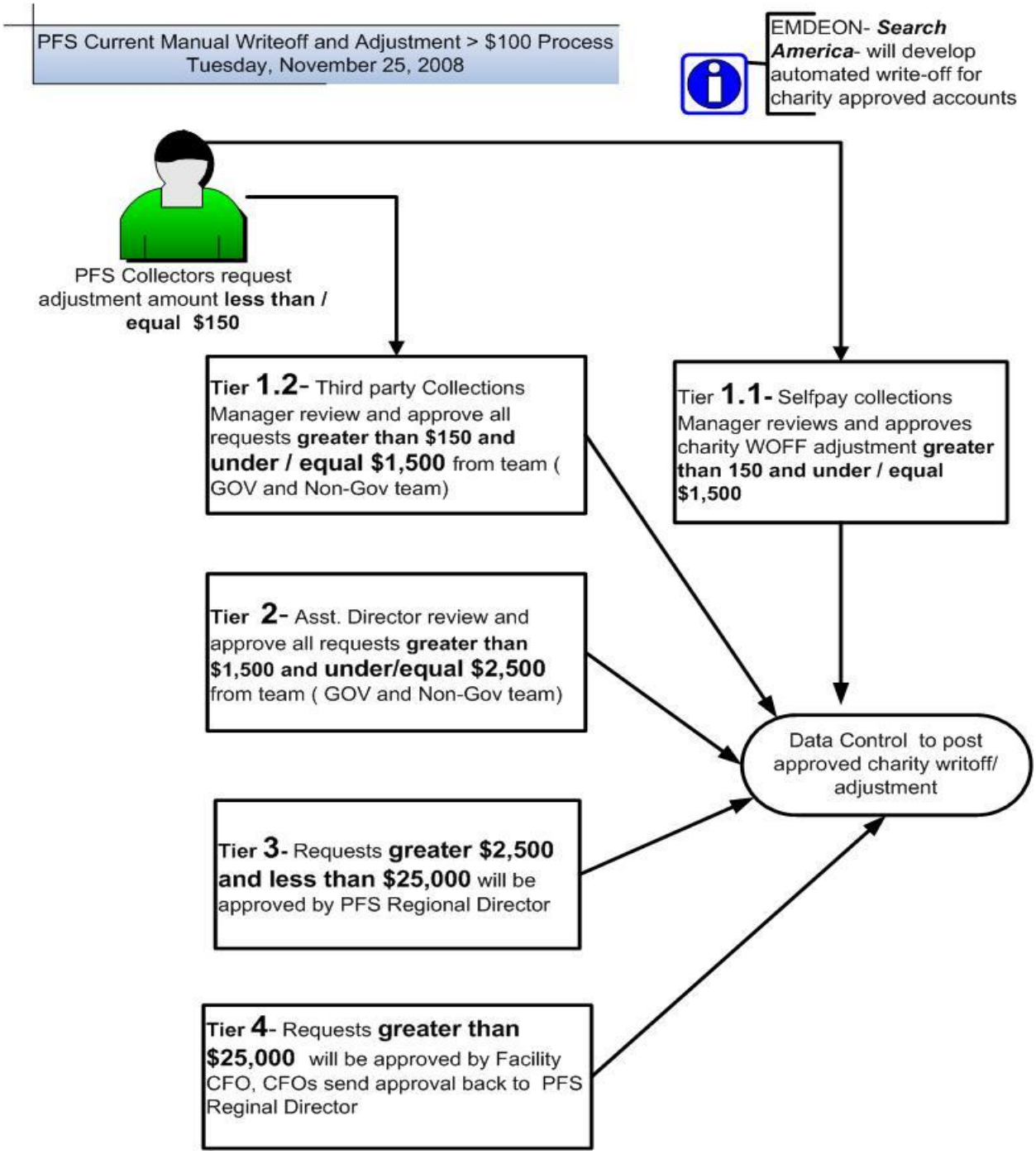
FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
\1	100%	$11,670	100%	0%
2	100%	$15,730	100%	0%
3	100%	$19,790	100%	0%
4	100%	$23,850	100%	0%
5	100%	$27,910	100%	0%
6	100%	$31,970	100%	0%
7	100%	$36,030	100%	0%
8	100%	$40,090	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	125%	$14,588	100%	0%
2	125%	$19,663	100%	0%
3	125%	$24,738	100%	0%
4	125%	$29,813	100%	0%
5	125%	$34,888	100%	0%
6	125%	$39,963	100%	0%
7	125%	$45,038	100%	0%
8	125%	$50,113	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	150%	$17,505	100%	0%
2	150%	$23,595	100%	0%
3	150%	$29,685	100%	0%
4	150%	$35,775	100%	0%
5	150%	$41,865	100%	0%
6	150%	$47,955	100%	0%
7	150%	$54,045	100%	0%
8	150%	$60,135	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**

1	175%	$20,423	100%	0%
2	175%	$27,528	100%	0%
3	175%	$34,633	100%	0%
4	175%	$41,738	100%	0%
5	175%	$48,843	100%	0%
6	175%	$55,948	100%	0%
7	175%	$63,053	100%	0%
8	175%	$70,158	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	200%	$23,340	100%	0%
2	200%	$31,460	100%	0%
3	200%	$39,580	100%	0%
4	200%	$47,700	100%	0%
5	200%	$55,820	100%	0%
6	200%	$63,940	100%	0%
7	200%	$72,060	100%	0%
8	200%	$80,180	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	225%	$26,258	90%	10%
2	225%	$35,393	90%	10%
3	225%	$44,528	90%	10%
4	225%	$53,663	90%	10%
5	225%	$62,798	90%	10%
6	225%	$71,933	90%	10%
7	225%	$81,068	90%	10%
8	225%	$90,203	90%	10%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	250%	$29,175	80%	20%
2	250%	$39,325	80%	20%
3	250%	$49,475	80%	20%

4	250%	$59,625	80%	20%
5	250%	$69,775	80%	20%
6	250%	$79,925	80%	20%
7	250%	$90,075	80%	20%
8	250%	$100,225	80%	20%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	275%	$32,093	70%	30%
2	275%	$43,258	70%	30%
3	275%	$54,423	70%	30%
4	275%	$65,588	70%	30%
5	275%	$76,753	70%	30%
6	275%	$87,918	70%	30%
7	275%	$99,083	70%	30%
8	275%	$110,248	70%	30%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	300%	$35,010	60%	40%
2	300%	$47,190	60%	40%
3	300%	$59,370	60%	40%
4	300%	$71,550	60%	40%
5	300%	$83,730	60%	40%
6	300%	$95,910	60%	40%
7	300%	$108,090	60%	40%
8	300%	$120,270	60%	40%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	350%	$40,845	50%	50%
2	350%	$55,055	50%	50%
3	350%	$69,265	50%	50%
4	350%	$83,475	50%	50%
5	350%	$97,685	50%	50%
6	350%	$111,895	50%	50%

7	350%	$126,105	50%	50%
8	350%	$140,315	50%	50%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	400%	$46,680	40%	60%
2	400%	$62,920	40%	60%
3	400%	$79,160	40%	60%
4	400%	$95,400	40%	60%
5	400%	$111,640	40%	60%
6	400%	$127,880	40%	60%
7	400%	$144,120	40%	60%
8	400%	$160,360	40%	60%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	450%	$52,515	30%	70%
2	450%	$70,785	30%	70%
3	450%	$89,055	30%	70%
4	450%	$107,325	30%	70%
5	450%	$125,595	30%	70%
6	450%	$143,865	30%	70%
7	450%	$162,135	30%	70%
8	450%	$180,405	30%	70%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	500%	$58,350	20%	80%
2	500%	$78,650	20%	80%
3	500%	$98,950	20%	80%
4	500%	$119,250	20%	80%
5	500%	$139,550	20%	80%
6	500%	$159,850	20%	80%
7	500%	$180,150	20%	80%
8	500%	$200,450	20%	80%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	550%	$80,231	10%	90%
2	550%	$108,144	10%	90%
3	550%	$136,056	10%	90%
4	550%	$163,969	10%	90%
5	550%	$191,881	10%	90%
6	550%	$219,794	10%	90%
7	550%	$247,706	10%	90%
8	550%	$275,619	10%	90%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	600%	$105,030	5%	95%
2	600%	$141,570	5%	95%
3	600%	$178,110	5%	95%
4	600%	$214,650	5%	95%
5	600%	$251,190	5%	95%
6	600%	$287,730	5%	95%
7	600%	$324,270	5%	95%
8	600%	$360,810	5%	95%


PFS Current Manual Writeoff and Adjustment > $100 Process
Tuesday, November 25, 2008
EMDEON- Search America- will develop automated write-off for charity approved accounts
PFS Collectors request adjustment amount less than / equal $150
Tier 1.2- Third party Collections Manager review and approve all requests greater than $150 and under / equal $1,500 from team (GOV and Non-Gov team)
Tier 1.1- Selfpay collections Manager reviews and approves charity WOFF adjustment greater than 150 and under / equal $1,500
Tier 2- Asst. Director review and approve all requests greater than $1,500 and under/equal $2,500 from team (GOV and Non-Gov team)
Data Control to post approved charity writoff/ adjustment
Tier 3- Requests greater $2,500 and less than $25,000 will be approved by PFS Regional Director
Tier 4- Requests greater than $25,000 will be approved by Facility CFO, CFOs send approval back to PFS Reginal Director

Appendix IV

Patient Information Sheet

Maryland Hospital Patient Information

Hospital Financial Assistance Policy

Washington Adventist Hospital is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. This hospital provides emergent and urgent care to all patients regardless of their ability to pay.
In compliance with Maryland law, Washington Adventist Hospital has a financial assistance policy and program.
You may be entitled to receive free or reduced-cost medically necessary hospital services.
This facility exceeds Maryland law by providing financial assistance based on a patient's need, income level, family size and financial resources.
Information about the financial assistance policy and program can be obtained from any Patient Access Representative and from the Billing Office.

Patients' Rights

As part of Adventist HealthCare's mission, patients who meet financial assistance criteria may receive assistance from the hospital in paying their bill.
Patients may also be eligible for Maryland Medical Assistance - a program funded jointly by state and federal governments. This program pays the full cost of healthcare coverage for low-income individuals meeting specific criteria (see contact information below).
Patients who believe they have been wrongly referred to a collection agency have the right to request assistance from the hospital.

Patients' Obligations

Patients with the ability to pay their bill have an obligation to pay the hospital in a timely manner.
Washington Adventist Hospital makes every effort to properly bill patient accounts. Patients have the responsibility to provide correct demographic and insurance information.
Patients who believe they may be eligible for assistance under the hospital's financial assistance policy, or who cannot afford to pay the bill in full, should contact a Financial Counselor or the Billing Department (see contact information below).
In applying for financial assistance, patients have the responsibility to provide accurate, complete financial information and to notify the Billing Department if their financial situation changes.
Patients who fail to meet their financial obligations may be referred to a collection agency.

Contact Information

To make payment arrangements for your bill, please call (301)315-3660 for assistance.

To inquire about assistance with your bill, please call the Billing Office at (301) 315-3660.

To inquire about Medical Assistance, please call (301)891-5250 for assistance.

Note: Physician services provided during your stay are not included on your hospital billing statement and will be billed separately.

Información del paciente de Maryland Hospital

Política de ayuda financiera del hospital

Washington Adventist Hospital está comprometido a cubrir las necesidades de salud de su comunidad a través de un ministerio de cuidado físico, mental y espiritual. Este hospital ofrece servicios de salud emergente y de urgencias a todos los pacientes, sin importar si tienen la capacidad de pagar. En cumplimiento con las leyes de Maryland, Washington Adventist Hospital tiene un programa y una política de ayuda financiera.

Usted podría tener el derecho a recibir servicios hospitalarios médicamente necesarios de manera gratuita o a un costo reducido.

Este hospital supera lo previsto en la ley de Maryland al ofrecer ayuda financiera con base en la necesidad, nivel de ingresos, tamaño de la familia y recursos financieros del paciente.

Para obtener información acerca del programa y de la política de ayuda financiera diríjase a cualquier representante de acceso de pacientes o a la oficina de cobranzas.

Derechos del paciente

Como parte de la misión de salud adventista, los pacientes que cumplan con los criterios para recibir ayuda financiera podrían recibir ayuda del hospital para el pago de su factura.

Los pacientes también podrían cumplir con los requisitos para participar en el programa Maryland Medical Assistance, financiado en conjunto por los gobiernos federal y estatal. Este programa paga el costo total de la cobertura de salud para individuos de bajos ingresos que cumplan con los criterios específicos (consulte la información de contacto que aparece más abajo).

Los pacientes que consideren que han sido remitidos por error a una agencia de cobranzas tienen derecho a solicitar ayuda al hospital.

Obligaciones del paciente

Los pacientes con capacidad de pagar sus facturas tienen la obligación de pagar a tiempo al hospital.

Washington Adventist Hospital se esfuerza en cobrar correctamente las cuentas de los pacientes. Los pacientes tienen la responsabilidad de entregar la información correcta acerca de sus datos demográficos e información de seguros.

Los pacientes que consideren que podrían calificar para el programa de ayuda financiera de acuerdo con las políticas del hospital o aquellos que no tengan capacidad de pagar la totalidad de la factura deberán contactar a un consejero financiero o al departamento de cobranzas (consulte la información de contacto que aparece más abajo).

Al solicitar ayuda financiera, los pacientes tienen la responsabilidad de entregar información financiera completa y veraz y de notificar al departamento de cobranzas si ocurren cambios en su situación financiera.

Aquellos pacientes que no cumplan con sus obligaciones financieras podrían ser remitidos a una agencia de cobranzas.

Información de contacto

Para solicitar un plan de pago de su factura llame al (301) 315-3660.

Para averiguar acerca de la ayuda financiera para el pago de su factura, llame a la oficina de cobranzas al (301) 315-3660.

Para averiguar acerca de ayuda médica llame al (301) 891-5250.

Nota: Los servicios que los doctores le proporcionen durante su estadía no están incluidos en su estado de cuenta del hospital y se le cobrarán por separado.

Appendix V

Hospital Mission, Vision, and Value Statements

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.