COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

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

The written document (CHNA), as provided in the ACA, must include the following:

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

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

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;

(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all 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:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
62	36,876	21811 21842 21813 21863 21851 21874 21841 21801 21843 21862	McCready Memorial Hospital Peninsula Regional Medical Center	Worcester County – 8% FY15 Sussex County 14% (2010 - most current from the county)	Worcester County 13% Sussex County 22.6%

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.

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

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

Data according to the Worcester County Health Department website:

Population	51,454
Median Age (years)	48.1
Under 5 years (percent of population)	4.5
65 years and over (percent of population)	23.2
Non-Hispanic White(percent of population)	80.3
Non- Hispanic Black (percent of population)	13.6
Hispanic or Latino origin (percent of population)	3.2
Others (percent of population)	2.9
Median household	$57,952
Persons below	10.9%

Nearly one fourth of the Worcester County residents are over age 65. Our majority of health care claims are Medicare (more than 55%). The over 65 aged population of the county grew 27% between 2000 and 2010.

The Regional Community Health Assessment data reports that 72.5% of residents are "overweight" or of an "unhealthy weight". Nearly one third are "obese". Our rate of diabetes in the county is 10.8%, though slightly lower than in the previous report, this continues to be higher than the national average. According to the latest state results the leading causes of death in the county include heart disease, cancer and stroke. At least 2 out of three of these leading causes may be secondary to diabetes.

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

is where the majority of the services are located and public transportation throughout the county is less than adequate.

Sussex County, DE, the other county in our CBSA is also a rural area. According to the most recent census the population of all of Sussex County is 197,145. We service the lower portion of the county. The population mix is 76% white, 12% black and 12% Latino/Hispanic and 8.3% report being non-English speaking at home. The population greater than 65 years of age is 20.8%. The per capita income is $26,689 and the median income is $52,692 with 12.2% of the people living below the poverty level. According to the Healthy Communities Institute 13 out of the 21 zip codes in Sussex County rank 3, 4, or 5 in health needs (ranking of 0 – lowest to 5 – highest need). Again, like in Worcester County, Sussex County is a rural, underserved area. There are many migrant workers in the area for at least a portion of the year. Because of the migratory habits the consistency of health care is poor and makes follow up care very difficult for that population. Public transportation is a problem in Sussex County as well.

The priorities of the goals are based on the needs of population determined by what percentage of the population is effected by risks such as uncontrolled weight, diabetes, heart and vascular disease risks.

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. (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).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA	Worcester Co. - $57,952 Sussex Co., DE - $52.692
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Worcester Co. - 6% Sussex Co., DE - 1%
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Worcester Co. – 14 5% Sussex Co., DE – 5%
Percentage of Medicaid recipients by County within the CBSA.	Worcester Co. – 13% Sussex C., DE – 22.6%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Worcester County – 79.6 Black – 76.3 White – 79.9 Sussex County – 77.0 Sources: MD SHIP, DE vital statistics
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	599 (actual) deaths in Worcester County White - 510 Black – 86 Hispanic – 1 Asian - 1 Sussex County – (adjusted rate of deaths per 100,000 population) 687.6 - overall 872.6 - White male 639.7 – White females 1057.8 – Black males 682.6 – Black females Sources: vital stats, Worcester and Sussex County Sites
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	In Worcester County it is estimated that 16.7% of the population does not have access to healthy foods and 26% live in inadequate housing. Though we are a farming community affordable access to healthy food is the issue. In the counties (in Md. and De.) that we serve food deserts are not the issue as much as social norms,

	affordability and education regarding food consumption. Though in Worcester County the SHIP reports food deserts at 16.7%. According ot SHIP our farmer's market density is 0.06 (in the Yellow), Fast Food outlets is at 1.73 (in the Red) and Healthy Food Outlets are 54.5% (in the Yellow). In Sussex Co., DE – 16% report severe housing problems, Air pollution is 11.8 compared to 9.5 nationally (particulate matter), 32% report having a long commute to work or school. Sources: CHIP board, DE County HD MD SHIP
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Percentages of population for Worcester Co. Non-Hispanic White – 80.3% Non-Hispanic Black – 13.6% Hispanic or Latino origin – 3.2% Others – 2.9% Sources: Worcester County Health Assessment Sussex County, DE: Latino 12% Non-Hispanic White – 76% Non-Hispanic Black – 12% Sources: US Census data
Other	Population per Physician in the CBSA: 3500:1 – Worcester County 2060:1 – Somerset County 1870:1 – Wicomico County 1165:1 – Sussex County Since the last health assessment the incidence of diagnosis of hypertension has decreased slightly while the incidence of high cholesterol has increased. The diseases higher in Worcester Co than in the state are: Heart Disease, Cancer,

	Hypertension, COPD/Asthma, Accidents, Diabetes, Obesity and tobacco use. All of which are health risks for chronic conditions. The 2013-14 youth health risk assessment done in Worcester County shows a rise in high risk behavior (alcohol and tobacco use) among the youth in the county. This has become a focus in the Worcester County health department prevention services and we partner with them on many initiatives including this one. Top reasons for not seeking health care in our communities are: lack of providers, cost and transportation. Sources: MD DHMH and Worcester County Health Assessment.

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. 12/10 /12 (mm/dd/yy)
   http://www.atlanticgeneral.org/documents/CNA-fy13-final-with-may-15-update-111915.pdf

   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).

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

   _X_Yes 06/30/14 (mm/dd/yy) Enter date approved by governing body here:
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://www.atlanticgeneral.org/documents/Implementation-Plan-Document-Final-v-FY15.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?

      _X_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 Benefits is a large part of planning the hospital's strategic plan. As we become more focused on population health management we realize that the hospital's job starts way before someone darkens the doors of any of our facilities. The key is to coordinate care for our patients by doing all the "Right" things. That is why our strategic plans involve the "Right Principles: Right Care, Right People, Right Place, Right Partners and Right Hospital.

Community Education and Health Literacy are one of the key initiatives in the strategic plan. These two things make up a large portion of our Community Benefit contribution. This graphic helps to explain our strategic plan that began in FY15.

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. _X_ CEO
2. _X_ CFO
3. _X_ Other (please specify)

These positions make up our Senior Leadership Team.

VP, Community Relations and Marketing✓
VP, Medical Staff Services
VP, Quality
VP, Planning and operations
VP, Professional Services
VP, Information Services

Hospital Board of Trustees✓

Describe the role of Senior Leadership.
The role of the Senior Leadership Team is to guide the operations of the organization: to develop the strategic plan, to set the annual organizational goals, ultimately guides the community benefit initiatives. The Community Education Manager report directly to the VP of Community Relations and Marketing and that department goals are a reflection of the organizational goals and the Strategic Plan.

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. _X_ Social Worker
4. _X_ Other (please specify)

Information Technology
Nursing
Patient Care Management
Emergency Department
Patient Centered Medical Home
AGHS
Behavioral Health Services
Laboratory
Endoscopy Center
Women's Diagnostic Center
Imaging
Cancer Care Services
Surgical Services
Medical Staff
Medical Information
Supportive Care Services

Describe the role of Clinical Leadership
Clinical leadership is involved in the Strategic Planning each year. It is through their input that goals and directions are set for the organization. It is the through the support of these teams (and the course set by the goals) that Community Benefits are accomplished. Each department plays an active role in the process and implementation of the Community Benefit goals each year.

iii. Community Benefit Operations

1. _ _Individual (please specify FTE)
2. _X_Committee (please list members) – see below
3. _X_Department (please list staff) – 1 Manager, 1 Clinical Assistant, 1 Health Literacy Liaison plus 5 casual employees
4. ___Task Force (please list members)
5. ___Other (please describe)

Community Benefit Committee

Althea Foreman	Erin Cowder	Melanie Windsor
Andi West-McCabe	Gail Mansell	Michelle Clifton
Betty Mitchell	Geri Rosol	Michele Clauser
Blanca Adams	Ingrid Cathell	Michelle Tingle
Bonnie Mannion	Jane King	Nancy Helgeson
Bonnie Sybert	Janet Smith	Nicole House-Blanc
Bruce Todd	Jill Todd	Niki Morris
Chuck Gizara	Kim Chew	Patti Wolfe
Connie Collins	Leslie Clark	Scott Rose
Crystal Mumford	Linda Dryden	Stefanie Morris
Darlene Jameson	Lisa Iszard	Sue Foskey
Dawn Denton	Lou Brecht	Tammy Simington
Denise Esham	Lynne Snyder	Toni Keiser
Deborah Wolf	Maria Phillips	Vinnie Caimi
Eileen Haffner	Michaelann Frate	

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

Community Education Manager –Community Benefit oversight.

Clinical Assistant – Performs CBISA data base management

Health Literacy Liaison – Oversees the Integrated Health Literacy Program with the Worcester County Schools

Outreach Providers – teach workshops and perform many health screenings in the community

Community benefit Committee – The reporters for each department –responsible for data input for their department regarding Community benefits. They meet quarterly and set annual goals for Community Benefits which stem from the organizational goals and the strategic plans. They meet quarterly to monitor the hospital's community benefits and to modify and plan accordingly to make sure we meet our goals.

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

Spreadsheet _X__yes _____no
Narrative _X__yes _____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

The audit is done quarterly by the Community Benefit Committee, Leadership Team, Senior Leadership and the Hospital Board of Trustees. The Community Benefit Committee and the Community Education Manager and the VP sign off on the reporting.

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

Spreadsheet __X__yes _____no
Narrative __X__yes _____no

If no, please explain why.

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:

__X__ Other hospital organizations
__X__ Local Health Department
__X__ Local health improvement coalitions (LHICs)
__X__ Schools
__X__ Behavioral health organizations
__X__ Faith based community organizations
__X__ 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	Name of Key Collaborator	Title	Collaboration Description
Peninsula Regional Medical Center	Nancy Creighton	Executive Director of Managed Care	Through Lower Shore Healthcare Reform
	Peggy Naleppa	CEO	Population health Management T –CHIP
McCready Memorial Hospital	Sharon Cooper	Community Relations Coordinator	Various community education events
Worcester County Health Department	Debbie Goellar	County Health Officer	Needs assessment Committees Wellness Initiatives Referral to programs
Sussex County Health Department	Anna Short	Clinical Manager	Provider group leader
Worcester County Board of Education	Dr. Jerry Wilson Dr. Quinn	Superintendent Vice Superintendent of curriculum	Grades 1 through 5 through our Integrated health

			Literacy Program
Worcester County Health Department Shepard Pratt	Jennifer LaMade	Director of Behavioral Health services	Coordinate care with mental health services. Telehealth program.
Faith Based Partnership Group	Gail Mansell	Director of Supportive Care Services	To disseminate health information through clergy and health ambassadors of local congregations and to get feedback and conduct focus groups.
Chamber of Commerce in local communities Komen MD ACS Tri County Diabetes Alliance TCHIP Worcester County School health Council Worcester Gold	Chamber Directors Lori Yates Arlene Schneider Darlene Jameson Kim Justice Dr. Dale Carol Jacobs	Various Area Coordinator Area Coordinator Diabetes Educator VP Coordinator of health services President	To collaborate on the health needs of the community To analyze and improve breast cancer rates To build strategies to decrease cancer rates To assess and improve rates of diabetes in the area To work with area agencies and health departments to improve the health of our area Assess the needs of the youth in the area and plan strategies. To plan an assist with strategies to meet the health needs of the

			underserved

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 __X__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?

__X_yes _____no

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?

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.

The identified needs that were chosen not to address are listed below along with the rationale for not moving forward to meet them.

1. Dental Health – at this time AGH/AGHS has no resources to meet this need other than referral services. The Worcester County Health Department does have a dental health program. In our neighboring counties (Somerset and Wicomico) there is a federally funded and run dental health program run through TLC clinic (Three Lower County). In lower Delaware the services are provided by La Red a comprehensive health service center.
2. Communicable Disease – Though not designated as a priority AGH does provide immunization services to the communities we serve. We provide free flu immunizations to all our associates and their families as well as all of the volunteers at the hospital. In addition we run approximately 20 flu clinics free to the communities in Worcester, and Sussex Counties. Our expenditure for Flu vaccines to the community was $291,838. Our neighboring hospital PRMC does a large drive-through flu event which services Wicomico and Somerset counties.
   In addition the Health Departments provide other services for communicable diseases to which we partner if there are any outbreaks where we are needed.
3. Transportation – Though transportation is a need in our rural communities there are other agencies who provide services: Go Getters, Road to Recovery (ACS), Shore Transit and DART as well a s smaller faith-based assistance programs such as Caregivers in our local Jewish Temple.

Our philosophy on addressing the transportation situation is to bring providers and services into the local towns. This is why each year we continue to recruit more physicians and have them practicing in more than one location, so we can bring general practitioners and specialists into the communities closer to where people live.

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)

STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
HEALTH CARE INNOVATIONS IN MARYLAND
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

The Community Benefits operation/activities at Atlantic General Hospital are in line with the State's initiative in all that we do. We keep those initiatives in the forefront when formulating our strategic plan. Of the 10 top priority diseases listed in the Maryland State Healthcare Innovation Plan we address directly 8 of those diseases and the other tow indirectly.

We have programs in place to manage chronic disease, infectious disease and prevention of disease. Because we are in an area of high senior aged population we are less likely to prevent chronic illness but we can help manage their disease.

Through our Integrated Health Literacy program we are imparting the health message to the younger ages to prevent bad behaviors which lead to chronic conditions. This program and many others that we have are about preventing disease. We work with our local businesses to help make the workforce healthier and better managed.

It is our goal, along with the state's, that the majority of our population will fall into the "Healthy" or "Chronically Ill but Under Control" categories. Through sharing data across organization, sharing resources and not duplicating programs we will be able to have healthier communities and lower healthcare costs.

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.

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

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. We continue to develop out Mental Health team and continue to utilize telemedicine collaboration with Shepard Pratt Hospital and other providers in the Baltimore area.

Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is higher than the national rate. In this area, there are two endocrinology practices and neither is located in this county. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go outside of the eastern shore area for diabetic care and many go untreated or minimally managed. There is a Tri County Diabetes Alliance that we are part of that through their web site and community activities provides screenings and education for diabetes. There are several Diabetes Education programs in the area, including the program at AGH. We also have a Diabetes community education program using the Stanford Chronic Disease Diabetes curriculum. We continue to recruit for this specialty to add to our AGHS staff of physicians.

Dermatology continues to be a specialty gap for us; however we have hired another full time provider.

AGHS has hired a Pediatrician, a Urologist/gynecologist, and Oncologist in FY15

Population per Physician in the CBSA:
3500:1 – Worcester County
2060:1 – Somerset County
1870:1 – Wicomico County
1165:1 – Sussex County

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

Our Physician Subsidies listed in Category "C" are losses ($5,169,191) associated with Hospital-based physicians with whom the hospital has an exclusive contract. Included in that figure is $52.825 spent on physician recruitment. Our area is deemed an underserved area for primary care providers and specialty providers. It is listed as one of the top three reasons for not seeking medical care in our area. See the question above to see the ratio of population to provider in our service areas.

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)
        - 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.

Appendix I

The FAP information is an information sheet which can be found in all public waiting areas of the hospital and health system sites. We also run articles in our newsletters that are distributed in the homes of all residents in the county and service areas. Our Case Management and Patient Financial Services Departments also assist in identifying those in need and guide them through the process as described above. Our Patient Financial team attends many community events to raise awareness of the services; some of these include health fairs and homeless days, soup kitchens and food distribution sites. The information is also found on our website. The financial team screens patients for financial assistance who do not have other means to pay their bills. They are also trained and work closely with the local Maryland Healthcare Exchange workers. All AGH associates are trained in their responsibility regarding FAP as part of our annual mandatory learning. The Patient Financial Assistants review, with the patients, the entire policy to revise the interpretation for patients who are approved for assistance and can discuss Medicaid and state programs that will assist the patient.

The information and services are available to everyone, not culturally exclusive and is written at a 5th grade level for comprehension. Spanish is the most prevalent language other than English and all of the information/application is available in Spanish.

Financial Assistance Application

Atlantic General Hospital
ATTN: Financial Assistance, Box # 10
9733 Healthway Drive
Berlin, MD 21811-1155
410-629-6025 Office
410-641-9210 Fax
www.atlanticgeneral.org

Atlantic General Hospital bases our Financial Assistance program on 200% to 500% of the Federal poverty guidelines. Eligibility is based on the previous twelve (12) months of income. **Each family member** who has a balance due at Atlantic General Hospital must complete a financial assistance application.

IMPORTANT NOTE: **Financial assistance cannot be applied, if you are not cooperative in the application process, do not follow your insurance guidelines, or if the account is for worker's compensation, litigation, or the balance pending an estate settlement. If approved, this financial assistance program covers bills from Atlantic General Hospital. It may not**

cover bills for other providers who rendered services, at Atlantic General Hospital, such as, but not limited to: Emergency Service Associates, Delmarva Radiology, Peninsula Cardiology, Delmarva Heart, Peninsula Pathology. You must contact them directly to inquire about assistance. If you are approved for financial assistance and return to the hospital within the approval period for another service we can require you to submit additional information.

If you do not have health coverage, please research your insurance options under the Health Insurance Exchange, otherwise known as 'Obama care' (www.healthcare.gov).

You may be required to apply for State Medical Assistance before we can complete your application.

If you or any of your dependents listed on your current federal tax return (1040) have bills at Atlantic General Hospital totaling more than 25% of your total family income for the past twelve months, each immediate family member listed on your tax return and living in the same household may be eligible for financial assistance hardship (25% off your Atlantic General Hospital bills).

If you or any of the dependents listed on your current federal tax return (1040) are receiving food stamps, WIC, Energy Assistance, or reduced or free lunch, please completely fill out the front page of the attached application and Section 1 – Family Income on back of application, sign, and date it, provide proof that you are receiving assistance from one of these programs and a copy of your current federal tax return (1040) and you **may** be automatically approved for 100% financial assistance.

If you are **not** enrolled in one of the above means tested programs (food stamps, WIC, Energy Assistance, or reduced cost or free lunch), in addition to this application, please provide the following proof(s) of income **for the past twelve months**:

1) The most recent paycheck stub(s) from all jobs reflecting your year to date gross earnings.
2) If a paycheck voucher is unavailable, a letter on company letterhead, signed by the employer reflecting dates of employment and gross year to date income.
3) Your current year's Federal tax return (1040), if a business is owned, your schedule "C" from your 1040 must also be included and a year-to-date profit and loss report. If you did not file a tax return, please provide a signed letter stating the reason no tax return was filed and provide proof of all income for anyone living in the household, including unrelated members.
4) Proof of income for all individuals filed as an exemption on your current federal income tax return.
5) If your income comes from a source other than employment, such as unemployment, social security, disability, retirement, pension, veteran's benefits, child support, alimony, etc. you will need to provide proof.

If the required documents are not submitted with the application, the application will not be processed and it will be returned to you. Atlantic General Hospital will only accept applications with the required documents attached.

Please return your completed financial assistance application and the required documents to Outpatient Registration, Cashier's
Office, Atlantic Health Center, Patient Accounting or mail it to:
Atlantic General Hospital
ATTN: Financial Assistance, Box # 10
9733 Healthway Drive
Berlin, MD 21811
You may be denied financial assistance if:
1) You do not meet the financial assistance income guidelines.
2) The application is not completed properly including your signature and date completed.
3) Supporting documentation (such as proof of income) is not returned within 14 days from the date of application.

If your Financial Assistance application is denied, you will be responsible for your bill.
If you have any questions, please call us at (410) 629-6025. Thank you.

Maryland State Uniform Financial Assistance Application

Information About You:

Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated

US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

_____ _____ _____
Name Age Relationship

_____ _____ _____
Name Age Relationship

_____ _____ _____
Name Age Relationship

_____ _____ _____
Name Age Relationship

_____ _____ _____
Name Age Relationship

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination?

_____

Do you receive any type of state or county assistance? Yes No

Please return completed application with documentation to:
Atlantic General Hospital
Attn: Financial Assistance, Box 10
9733 Healthway Drive
Berlin, MD 21811

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

Monthly Amount

Employment _____
Retirement/pension benefits _____
Social security benefits _____
Public assistance benefits _____
Disability benefits _____
Unemployment benefits _____
Veterans benefits _____
Alimony _____
Rental property income _____
Strike benefits _____
Military allotment _____
Farm or self employment _____
Other income source _____
Total _ _ _ _ _ _ _ _ _ _ _ _ _

II. Liquid Assets Current Balance

Checking account _____
Savings account _____
Stocks, bonds, CD, or money market _____
Other accounts _____
Total _____

III. Other Assets

If you own any of the following items, please list the type and approximate value.
Home Loan Balance _____ Approximate value _____
Automobile Make _____ Year _____ Approximate value _____
Additional vehicle Make _____ Year _____ Approximate value _____
Other property Approximate value _____
Total _____

IV. Monthly Expenses Amount

Rent or Mortgage _____
Utilities _____
Car payment(s) _____
Credit card(s) _____
Car insurance _____
Health insurance _____
Other medical expenses _____
Other expenses _____
Total _____
Do you have any other unpaid medical bills? Yes No
For what service?
_____

If you have arranged a payment plan, what is the monthly payment?

_____

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

_____ _____

Applicant signature Date

_____

Relationship to Patient

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

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).

Appendix II

We now provide counseling to patients who do not have insurance but could possibly qualify for ACA Healthcare expansion. We have someone from the health department who will assist patients with their applications and questions on site at the hospital.

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

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE: PATIENT FINANCIAL ASSISTANCE

DEPARTMENT: PATIENT FINANCIAL SERVICES

Effective Date:	10/22/97	Number:	5
Revised:	12/1/10 1/1/12.3/1/12 5/30/12 12/01/12 3/25/2013 3/17/14 5/1/2014	Pages:	6
Reviewed:	8/15		

Signature:

Vice President, Finance

POLICY:

It is the policy of Atlantic General Hospital/Health System to provide medically necessary services without charge or at a reduced cost to all eligible persons who are unable to pay according to the Hospital's guidelines. Atlantic General Hospital defines medical necessary services as:

"Medical treatment that is, per the patient's physician, absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient." Atlantic General Hospital defines all emergency room care as medically necessary even though decisions by payers may be in conflict with this decision.

Atlantic General's Financial Assistance program is granted after all other avenues have been explored, including: Medical Assistance, private funding, family members, credit cards, and/or

payment arrangements. A distinction is made between financial assistance and bad debts:

- Financial Assistance is amounts due the Hospital from patients not having the income or resources necessary to meet their responsibility to pay for their health care services within an appropriate length of time.
- Bad debts are amounts due from patients who are able, but unwilling to pay.

Financial Assistance will be available to all patients without discrimination on the grounds of race, color, national origin, age, gender, religion, and creed. A patient must have a valid social security number in order to be eligible for Financial Assistance.

AGH bases Financial Assistance on the patient's income level falling within these ranges:

- 0% to 200% of the Federal poverty guidelines-free medically necessary care.
- Between 200% and 300% of the Federal poverty guidelines- reduced cost medically necessary care at 50% of charges (the reduced cost care cannot exceed the charges minus the HSCRC markup)
- Below 500%- may qualify for financial hardship at 25% of charges.
- In cases where a patient's amount of reduced-cost care may be calculated using more than one of the above, the amount which best favors the patient shall be used.

Presumptive Eligibility

If the patient is already enrolled in a means-tested program, the application is deemed eligible for free care on a presumptive basis, not requiring any of the financial documents required on a full application (examples of means-tested programs include: reduced/free school lunches, SNAP(food stamps) and MEAP (energy assistance). If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital services, all overpayments will be refunded according to the terms of the patient's plan. It is the patient's responsibility to inform the hospital that they are enrolled in a means-tested program and provide documentation.

Eligibility Consideration

Only income and family size will be considered in approving applications for Financial Assistance unless one of the following three scenarios occurs:

- the amount requested is greater than $20,000,
- the tax return shows a significant amount of interest income,

- or the patient states they have been living off their savings accounts.

If one of the above three scenarios are applicable in the application, liquid assets will be considered including: checking and savings accounts, stocks, bonds, CD's, money market or any other accounts for the past three months along with the past year's tax return, and a credit report may be reviewed. The following assets are excluded:

- The first $10,000 of monetary assets.
- Up to $150,000 in a primary residence.
- Certain retirement benefits (such as a 401K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans) where the patient potentially could pay taxes and/or penalties by cashing in the benefit.

Atlantic General Hospital defines Family Size and Income as:

- Family Size- a family unit is defined as all exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household must be submitted.
- Income- Income is to be determined for the family as defined above. It should be supplied for the approximately twelve months preceding the application processing time frame. Income must be verified through a most current pay stub and the previous year's tax return. The annual income or the annualized income will be compared to the Federal Poverty Guidelines to determine eligibility. If anyone in the family unit owns a business, the net income from the business will be used for the calculation; additionally, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year's tax return 1040 and Schedule C must be submitted. For each family member receiving unearned income the following must be submitted with the application:
    - Proof of Social Security Benefits
    - Proof of Disability Benefits
    - Proof of Retirement/Pension Benefits
    - Proof of Veterans Benefits

- Proof of Child Support

Approval Lengths Not Involving Financial Hardship

1. Approvals not involving financial hardship can remain active for one year for Maryland residents from the date of approval provided all information is reaffirmed. If information has changed at the time of reaffirmation, a new application must be submitted for approval. In special circumstances the Patient Financial Assistance Committee and/or senior leadership may only grant financial assistance for accounts on the current application and not extend the financial assistance for one year. If the patient is not a Maryland resident, approvals cannot be active for one year, unless the patient has proof they applied for Medical Assistance in the state which they reside and have been denied. Only the first initial application at the hospital will be approved. All subsequent visits will only be granted Financial Assistance if the patient has applied and the Medical Assistance process is pending, or a decision has been rendered.

2. When a patient is approved for financial assistance, the hospital will apply the financial assistance to all outstanding balances on the patient's account. The hospital will provide a refund of amounts paid in excess of $25 collected from a patient or the guarantor of the patient who was found to be eligible for free care on the date of service. The refund will only be applied to outstanding balances where the date of service was within two years of the date the patient submitted the application for Financial Assistance eligibility.

The two year period under this policy may be reduced to no less than 30 days after the hospital requests relevant information from the patient in order to make a determination of eligibility for financial assistance, if documentation exists of the patient's (or the guarantor's) unwillingness or refusal to provide documentation or the patient is otherwise uncooperative regarding his or her patient responsibilities. If the hospital had obtained a judgment or reported adverse information to a credit reporting agency for a patient that was later found to be eligible for free care, the hospital shall seek to vacate the judgment or strike the adverse information.

3. Patients are not eligible for Financial Assistance if the account is for worker's compensation, litigation, or the balance is pending an estate settlement.

4. If a patient is approved for Medicaid with a spend down, has a service not covered by Maryland Medicaid such as MRA's, or receives denials by the payer for not medically necessary care in the Emergency Room Financial Assistance can be applied without completing the application process.

Note-this does not grant Financial Assistance for a year, this automatic Financial Assistance only applies to the date of service.

5. If a patient submits an application for Financial Assistance and has Medicaid for all dates of service the patient will be notified an application is not required. If a patient is approved for the Qualified Medicaid Beneficiary Program (QMB) or the Specified Low Income Beneficiary Program (SLMB I or II) Financial Assistance can be applied at 100% without completing the application process.

6. If patients are approved for the Breast and Cervical Cancer Care Program (BCCP), BCCP will pay 50 percent of the contracted rate, and Financial Assistance will be automatically applied to the balance. This only applies to the account for BCCP services.

7. If patients are approved for the Wicomico County Health Department (WCHD) Susan G. Komen Grant for the purpose of early detection of breast and cervical cancer for Hispanic women, Wicomico County will pay 50% and Financial Assistance will be automatically applied to the balance. This only applies to the account for the WCHD services.

8. If patients are approved for the Colorectal Screening Program, they will pay $500.00 and Financial Assistance will be automatically applied to the balance. This applies only to the account for the Colorectal Screening Program.

9. If patients do not comply with insurance requirements for non-emergency care which results in a denial by the insurance company, they will not be eligible for Patient Financial Assistance. If a waiver is offered that indicates the patient understands the insurance company will not cover the claim and the patient either signs or refuses to sign, Financial Assistance cannot be granted. The exception to this is if patients have Medicare primary, Maryland Medicaid secondary, and the patient signs an ABN the non-covered amount will be applied to Financial Assistance.

10. If patients do not agree with the decision, they can file a written appeal to the Director of Patient Financial Services within 30 days, who will review the documentation and make a recommendation to the Patient Financial Services Committee for a decision.

11. The Collection Specialist may not review any documentation of a relative who is applying for Financial Assistance through Atlantic General Hospital. The application will be referred to another Collection Specialist for review.

Financial Hardship

Maryland law requires special consideration when a patient has incurred a financial hardship. A financial hardship means medical debt incurred by a family over a twelve month period that exceeds 25% of the family's income. Medical debt is defined as out of pocket expenses (excluding copayments, coinsurance, and deductibles) for medical costs billed by a hospital. In these instances,

the hospital must provide reduced-cost, medically necessary care to patients with family income below 500% of the Federal Poverty Level.

If a patient has received reduced-cost, medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household shall remain eligible for reduced-cost, medically necessary care when seeking subsequent care at the same hospital during the 12 month period beginning on the date on which the reduced-cost, medically necessary care was initially received. It is the patient's responsibility to notify the hospital when receiving services that they are eligible for reduced-cost, medically necessary care during the 12 month period.

Immediate family is defined as:

- If the patient is a minor--mother, father, unmarried minor siblings (natural or adopted), residing in the same household.
- If the patient is an adult--spouse, natural or adopted unmarried minor children, or any guardianship living in the same household.

Automatic Financial Assistance

The hospital will automatically approve Financial Assistance for one visit when accounts are returned from Outsourcing and prior to placement with a Collection Agency based on the following criteria:

- Result of E- Bureau calculation for E Score propensity to pay -100 % write off for those patients that are within 100% of the poverty guideline considering income and family members.

Education and Outreach

Signage will be posted in conspicuous places throughout the hospital, including the billing office, informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

An information sheet will be provided to all inpatients at discharge, with the hospital bills, and on request explaining all pertinent information related to financial assistance, patient rights, hospital contact information, how to apply for Medicaid and the fact that physician charges are separate from hospital charges.

The hospital is responsible for providing trained staff to work with patients and their representatives on understanding the bill, their rights and obligations, how to apply for Medicaid, and how to contact the hospital for additional assistance.

Application Approval

If the amount requested is greater than $20,000 the application and supporting documentation will be forwarded to the Patient Financial Assistance Committee for recommendation to senior leadership. All recommendations and decisions will be made on a case by case basis based on the documentation provided. Committee and senior leadership have the discretion to approve a partial balance or deny the application (as long as denying the partial or full amount does not conflict with the regulations set forth by the Health Services Cost Review Commission).

Once the Patient Financial Assistance Approval Request form has been completed, it will be referred for the following authorized signatures (based upon the amount of charges to be written off):

- Less than $10,000: Director — Fin Counselor, Fin Counseling Supervisor & of PFS
- $10,000 - $20,000 — Registration Manager and Director of PFS
- Over $20,000: Leadership — Committee/Direct of PFS, /Senior
- Appeals under $20,000: — Director of PFS and Committee
- Appeals/balances over $20,000: — Committee, Director of PFS and Senior Leadership

Application Approval for Medicaid denials for non covered services

All Financial Assistance approvals where the patient has Medicaid non covered services will be validated using the electronic verification system to validate Medicaid coverage.

The hospital shall make available interest-free payment plans to uninsured patients with income between 200% and 500% of the Federal Poverty Level that request assistance.

Policy Review and Approval

This policy may not be changed without the approval of the Board of Directors. Furthermore, this policy must be reviewed by the Board and re-approved at least every two years.

c. 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).

Appendix IV

ATLANTIC GENERAL HOSPITAL
care.givers

Financial Assistance

Atlantic General Hospital and Health System is committed to providing quality care, personalized service and education to improve individual and community health. We continuously seek to be the leader in promoting access to our services for the residents and visitors of Worcester County and the surrounding region.

We have a policy to provide services to all eligible patients who are willing to pay their hospital bills, but are unable to pay according to the hospital's guidelines.

We base our Financial Assistance on a range of 200% to 300% of the poverty guidelines set by the federal government. Income and the number of people in the household will be considered in approving applications for Financial Assistance. Families earning less than 500% of the Federal Poverty Guidelines and who have charges at Atlantic General Hospital greater than 25% of their income, may qualify for our financial hardship program.

Financial Assistance is available to all patients without discrimination on the grounds of race, color, national origin, age, gender, religion, creed and payer.

If a patient has a balance remaining after the insurance has paid or if he/she does not have health insurance and cannot pay his/her bill, we will exhaust every effort possible to resolve the situation. We work with the patient to investigate if State Medical Assistance (Medicaid) is available, if private funding is available, if there are family members to help, or if credit cards and/or payment arrangements can be made. If the patient still has no resource for payment, we can begin the Financial Assistance application process.

Financial Assistance approvals may be active for up to one year from date of approval. If there are additional bills during this period of time, they may be included in the original approval provided all information has been reaffirmed.

Patients are not eligible for Financial Assistance if the account is for workers' compensation, litigation, or if the balance is pending an estate settlement.

If you have any questions or know someone who could benefit from this program, please feel free to contact the Patient Accounting Office at (410) 641-9101 or visit us on our website at www.atlanticgeneral.org/main/financialassistance.aspx

Financial Assistance – 11-1-11

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

Appendix V

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

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

Effective Date:	5/93	Number:	A-53
Revised:	5/00, 11/00, 5/95 5/97,11/01, 11/02, 3/10, 2/12	Pages:	Two (2)
Reviewed:	9/99,5/00, 11/00 10/01,11/01,11/02 6/06, 3/10, 2/12		
Signature:			

President/CEO

APPROVAL DATE:

11/1/01, 2/12
Board of Directors

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

ATLANTIC GENERAL HOSPITAL

care.givers

VISION

To be the leader in caring for people and advancing health for the residents of and visitors to our community.

MISSION

To create a coordinated care delivery system that will provide access to quality care, personalized service and education to improve individual and community health.

VALUES

(Putting "PATIENTS" at the Center of our Values)

P Patient safety first
A Accountability for financial resources
T Trust, respect & kindness
I Integrity, honesty & dignity
E Education – continued learning & improvement
N Needs of our community – Participation & community commitment
T Teamwork, partnership & communication
S Service & personalized attention

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

ETHICAL COMMITMENT

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

QUALITY STATEMENT

We deliver care that is accessible, safe, appropriate, coordinated, effective, and centered on the needs of individuals within a system that demonstrates continual improvement.

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SLECTED POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to behavioral health
- Reduce Fall-related death rate

Table III Initiative I – Obesity/Overweight

a. 1. Identified Need 2. Was this identified through the CHNA process?	Obesity/Overweight Yes this was identified through the CHNA process by the county health rankings and the county needs assessment. Maryland at 15.7% and the Healthy People 2020 goal is to reduce the national average to 9.6% Yes this was identified through the CHNA process.
b. Hospital Initiative	BMI screenings Nutritional Counseling Nutrition Speakers through speaker bureau Education through the Faith based Partnership Integrated Health Literacy Program in the public schools Support Groups – TOPS and OA
c. Total Number of People Within the Target Population	Worcester County - 72.5% of adult population is overweight or obese and 12.4% of adolescents are obese (figures from Creating Healthy Communities) Sussex County – 67.0% of adult population is overweight or obese (measurement 2012) Adolescent numbers not available.
d. Total Number of People Reached by the Initiative Within the Target Population	Number of students in IHLP – 600 students (1st grade to 5the grade involved in year two of the pilot program) Number of people reached through: BMI screening - 221 Nutrition presentations - 500 Bulletin inserts – 2000 Support Groups - 1000
e. Primary Objective of the Initiative	Support community members in achieving a healthy weight through education and monitoring.
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff: nutritionists, Community Education Outreach Providers, Diabetes Educators, Health Literacy Liaison Worcester County Public Schools grade 1 through 5. Worcester County Health Department. Sussex County Health Department. Healthiest Businesses in Worcester and Sussex Counties. Indian River School District in Sussex County.
h. Impact/Outcome of Hospital Initiative?	IHLP –100% of students could recognize My Plate High Health Liteacy Scores increased from 8% to 19.5% 63% of students recognized the tern heart healthy There was a 58% in students who felt comfortable talking to their doctors and nurses Won't know the county impact until the next health assessment. Check healthy communities
i. Evaluation of Outcomes:	The last measurement for adults who are overweight and obese was 2013 – 72.5% The last measurement for adolescents was 2010 at 12.4% According to healthy People 2020 the targets are 30.5% for adults and 14.5% for children and adolescents. Target according to Maryland SHIP is 11.3% of adolescents

Table III Initiative I – Obesity/Overweight

j. Continuation of Initiative?	There is a continuation of the initiative through all of the programs mentioned above	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $108,000	B. Direct Offsetting Revenue from Restricted Grants - $15,000

Table III Initiative 2 –Diabetes

a. 1. Identified Need 2. Was this identified through the CHNA process?	Diabetes numbers and Management in the community Yes this was identified through the CHNA process.
b. Hospital Initiative	Diabetes Education Chronic Disease Self-Management Program (evidence Based) Patient Centered Medical Home Model Faith Based Partnerships Care Coordination Team
c. Total Number of People Within the Target Population	Sussex County 12.2% of adult population with Diabetes Worcester County 19.2% of population with Diabetes Figures from Creating Healthy Communities)
d. Total Number of People Reached by the Initiative Within the Target Population	2500
e. Primary Objective of the Initiative	Incorporate Diabetes Education into Patient Centered Medical Home Partner with local health agencies to facilitate grant applications to fund diabetes programs Provide education through Pre-diabetes, Diabetes Education and Self-Management Programs Participate on Tri-County Diabetes Coalition Provide Diabetes screenings in the community Recruit nephrologist to community
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	Diabetes Education Community Education Department County Health Departments Patient Centered Medical Home Atlantic General Health System Faith Based Partnership Patient Centered Medical Home Care Coordination team Area Agencies on Aging
h. Impact/Outcome of Hospital Initiative?	Referral process put in place from hospital to health departments. Workshops of Diabetes Self- Management program being taught in service area Screenings being done at homeless resource days throughout the county Screenings being done at health fairs
i. Evaluation of Outcomes:	According to the SHIP measures and our internal audits the ED visits for diabetes are decreasing.
j. Continuation of Initiative?	Yes, there will be continuation of this initiative.

Table III Initiative 2 –Diabetes

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 22,000	B. Direct Offsetting Revenue from Restricted Grants - none

Table III Initiative 3 –Access to Care

a. 1. Identified Need 2. Was this identified through the CHNA process?	Access to Care Yes this was identified through the CHNA process.
b. Hospital Initiative	Improve access to care for Southern Delaware Improve access to care and reduce disparities in chronic disease Remove ability to pay as a barrier to necessary healthcare services
c. Total Number of People Within the Target Population	15% of people are uninsured Percentages of population for Worcester Co. Non-Hispanic White – 80.3% Non-Hispanic Black – 13.6% Hispanic or Latino origin – 3.2% Others – 2.9% Sources: Worcester County Health Assessment Sussex County, DE: Latino 12% Non-Hispanic White – 76% Non-Hispanic Black – 12% Sources: US Census data 3500:1 – Worcester County 2060:1 – Somerset County 1870:1 – Wicomico County 1165:1 – Sussex County
d. Total Number of People Reached by the Initiative Within the Target Population	At community screenings we saw an increase in minorities screened by 3% to 17% (depending on the screening).
e. Primary Objective of the Initiative	Improve DE providers and partners Improve minorities screened Assist community members with enrolling in insurance plans
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	Maryland Lower Shore Health Insurance Assistance Program Local Management Board ACO Delaware Providers Group Mountaire Farms Perdue Farms Indian river School District El Centuro Atlantic General Health System La Red health Services Patient Financial Services Department

Table III Initiative 3 –Access to Care

h. Impact/Outcome of Hospital Initiative?	Assisted with Maryland State insurance assistance enrollment Provided screenings at health fairs throughout service area Provided screenings and education to employees at the poultry plants Recruited new physicians to the Delaware area Provided screenings at the Homeless Resource Days	
i. Evaluation of Outcomes:	Uninsured rates went from 15% to 8% AGHS Delaware physicians providers increased Increase in minorities screened by 11% from previous year	
j. Continuation of Initiative?	Yes, the initiative will continue	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 219,657	B. Direct Offsetting Revenue from Restricted Grants - none

Table III Initiative 4 –Cancer

a. 1. Identified Need 2. Was this identified through the CHNA process?	Cancer Yes this was identified through the CHNA process. Breast Cancer – 139.6/100,000 population Colorectal cancer – 36.3/100,000 population Lung – 59.0/100,000 population	
b. Hospital Initiative	Recruit proper professionals in the community Provide Health Screenings Decrease minority disparities in screenings Educate the communities	
c. Total Number of People Within the Target Population	Breast Cancer Target – to increase screening or African American and Hispanic populations Colorectal Cancer Target 5% African American of total of the population screened Lung no target since it was new screening	
d. Total Number of People Reached by the Initiative Within the Target Population	Breast – insignificant change from FY14 Colorectal African American screening – target reached each month (percentage of AA screened) 7% to 12% = average of 7.6% Lung – 15 – 100% increase from previous year	
e. Primary Objective of the Initiative	Decrease the number of advanced breast, lung and colon cancer in the community.	
f. Single or Multi-Year Initiative –Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Regional Cancer Care Center Local AARP Chapter 21st Century Oncology Faith Based Partnership Local Health Departments Komen MD affiliate American cancer Society Women Supporting Women	
h. Impact/Outcome of Hospital Initiative?	Screenings and education for cancer prevention done at local health fairs and through the hospital Speaker's Bureau providing education to the community	
i. Evaluation of Outcomes:	Total of 2290 persons were screened/educated at events	
j. Continuation of Initiative?	Yes, we continue to increase of cancer services to the local community	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 28,386	B. Direct Offsetting Revenue from Restricted Grants - none

Table III Initiative 5–Heart Disease

a. 1. Identified Need 2. Was this identified through the CHNA process?	Heart Disease Yes this was identified through the CHNA process.
b. Hospital Initiative	AGH/AGHS campuses remain tobacco free Community screenings for blood pressure and cholesterol levels Chronic Disease Self-Management Workshops (evidence based program) Living Healthy with Hypertension Workshop (evidence based program) Education through Speaker's Bureau and Faith Based Partnership Integrated Health Literacy Program with Worcester County Board of Education
c. Total Number of People Within the Target Population	Maryland SHIP for 2011 to 2013 shows Worcester County death because of heart disease at 183.4/100,000 population compared to MD state at 173.4/100,000 population Creating Healthy Communities shows Sussex County death because of heart disease to be 160.8/100,000
d. Total Number of People Reached by the Initiative Within the Target Population	2668 people reached through screenings 2000 people reached through Speaker's Bureau , Faith based Education and other workshops 600 Students through the Integrated Health Literacy Program
e. Primary Objective of the Initiative	Improve the cardiovascular health of the community
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	Worcester County Board of Education Faith based Partnership AARP Various Civic groups Worcester County Employees Sussex County Employees Healthiest businesses Initiative UMES and SU Patient Centered Medical Home Local pharmacies
h. Impact/Outcome of Hospital Initiative?	63% increase in the number of students in IHLP who knew the term Heart Healthy Continue to hold 12 hypertension clinics monthly Hold regular workshop on hypertension management and chronic disease management
i. Evaluation of Outcomes:	Increased the number screened in hypertension clinics by 462 Saw a 5% increase in abnormal finding in hypertension screenings Maryland is seeing a decrease in number of ED visits related to Heart Disease
j. Continuation of Initiative?	Yes, we continue to address this initiative

Table III Initiative 5–Heart Disease

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 45,496	B. Direct Offsetting Revenue from Restricted Grants - none

Table III Initiative 6 –Mental Health

a. 1. Identified Need 2. Was this identified through the CHNA process?	Mental Health Yes this was identified through the CHNA process. ED visits for mental health disorders have more than doubled in 4 years	
b. Hospital Initiative	Participate in community events to raise awareness of mental health services Partner with right agencies in the community to destigmatize mental health disorders	
c. Total Number of People Within the Target Population	Sussex County suicide rate 13.1/100,000population Worcester County suicide rate 12.0/100,000 population ER rate for mental health disorders 6792.3/100,000 population Those who rated having adequate mental health support – 83.3%	
d. Total Number of People Reached by the Initiative Within the Target Population	903 people through community outreach	
e. Primary Objective of the Initiative	Promote and ensure local resources are in place to address the mental health on the community.	
f. Single or Multi-Year Initiative –Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Atlantic Health Center Coalition to Destigmatize Mental Health Disorders Out of the Darkness Walk Committee Autism Speaks Chapter Jesse's Paddle Organization Health Department mental health services Surfer's Healing Camps Kennedy Krieger Institute	
h. Impact/Outcome of Hospital Initiative?	ED visits for mental health disorders was 7509 Attendance The Out of the Darkness Suicide Awareness walk increases each year More patients are being seen through telemedicine in relationship with Shepard Pratt – awareness raised through community events and outreach	
i. Evaluation of Outcomes:	ED visits continue to rise Increase in professional help available through increase in providers and telemedicine.	
j. Continuation of Initiative?	Yes, we continue to address this initiative with the community partners listed and other partnerships	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 5,884	B. Direct Offsetting Revenue from Restricted Grants - none