COMMUNITY BENEFIT NARRATIVE

Effective for FY2016 Community Benefit Reporting

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

December 15, 2016

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).**
    - Bed Designation – The number of licensed Beds;
    - Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    - Primary Service Area Zip Codes;
    - List all other Maryland hospitals sharing your primary service area;
    - The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
    - The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
    - The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

Bed Designation:	Inpatient Admissions (CY2015):	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients (CY2015):	Percentage of the Hospital's Patients who are Medicaid Recipients (CY2015):	Percentage of the Hospital's Patients who are Medicare Beneficiaries (CY2015):
87	1,943	20878 20850 20854 20874 20886 20906 20877 20852 20783 20855 20904 20853 20912 20902 20901	**Brooklane** 20874, 20878, 20886, 20854 **Adventist Behavioral Health** 20874, 20878, 20850, 20877, 20886, 20906, 20854, 20852, 20904, 20853, 20902, 20855, 20901 **Holy Cross of Silver Spring** 20904, 20906, 20902, 20901, 20783, 20853, 20912, 20877,	0.7% of overall patients were uninsured. Of these patients: 0.5% were from Montgomery County *Source: review of hospital discharge data*	8.3% *Source: review of hospital discharge data*	53.4% *Source: review of hospital discharge data*

			20874, 20852 **Johns Hopkins** 20854 **Washington Adventist** 20783, 20912, 20901, 20904, 20906, 20902 **Montgomery General** 20906, 20853, 20904, 20902 **Suburban** 20852, 20854, 20906, 20850, 20902, 20878, 20853, 20874, 20904 **Union of Cecil County** 20906, 20852, 20874 **Shady Grove Medical Center** 20874, 20878, 20850, 20877, 20886, 20852, 20854			

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):
   i. A list of the zip codes included in the organization's CBSA, and
   ii. An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.
   iii. Describe how the organization identified its CBSA, (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 community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Table II

Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside

Zip Codes in the CBSA

Primary Service Area

20705 – Beltsville, 20783 – Hyattsville, 20815 – Chevy Chase, 20817 – Bethesda, 20832 – Olney, 20850 – Rockville, 20852 – Rockville, 20853 – Rockville, 20854 – Potomac, 20874 – Germantown, 20876 – Germantown, 20877 – Gaithersburg, 20878 – Gaithersburg, 20879 – Gaithersburg, 20886 – Montgomery Village, 20895 – Kensington, 20901 – Silver Spring, 20902 – Silver Spring, 20904 – Silver Spring, 20906 – Silver Spring, 20910 – Silver Spring, and 20912 – Takoma Park

Secondary Service Area

20011 – Washington, 20016 – Washington, 20706 – Lanham, 20707 – Laurel, 20708 – Lanham, 20710 – Bladensburg, 20721 – Bowie, 20737 – Riverdale, 20740 – College Park, 20743 – Capitol Heights, 20744 – Fort Washington, 20746 – Suitland, 20747 – District Heights, 20748 – Temple Hills, 20770 – Greenbelt, 20772 – Upper Marlboro, 20774 – Upper Marlboro, 20782 – Hyattsville, 20784 – Hyattsville, 20785 – Hyattsville, 20814 – Bethesda, 20833 – Brookeville, 20837 – Poolesville, 20841 – Boyds, 20851 – Rockville, 20855 – Derwood, 20871 – Damascus, 20882 – Gaithersburg, 20903 – Silver Spring, 20905 – Silver Spring, 21702 – Frederick, and 21771 – Mount Airy

Household income can be considered a barrier to health and wellness as income can affect a family's ability to pay for necessities including, but not limited to: healthcare services; healthy foods; and education. 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.

Median Household Income within the CBSA (2015)		
Population	**Zip Codes**	**Median Household Income (2015)**
Montgomery County	20815	$140,803
	20817	$169,485
	20832	$126,762
	20850	$107,170
	20852	$97,151
	20853	$100,965
	20874	$81,769
	20876	$91,359
	20877	$65,853
	20878	$117,261
	20879	$88,777
	20886	$75,593
	20895	$130,130
	20902	$85,044
	20904	$72,458
	20905	$116,141
	20906	$71,423
	20910	$77,986
	20912	$69,721
	20814	$115,359
	20833	$140,885
	20841	$152,853
	20851	$82,017
	20855	$120,060
	20882	$145,054
	Overall	$99,435
Prince George's County	20705	$70,754
	20706	$70,754
	20707	$75,742
	20708	$64,134
	20710	$42,226
	20721	$120,994
	20737	$56,672
	20740	$59,633
	20743	$57,671
	20744	$88,384
	20746	$64,959
	20747	$60,421
	20748	$62,720

	20770	$62,909
	20772	$98,147
	20774	$93,216
	20782	$64,562
	20783	$60,958
	20784	$58,564
	20785	$60,883
	Overall	$74,260
Frederick County	21702	$70,783
	21771	$113,502
	Overall	$83,700
Maryland	*Overall*	$74,551
District of Columbia	20011	$62,281
	20016	$124,080
	Overall	$70,848
*Note: Household income by zip code values are compared to the overall county median household income. Green indicates the location's income is above the county value. Red indicates the location's income is below the county value (i.e. a potentially vulnerable population.)		

Figure 1. Household Income by zip codes, Montgomery County, Prince George's County, Frederick County, Maryland, and District of Columbia, 2015
(Source: U.S. Census Bureau, 2015 ACS 5-Year Estimates)

Median Household Income within the CBSA

Median Household Income
Prince George's County: $76,741
Montgomery County: $98,917
Source: US Census Bureau, 2015 1-Year ACS Estimates

Household income has a direct influence on a family's ability to pay for necessities, including health insurance and healthcare services. Throughout the CBSA served by Adventist HealthCare Rehabilitation (primarily 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 2). However, when looking at the state of Maryland as a whole, Asians have the highest median income.

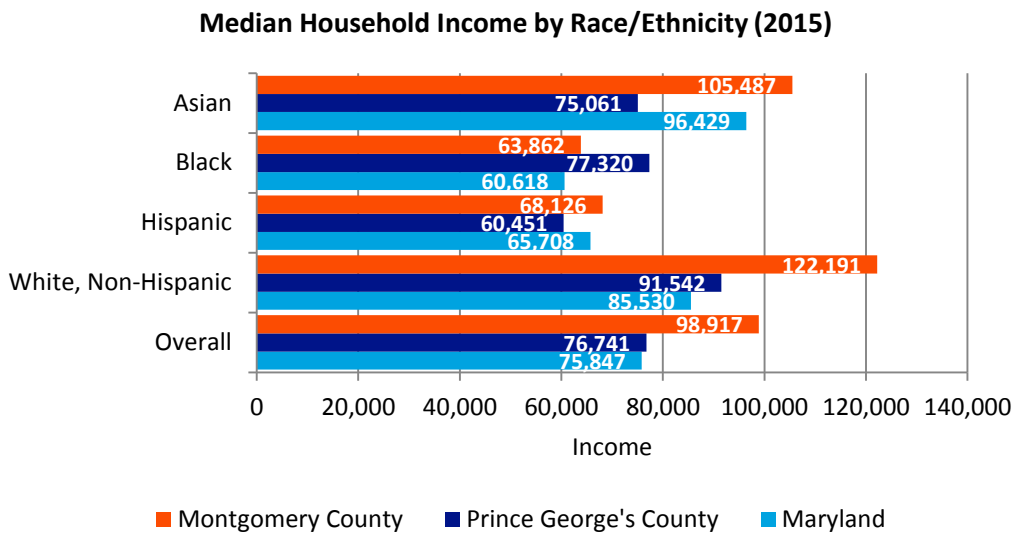


Figure 2. Median Household Income, Prince George's County, Montgomery County and Maryland by Race and Ethnicity 2015
(Source: US Census Bureau, 2015 1-Year ACS Estimates)

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

In 2015, Montgomery County experienced poverty levels lower than that of the state of Maryland overall. According to the U.S. Census Bureau, 7.5 percent of Montgomery County residents and 9.3 percent of Prince George's County residents were living in poverty compared to 9.7 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 3.6 percent and highest among Blacks at 12.1 percent and Hispanics at 13.1 percent (see Figure 3).

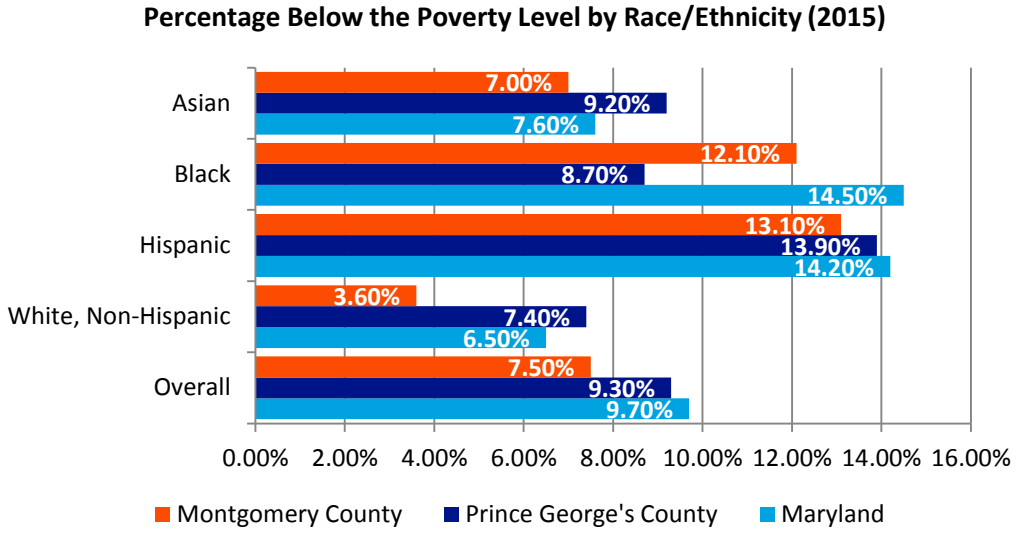


Figure 3. Poverty Status by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year ACS Estimates)

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

Approximately 8.2 percent of all civilian non-institutionalized Montgomery County residents and 10.9 percent of Prince George's County residents are uninsured. This number is compared to 6.6 percent of Maryland residents (see Figure 4).

Across Montgomery County, Prince George's County, and Maryland, Hispanics are uninsured at rates significantly higher than whites, Blacks, and Asians. Approximately 32.5 percent of Hispanics are uninsured in Prince George's County, compared to 21.7 percent in Montgomery County and 23.6 percent in Maryland (see Figure 4). Whites are least likely to be uninsured across Prince George's County, Montgomery County, and Maryland.

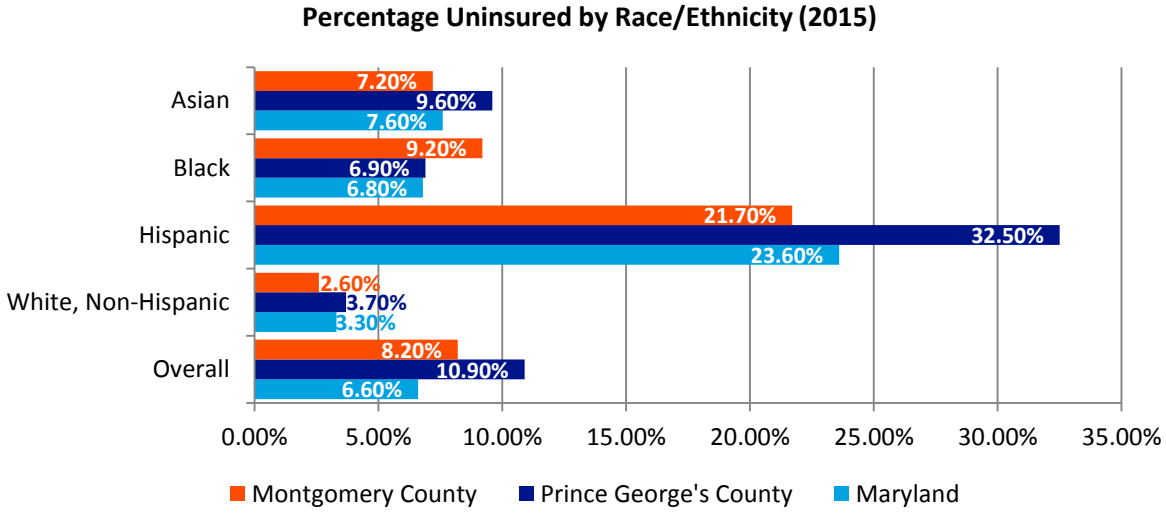


Figure 4. Percentage Uninsured by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year ACS Estimates)

Percentage of Medicaid recipients by County within the CBSA.

Percentage of Medicaid Recipients by County within the CBSA:
Montgomery County: 9.90% (102,634)
Prince George's County: 16.7% (150,960)
Source: US Census Bureau, 2015 1-Year ACS Estimates

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 (SHIP), the overall life expectancy for Montgomery County is 84.6 years, 4.8 years greater than the Maryland 2017 target of 79.8 years (see Figure 5). 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 84.4 years and 82.5 years for Black residents (see Figure 5). In Prince George's County, the overall life expectancy is 80 years, which is higher than that of Maryland (79.8 years). When stratifying by race, the life expectancy for white residents is 80.7 years, compared to only 79.3 years among Black residents of Prince George's County (see Figure 5).

County	SHIP Objective	SHIP 2013 County Baseline	SHIP 2014 County Update	SHIP 2014 County Update (Race/ Ethnicity)	SHIP 2014 Maryland Update	SHIP 2014 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Increase life expectancy in Maryland	79.6	80	Black – 79.3 White – 80.7	79.8	Black – 77.5 White – 80.4	79.8
Montgomery		84.3	84.6	Black – 82.5 White – 84.4			

Figure 5. Life expectancy at Birth (in years), Prince George's and Montgomery Counties, 2014
(Source: Maryland Department of Health and Mental Hygiene (DHMH) Vital Statistics Administration, 2014)

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

The mortality rate in Montgomery County is 573.2 per 100,000 population and 593.6 per 100,000 population in Prince George's County. These rates are lower than the mortality rate for the state of Maryland overall (764.5 per 100,000) (see Figure 6). Whites have the highest death rates in both counties and the state of Maryland overall while Hispanics have the lowest death rates.

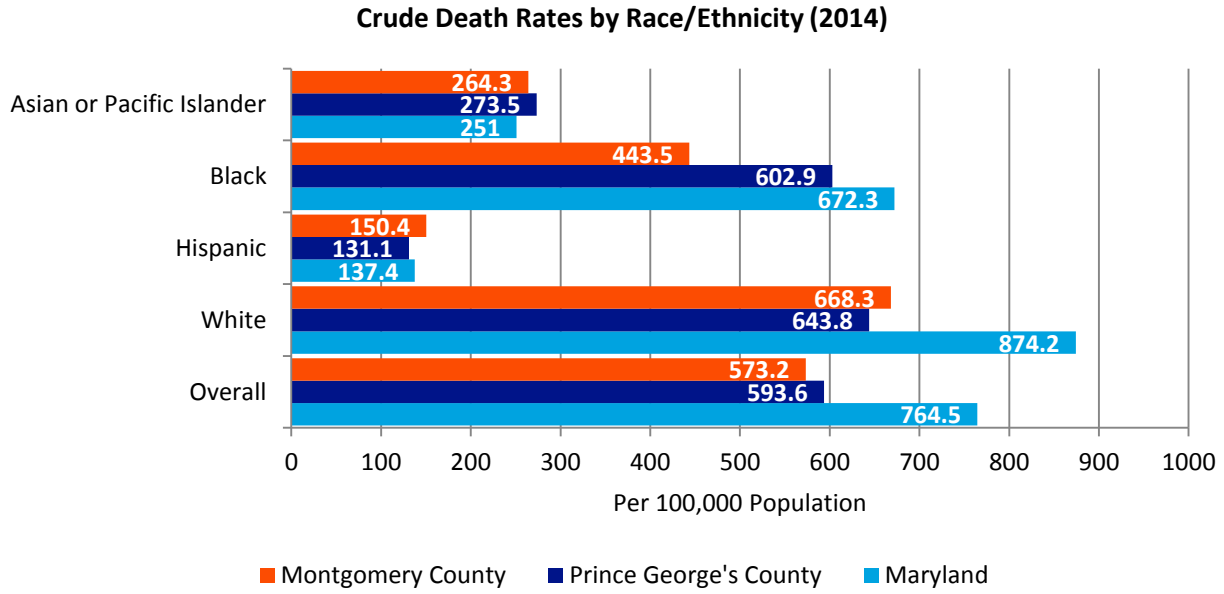


Figure 6. Crude Death Rate by Race and Ethnicity for Prince George's County, Montgomery County, and Maryland, 2014
(Source: Maryland Department of Health and Mental Hygiene, Maryland *Vital Statistics Annual Report, 2014*)

Infant Mortality Rate

Overall, Montgomery County (4.8 per 1,000 live births) has met the Maryland SHIP 2017 target (6.3 per 1,000 live births), but Prince George's County did not meet the target (6.9 per 1,000 live births). Blacks in Montgomery and Prince George's Counties and the state overall are disproportionately affected by high infant mortality rate. They failed to meet the Maryland SHIP 2017 target (6.3 infant deaths per 1,000 live births) while Hispanics and whites met the target (see Figure 7).

County	SHIP Objective	SHIP 2013 County Baseline	SHIP 2014 County Update	SHIP 2013 County Update (Race/ Ethnicity)	SHIP 2014 Maryland Update	SHIP 2014 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Reduce Infant Deaths	7.8	6.9	NH Black – 8.2 Hispanic – 5.2 NH White – 5.2	6.5	NH Black – 10.7 Hispanic – 4.4 NH White -- 4.4	6.3
Montgomery		4.7	4.8	NH Black – 7.8 Hispanic – 4.4 NH White – 4.4			

Figure 7. Infant Mortality Rate (per 1,000 Live Births) by Race/Ethnicity in Prince George's and Montgomery Counties, 2014 (Source: DHMH State Health Improvement Process (SHIP), 2014)

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 and Maryland's average of 72.4 percent (see Figure 8).

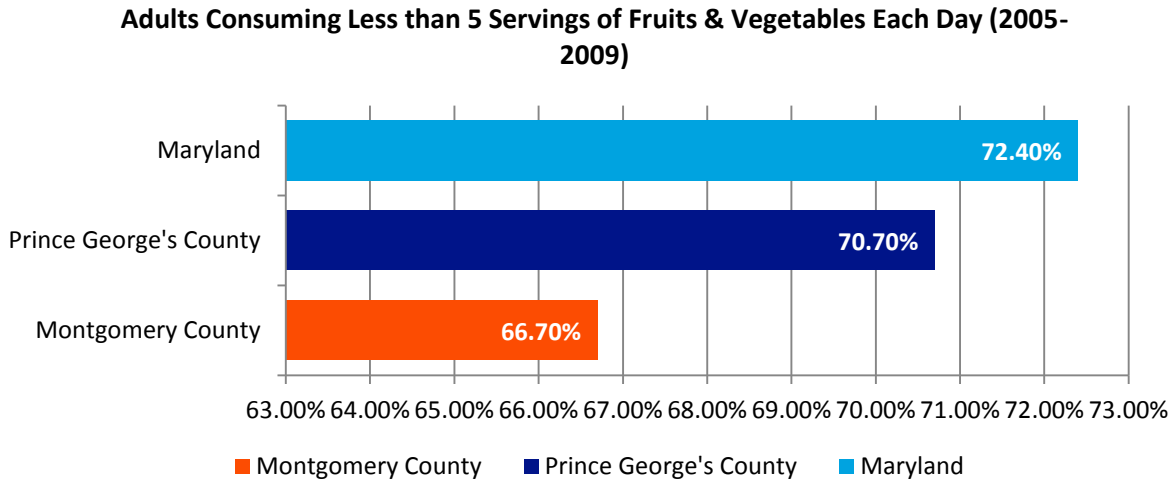


Figure 8. Adults Consuming Less Than 5 Servings of Fruits & Vegetables Each Day (Source: Community Commons Community Health Needs Assessment, 2013)

Fruit and vegetable consumption varies among racial and ethnic groups in Montgomery County. A higher percentage of white (33 percent) and Asian (31 percent) residents consume the recommended five or more servings of fruits and vegetables daily, as opposed to the county as a whole (29.6 percent). However, Hispanics have the lowest percentage of adult fruit and vegetable consumption within the county at 14.2 percent (see Figure 9).

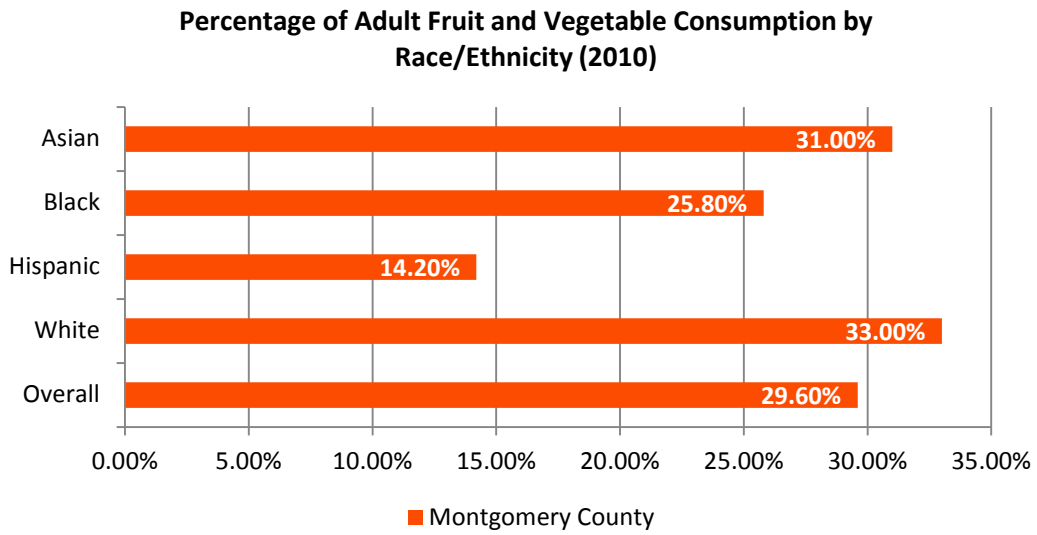


Figure 9. Fruit and Vegetable Consumption by Race and Ethnicity, Montgomery County, 2010
(Source: Healthy Montgomery)

Food Environment

The USDA defines food insecurity as the lack of access to enough food necessary for a healthy life, and limited or uncertain availability of adequately nutritious foods[1]. In 2014, 7.0 percent of Montgomery County experienced food insecurity which is lower than Maryland (12.7 percent) as a whole. In comparison, Prince George's County had a higher food insecurity rate (15.5 percent) than both Montgomery County and the state (see Figure 10).

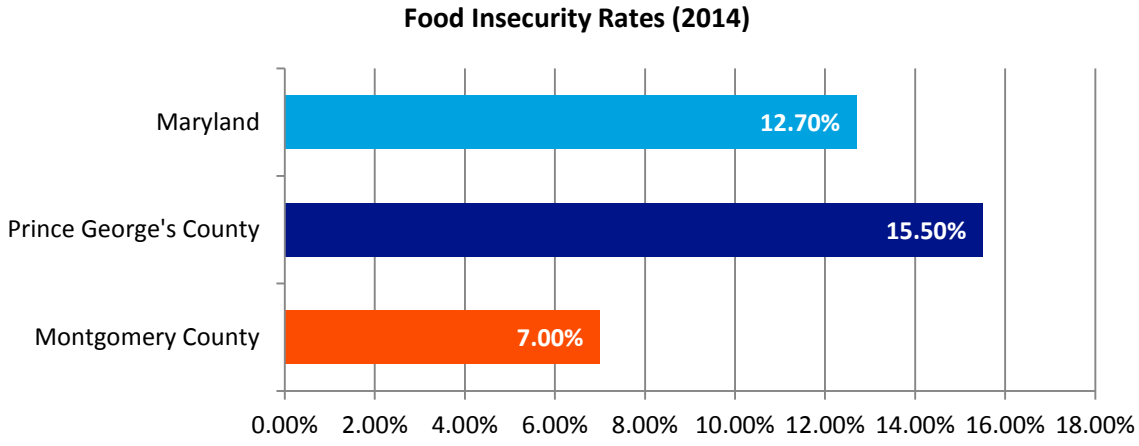


Figure 10. Percentage of Food Insecure Population, 2014
(Source: Feeding America, *Map the Meal Gap*, 2014)

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 20.79 grocery stores per 100,000 population, a rate similar to Maryland (21.3 per 100,000 population). However, there are only 18.53 grocery stores per 100,000 population in Prince George's County (see Figure 11).

[1] Feeding America (2016). Map the Meal Gap. Retrieved from: http://map.feedingamerica.org/county/2014/overall/maryland

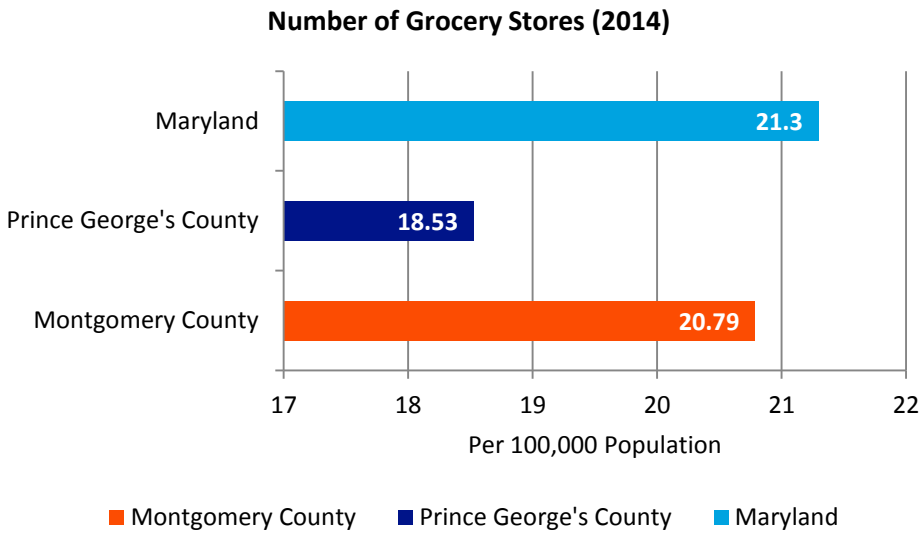


Figure 11. Number of Grocery Stores per 100,000 Population, 2014
(Source: Community Commons. Community Health Needs Assessment, 2014)

Fast food restaurant access has been rising at the local and national levels for the past several years. From 2009 to 2013, the rate in Maryland increased from 78.37 to 86.64 per 100,000 population[2]. In Prince George's County, residents have a higher rate of access to fast food restaurants (87.21 per 100,000 population) than both Montgomery County (81.71 per 100,000 population) and Maryland (84.8 per 100,000) (see Figure 12).

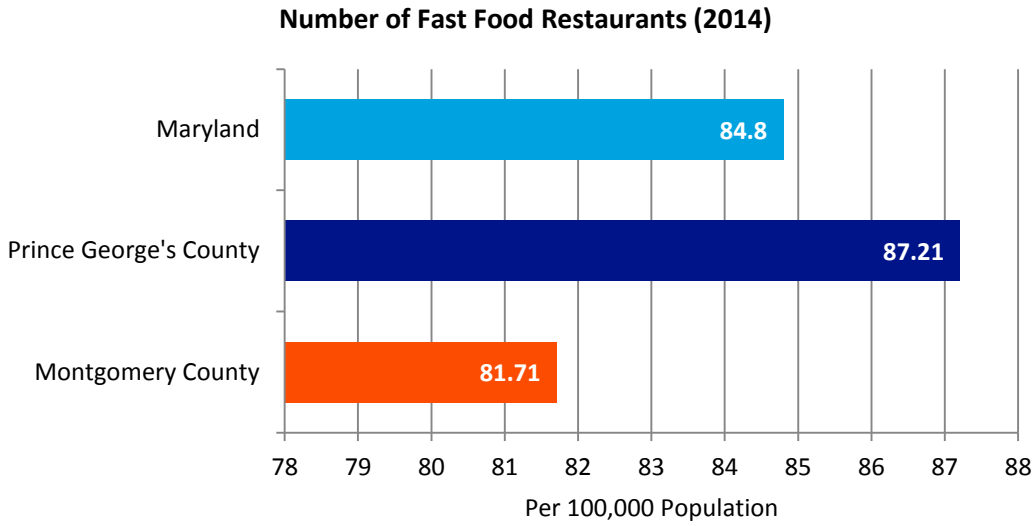


Figure 12. Number of Fast Food Restaurants per 100,000 Population, 2014
(Source: Community Commons. Community Health Needs Assessment, 2014)

[2] Community Commons. *Community Health Needs Assessment*. (2014). Retrieved from: http://assessment.communitycommons.org/CHNA/report?page=3&id=401&reporttype=libraryCHNA

Transportation

Commuting

The majority of both Montgomery and Prince George's Counties drive alone to work (65.6 percent and 61.1 percent, respectively) or utilize public transportation (15.9 percent and 17.1 percent, respectively) (see Figure 13).

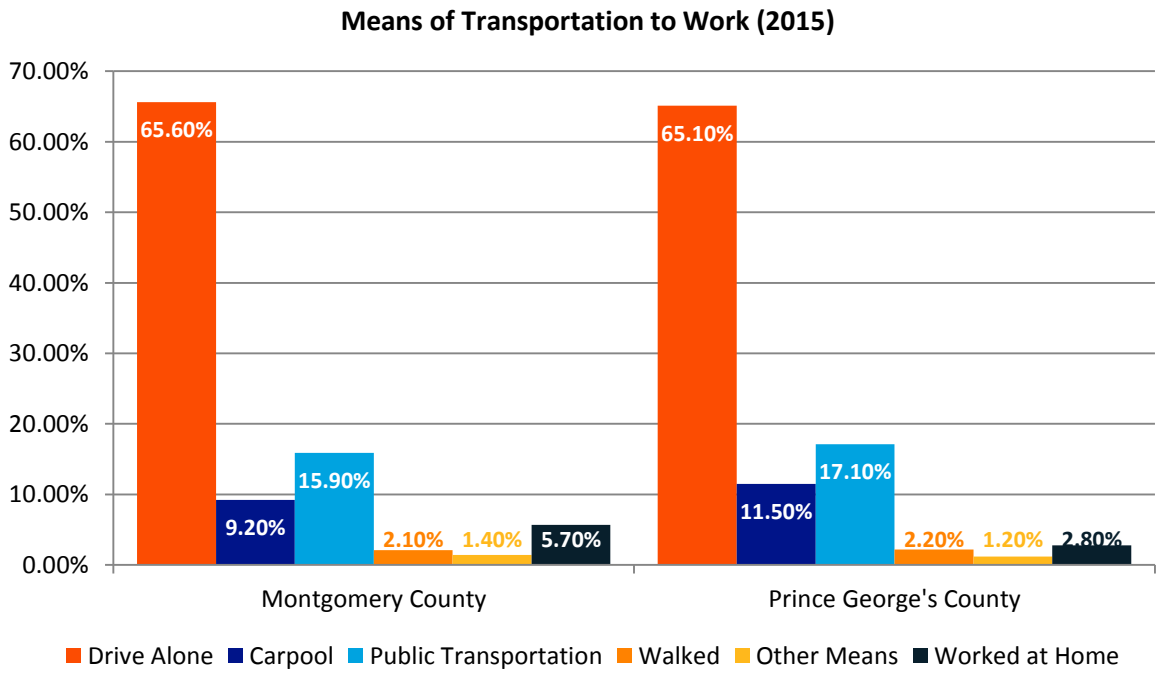


Figure 13. Means of Transportation to Work, Montgomery and Prince George's Counties, 2015
(Source: US Census Bureau, 2015 ACS 1-Year Estimates)

The mean travel time to work for Montgomery County is 34.4 minutes; whereas the mean travel time for Prince George's County is 36.2 minutes (see Figure 14).

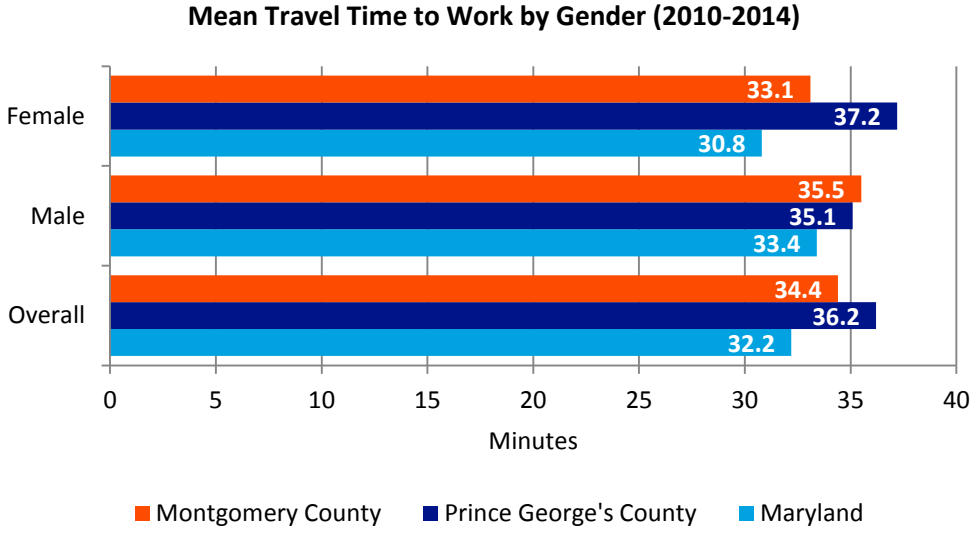


Figure 14. Mean Travel Time to Work by Gender for Prince George's County and Montgomery County, 2015
(Source: Healthy Montgomery, 2010-2014; PGC Health Zone, 2010-2014)

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 (42.6 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 15).

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	42.6	35.6
Montgomery		40.1	35.6	41.3		

Figure 15. Rate of Pedestrian Injuries per 100,000 Population, Prince George's and Montgomery Counties, 2014
(Source: Maryland SHIP, 2014)

The pedestrian death rate in Montgomery County at 1.18 deaths per 100,000 population, is higher than that of Maryland (0.91 per 100,000 population)[3] 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 1.69 deaths per 100,000 population is higher than both state and national rates[4].

From 2011 to 2014 in Montgomery County, white non-Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (see Figure 16-A).

[3] U.S. Department of Transportation National Highway Traffic Safety Administration. *2013 Ranking of COUNTY Pedestrian Fatality Rates – Maryland*. Accessed from: http://www-fars.nhtsa.dot.gov/States/StatesPedestrians.aspx

[4] U.S. Department of Transportation National Highway Traffic Safety Administration. *2013 Ranking of COUNTY Pedestrian Fatality Rates – Maryland*. Accessed from: http://www-fars.nhtsa.dot.gov/States/StatesPedestrians.aspx

Montgomery County Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	0	2	5	4
	White Non-Hispanic	9	11	12	13
	Black, Non-Hispanic	1	7	6	4
	Asian, Non-Hispanic/Unknown	0	0	0	0
	All Other Non-Hispanic or Race	1	3	3	4
	Unknown Race and Unknown Hispanic	19	7	1	3
	Total	30	30	27	28
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	0	0	1	1
	White Non-Hispanic	2	4	6	4
	Black, Non-Hispanic	1	2	4	1
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	7	1	1	4
	Total	10	7	13	11
Total	Hispanic	0	2	6	5
	White Non-Hispanic	11	15	18	17
	Black, Non-Hispanic	2	9	10	5
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	1	3	3	4
	Unknown Race and Unknown Hispanic	26	8	2	7
	Total	40	37	40	39

Figure 16-A. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Prince George's County Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	3	5	7	3
	White Non-Hispanic	13	7	8	8
	Black, Non-Hispanic	26	36	35	47
	All Other Non-Hispanic or Race	1	0	3	1
	Unknown Race and Unknown Hispanic	31	15	17	9
	Total	74	63	70	68
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	2	1	0	4
	White Non-Hispanic	5	4	1	6
	Black, Non-Hispanic	9	14	10	12
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	15	5	6	8
	Total	31	24	17	30
Total	Hispanic	5	6	7	7
	White Non-Hispanic	18	11	9	14
	Black, Non-Hispanic	35	50	45	59
	All Other Non-Hispanic or Race	1	0	3	1
	Unknown Race and Unknown Hispanic	46	20	23	17
	Total	105	87	87	98

Figure 16-B. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Maryland Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	7	20	22	14
	White Non-Hispanic	179	234	192	176
	Black, Non-Hispanic	60	90	83	93
	American Indian, Non-Hispanic/Unknown	1	2	0	1
	Asian, Non-Hispanic/Unknown	1	4	1	1
	All Other Non-Hispanic or Race	4	12	18	10
	Unknown Race and Unknown Hispanic	122	46	32	38
	Total	374	408	348	333
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	3	3	5	6
	White Non-Hispanic	40	49	54	57
	Black, Non-Hispanic	21	35	42	27
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	1	2	2	0
	Unknown Race and Unknown Hispanic	46	14	13	18
	Total	111	103	117	109
Total	Hispanic	10	23	27	20
	White Non-Hispanic	219	283	246	233
	Black, Non-Hispanic	81	125	125	120
	American Indian, Non-Hispanic/Unknown	1	2	0	1
	Asian, Non-Hispanic/Unknown	1	4	2	2
	All Other Non-Hispanic or Race	5	14	20	10
	Unknown Race and Unknown Hispanic	168	60	45	56
	Total	485	511	465	442

Figure 16-C. Maryland Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Education

Graduation and Educational Attainment

In 2015, 89.36 percent of Montgomery County students graduated high school within four years. The four-year graduation rate for the county is lower than that of the state (86.98 percent. While both the state overall and Montgomery County surpassed the Health People 2020 high school graduation goal of 82.4 percent[5], Prince George's County (78.75 percent) did not (see Figure 17).

High School Graduation Rate by Race/Ethnicity (2015)

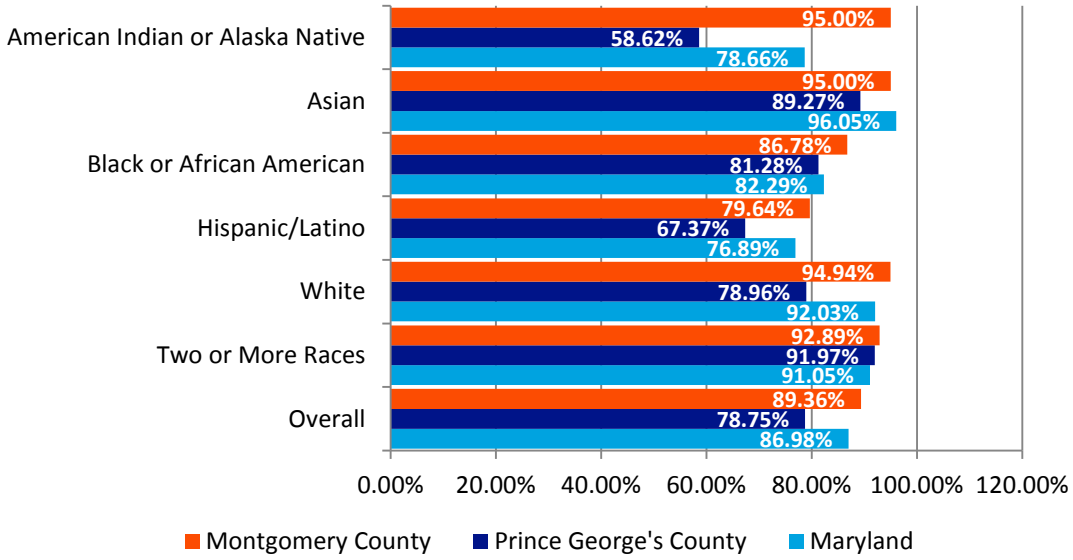


Figure 17. High School Graduation Rates by Race/Ethnicity in Montgomery and Prince George's Counties and Maryland, 2015
(Source: 2016 Maryland Report Card)

Disparities in education 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 27.15 percent which is higher than both the state (21.12 percent) and Prince George's County (18.94 percent). However, when stratified by race and ethnicity, Whites have the highest percentage in Montgomery County (71.14 percent), but more Asians over 25 have a bachelor's degree in both Prince George's County (54.72 percent) and Maryland (63.72 percent) than any other racial or ethnic group. There are large disparities within Prince George's County as well, with 54.72 percent of Asians obtaining a bachelor's degree compared to 10.52 percent of Hispanics (see Figure 18).

[5] Healthy Communities (2016). Montgomery County: High school graduation rate. *Healthy Montgomery.* Retrieved from: http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=13&localeId=1259

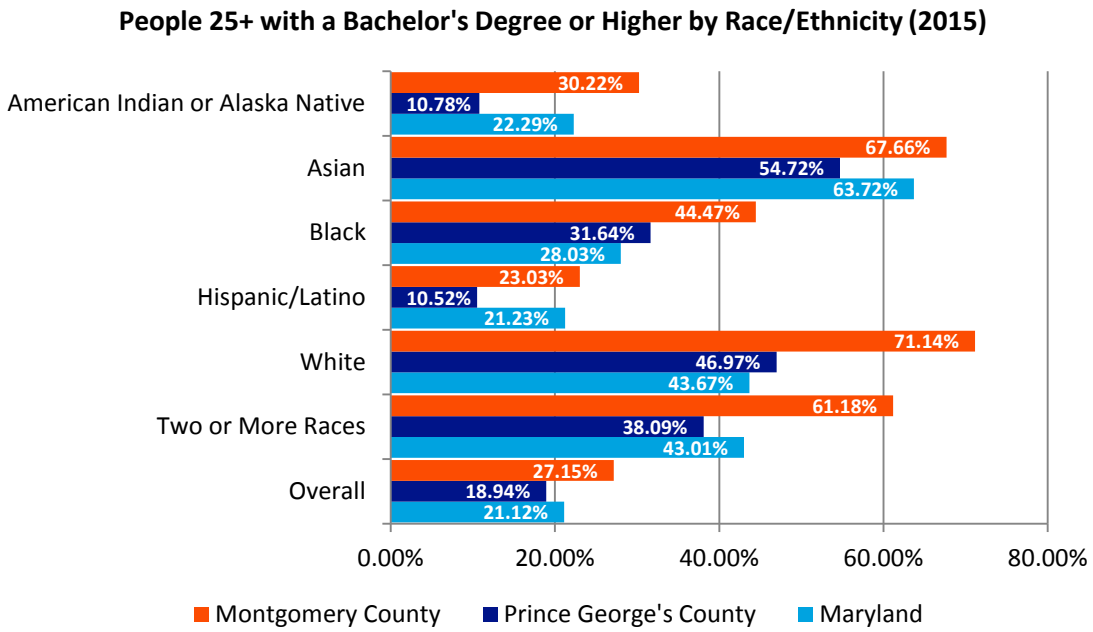


Figure 18. People 25 and Over with a Bachelor's Degree or Higher by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year Estimates)

English and Algebra Proficiency

Based on student scores on the Maryland High School Assessment (HSA), 95 percent of white and approximately 93 percent of Asian 12th graders are proficient in English compared to 78 percent of Hispanic and about 80 percent of Black students in Montgomery County. In Prince George's County, there are also racial and ethnic disparities among 12th graders in English proficiency, with white 12th graders testing highest at 89.4 percent and Hispanic students testing at 67.3 percent proficient. More Asian 12th graders in Maryland (91.5 percent) test proficient in English in Maryland than all other racial and ethnic groups while Black 12th graders have the lowest proficiency rate (73.1 percent) (see Figure 19).

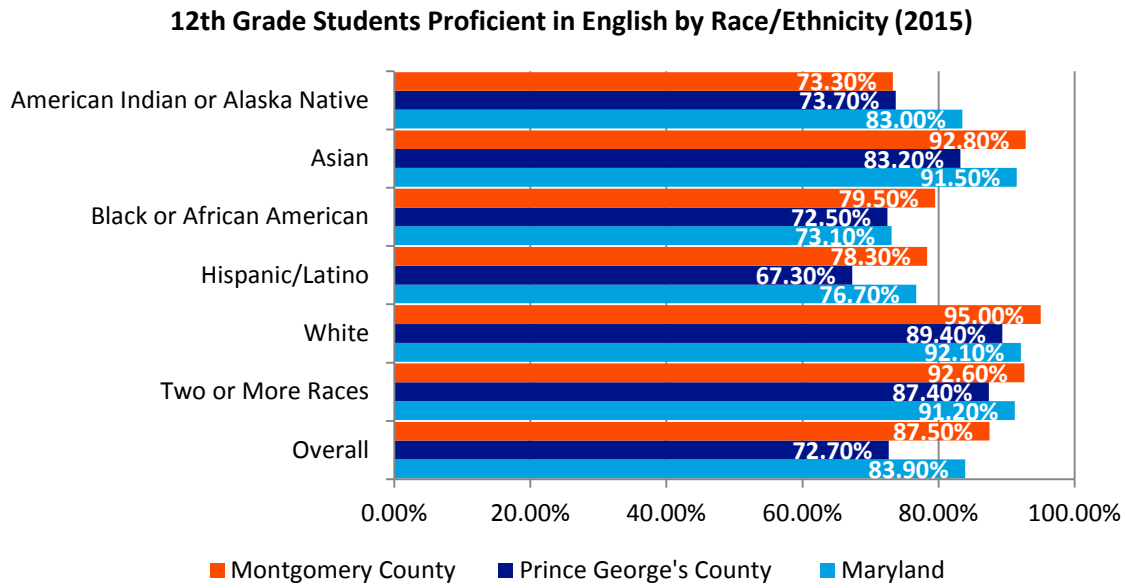


Figure 19. 12th Grade Students Proficient in English by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: 2016 Maryland Report Card)

A similar trend can be seen for algebra proficiency among 12th graders. In Montgomery County, at least 95 percent of both white and Asian 12th graders are proficient in algebra compared to 82.4 percent of American Indian or Alaska Native and 84.5 percent of Black students. In Prince George's County, 89.4 percent of white students are proficient in algebra compared to 70.4 percent of Black students. Regarding the state overall, 87.4 percent of 12th graders are proficient in algebra. More white (96 percent) and Asian students (96.3 percent) have tested proficient in algebra than all other racial or ethnic groups within Maryland while Black students (75.3 percent) have the lowest proficiency rate (see Figure 20).

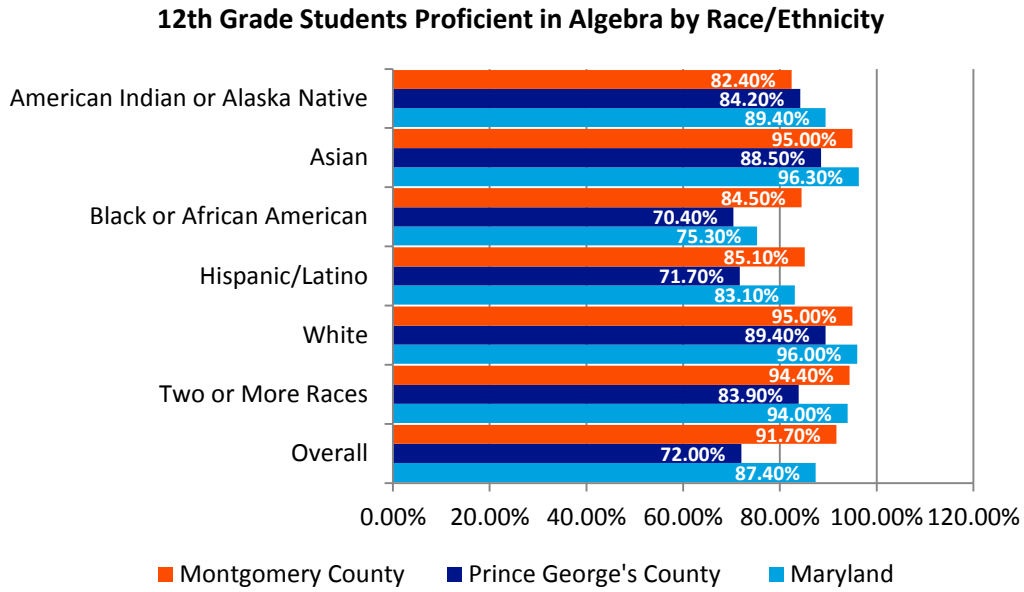


Figure 20. 12th Grade Students Proficient in Algebra by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: 2016 Maryland Report Card)

Readiness for Kindergarten

The percentage of children who enter kindergarten ready to learn in Montgomery County increased from 48 percent in 2014 to 49 percent in 2015, but is still higher than Maryland overall (45 percent). Hispanic children were among those least likely to be prepared for kindergarten in Montgomery County (28 percent). White (68 percent) and Asian (58 percent) children were among those most prepared to enter kindergarten in Montgomery County (see Figure 20).

The percentage of children who enter kindergarten ready to learn in Prince George's County increased from 34 percent in 2014 to 38 percent in 2015, but remained lower than that of the state overall (45 percent). Hispanic children were the least likely to be prepared for kindergarten at 22 percent, while Asian and white children were among those most prepared to enter kindergarten in Prince George's County at 46 percent and 59 percent, respectively (see Figure 21).

County	SHIP Measure	County 2014 Measure	SHIP 2015 County Update	SHIP 2014 County Update (Race & Ethnicity)	SHIP 2015 Maryland Update	Maryland Target 2017
Prince George's County	Percentage of children who enter kindergarten ready to learn	34%	38%	Asian–46%; AA-45% Hispanic-22% White-59%	45%	85.5%
Montgomery County		48%	49%	Asian–58%; AA-40% Hispanic-28% White-68%		

Figure 21. Percentage of Children Entering Kindergarten Ready to Learn, Prince George's and Montgomery Counties
(Source: Maryland SHIP, 2015)

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 U.S., a disproportionate percentage of minority households are affected by moderate and severe housing problems (see Figure 22).

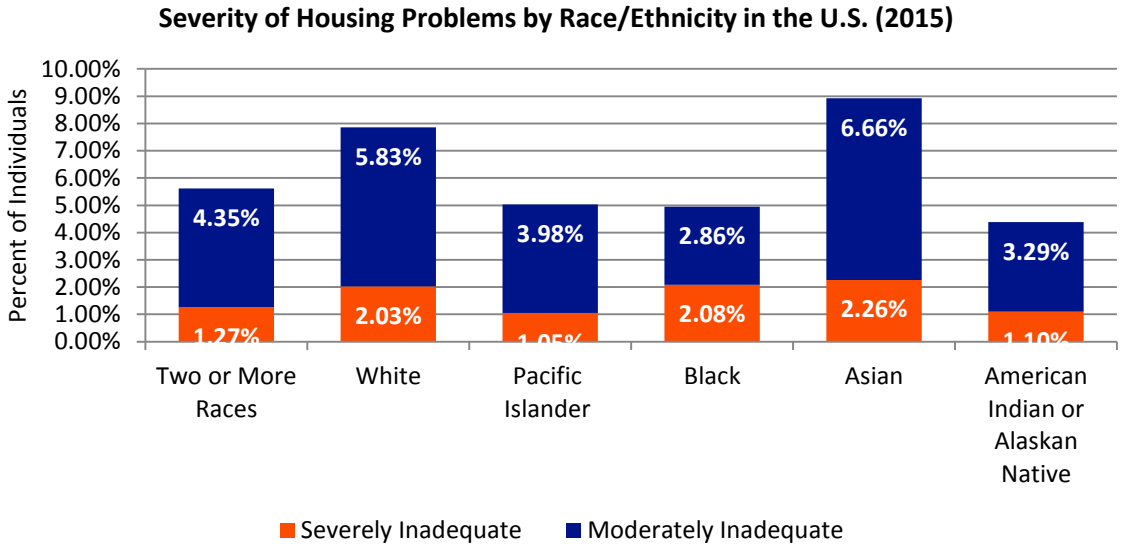


Figure 22. Severity of Housing Problems by Race/Ethnicity in the U.S., 2015
Note: Physical problems include plumbing, heating, electrical and upkeep
(Source: U.S. Census Bureau, American Housing Serving, 2015)

At the local level, 17 percent of households in Maryland, 18 percent of households in Montgomery County, and 20 percent of households in Prince George's County were identified as having at least 1 of 4 severe housing problems: overcrowding; high housing costs; and lack of kitchen or plumbing facilities[6].

Montgomery County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 52.7 percent
- Homeowner vacancy rate: 0.8
- Housing units in multi-unit structures: 34.3 percent
- Housing units: 389,030 (2015)
- Homeownership rate: 64.3 percent
  Median value of owner-occupied housing units: $474,900
  (Source: U.S. Census Bureau, ACS, 1-Year Estimate, 2015)
- Households: 365,235
- Persons per household: 2.76
  (Source: U.S. Census Bureau, QuickFacts, 2011–2015)

Prince George's County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 52.4 percent
- Homeowner vacancy rate: 1.7

[6] University of Wisconsin – Population Health Institute. (2016). Compare counties. *County Health Rankings*. Retrieved from: http://www.countyhealthrankings.org/app/maryland/2016/compare/snapshot?counties=24_031%2B24_033

- Housing units in multi-unit structures: 32.5 percent
- Housing units: 331,294
- Homeownership rate: 61.3 percent
  Median value of owner-occupied housing units: $272,200
  (Source: U.S. Census Bureau, ACS, 1-Year Estimate, 2015)
- Households: 305,610
- Persons per household: 2.86
  (Source: U.S. Census Bureau, QuickFacts, 2011–2015)

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 2016, a Point-In-Time Enumeration survey found there has been a decrease in the homeless population in both Montgomery County and Prince George's County (Figure 23).

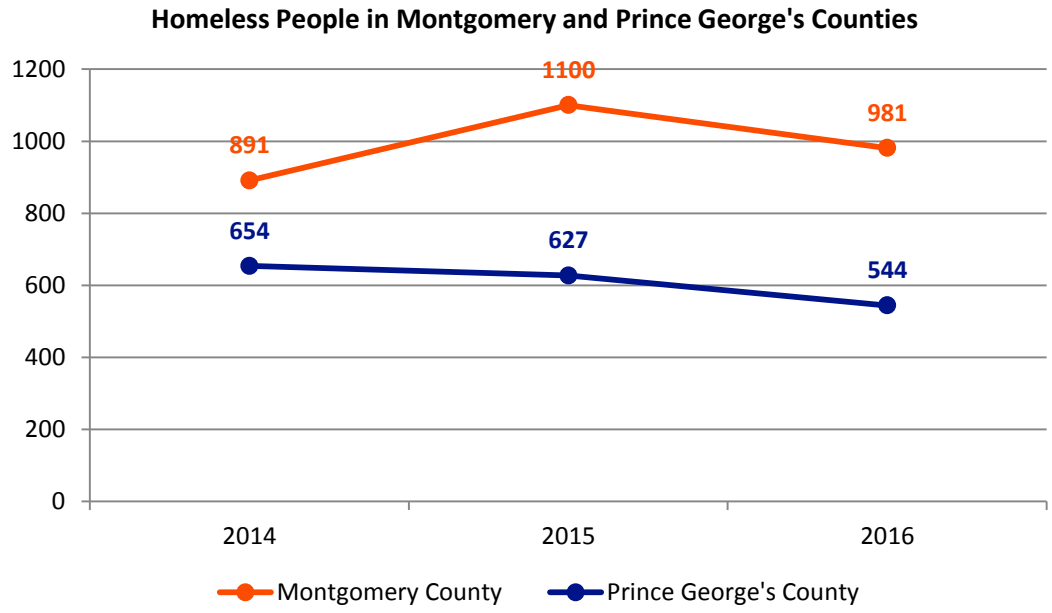


Figure 23. Number of Homeless People in Montgomery County and Prince George's County from 2014 to 2016
(Source**:** Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

In Montgomery County, the homeless population in 2016 included 109 homeless family units, made up of 128 adults and 230 children (Figure 24-A). Prince George's County's homeless population comprised of 105 family units, which included 118 adults, and 190 children (Figure 24-B).

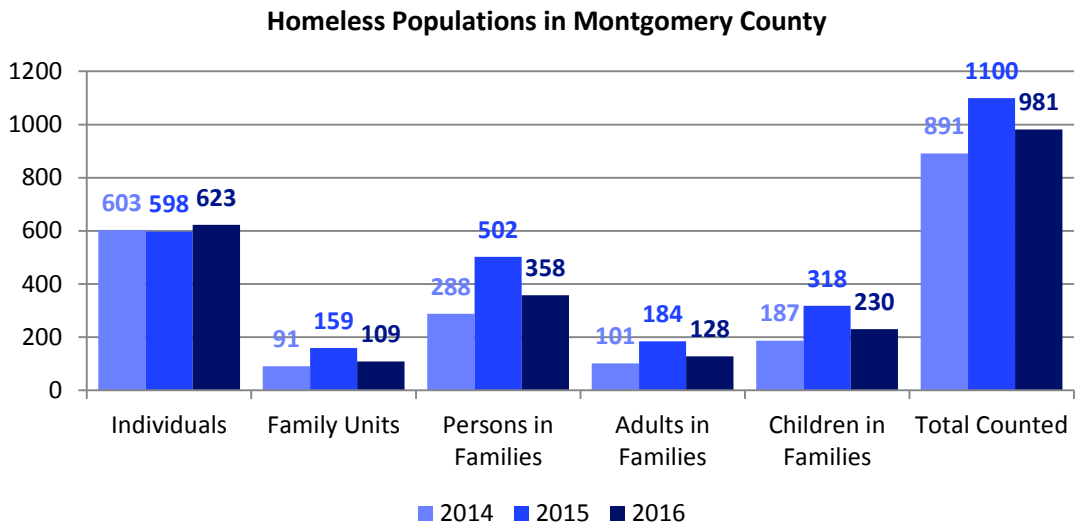


Figure 24-A. Homeless Populations in Montgomery County, 2014-2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

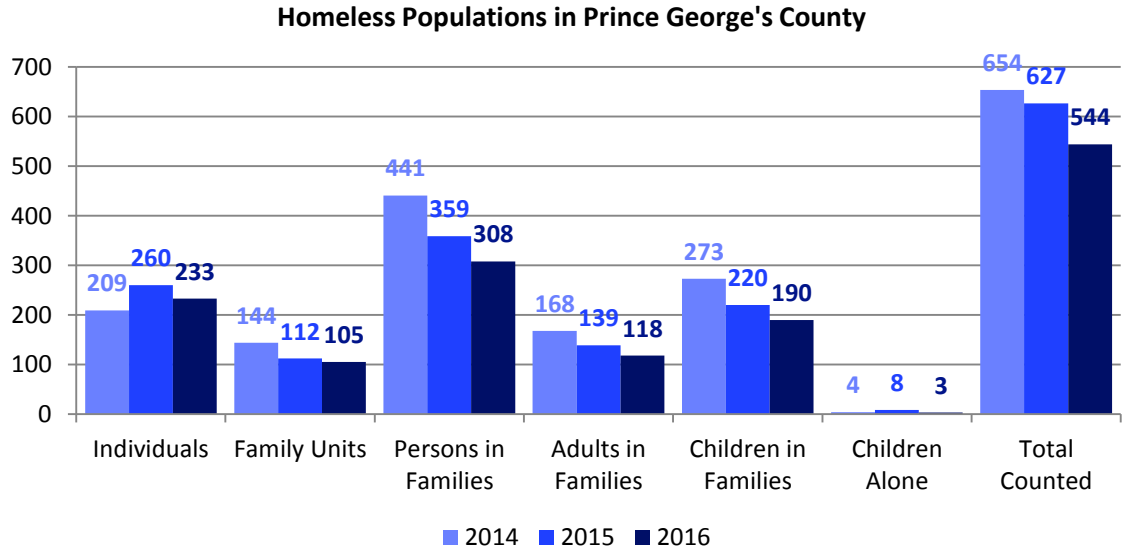


Figure 24-B. Homeless Populations in Prince George's County, 2014-2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

Among the homeless populations, numerous individuals reported various health, mental, and physical issues. In Montgomery County, 151 individuals were chronically homeless, 17 were US veterans, 127 were victims of domestic violence, 114 were suffering from co-occurring disorders (mental and substance abuse), 80 were physically disabled, and 85 were individuals with limited English proficiency. Similar issues were found among the Prince George's County homeless population (Figure 25).

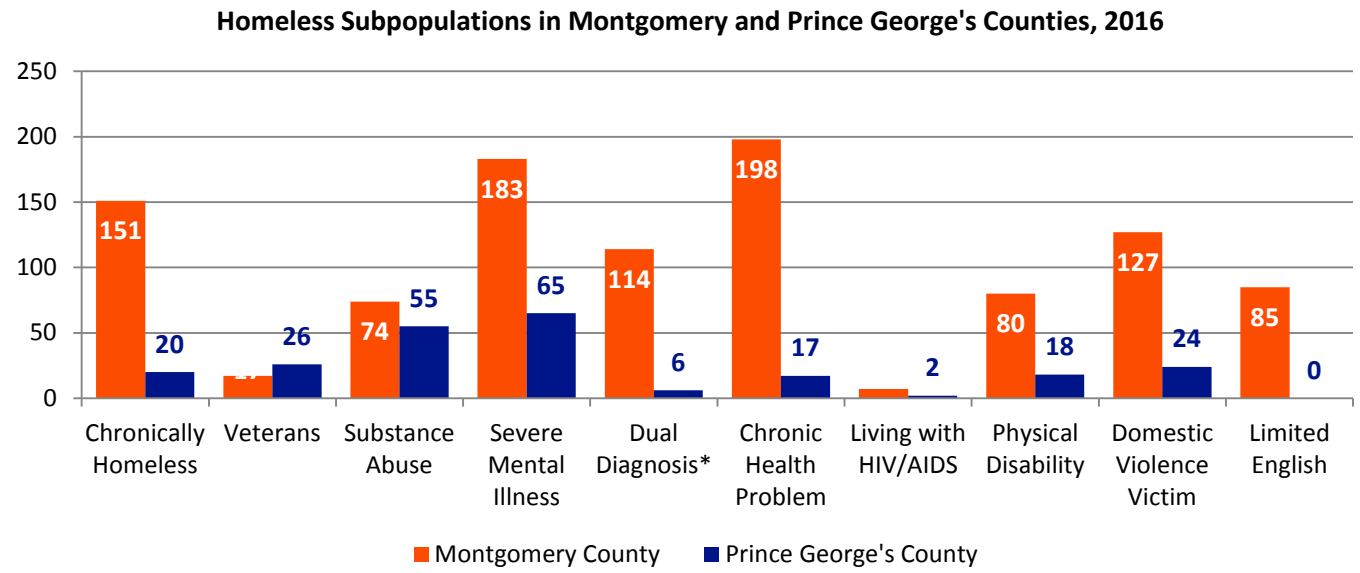


Figure 25 Homeless Subpopulations in Montgomery County and Prince George's County in 2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

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 U.S. standards in three years, Montgomery County received a grade of D from the American Lung Association[7]; Prince George's County received a grade of F.[8] Prince George's County also has a high quantity (1,540lbs) of carcinogens released into the air[9].

[7] Healthy Communities Institute. (2016). Annual ozone air quality, 2012-2014. *Healthy Montgomery*. Retrieved from: http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeTypeId=2&localeId=1259

[8] Healthy Communities Institute (2016). Annual ozone air quality, 2012-2014. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeId=1260

[9] Healthy Communities Institute (2016). Recognized carcinogens released into air, 2014. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=389&localeId=1260

Available detail on race, ethnicity, and language within CBSA ***See SHIP County profiles for demographic information of Maryland jurisdictions.***			
Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	1,040,116	909,535	321,418,820
Age, %*			
Under 5 Years	6.5%	6.6%	6.2%
Under 18 Years	23.4%	22.5%	22.9%
65 Years and Older	14.1%	11.7%	14.1%
Race/Ethnicity, %*			
White	45.2%	13.9%	61.6%
Black or African American	19.1%	64.6%	12.6%
Native American & Alaskan Native	0.7%	1.0%	1.2%
Asian	15.2%	4.7%	5.6%
Native Hawaiian & Other Pacific Islander	0.1%	0.2%	0.2%
Hispanic	19.0%	17.2%	17.6%
Language Other than English Spoken at Home, % age 5+*	39.3%	21.3%	20.9%
Median Household Income*	$98,704	$73,856	$53,482
Persons below Poverty Level, %*	7.2%	10.3%	13.5%
Pop. 25+ Without H.S. Diploma, %*	8.7%	14.4%	13.7%
Pop. 25+ With Bachelor's Degree or Above, %*	57.4%	30.4%	29.3%
Sources: * U.S. Census Bureau. (2015). QuickFacts. Retrieved from: https://www.census.gov/quickfacts/table/PST045215/24031,24033,00			

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?**

   _X_Yes
   ___No

   Provide date here. 10/23/2013 **(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/3275/2013-CHNA-ARHM.pdf

   New CHNA will be completed and made available by December 31, 2016.

2. **Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?**

   _X_Yes 4/24/2014 **(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.adventisthealthcare.com/app/files/public/3446/2013-CHNA-ARHM-ImplementationStrategy.pdf

   New Implementation Strategy will be completed and made available by May 15, 2017.

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. **Are Community Benefits planning and investments part of your hospital's internal 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.

      As a part of Adventist HealthCare, Adventist Rehabilitation is dedicated to Community Benefit which aligns with the system's core mission and values. Within Adventist Rehabilitation's strategic plan, the hospital's commitment to Community Benefit is outlined and an overview of the infrastructure is described. Stemming from the upcoming CHNA (2017-2019) which will be released in December 2016, the strategic plan also outlines the health needs prioritization as was approved by the Board of Trustees. As the implementation strategy is developed and put into place in the spring of 2017, the Community Benefit

section of the strategic plan will be updated to include the specific initiatives, objectives and committed resources. The section of the strategic plan applying to Community Benefit is included below.

Community Benefit

Adventist HealthCare Rehabilitation is dedicated to its mission of "demonstrating God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing." Community benefit is an embodiment of Adventist Rehab's dedication to enacting its community-based mission and improving the health and wellbeing of the communities it serves.

As a hospital and part of the Adventist HealthCare system, Adventist Rehab is committed to:

- Continually developing infrastructure to improve the implementation, evaluation, and reporting of its community benefit activities
- The alignment of clinical service lines and community benefit focus areas with needs identified through the community
- An investment of resources to improve population health (one of the 6 Pillars of Excellence) in the communities it serves

System-Wide Infrastructure

Center for Health Equity & Wellness (The Center): The Center aims to improve the health of communities by raising awareness of community health needs and local disparities, improving access to culturally appropriate care, and providing community wellness outreach and education.

Community Benefit Council (CBC): Composed of representatives from each of the four hospitals as well as from system wide-departments, the CBC functions to ensure that Adventist HealthCare is meeting all of the requirements for Community Benefit both on the state and federal levels.

Community Partnership Fund (CPF): The CPF provides funding for organizations whose activities support AHC's mission to improve the health and wellbeing of the community, especially for those that have poor access to care and poor health outcomes. Funding requests must align with AHC's funding objectives and priorities as outlined below:

- **Funding objectives**: health and wellness, partnerships, and capacity building
- **Priorities**: addressing a priority area of need identified in our hospitals' Community Health Needs Assessment, targeting populations in AHC's service area that are socially and economically disadvantaged or medically underserved, aligning with AHC's community-based mission, and having a measurable impact

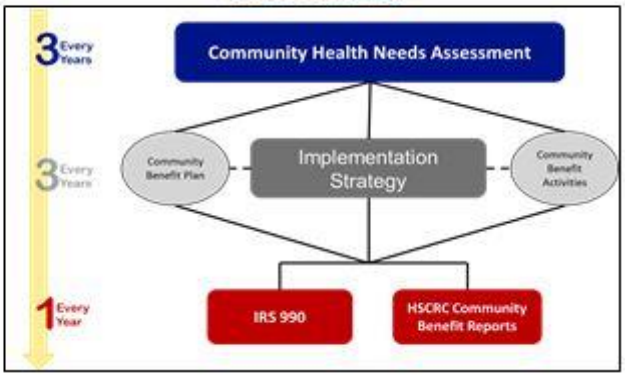
Community Health Needs Assessment Prioritization: 2017-2019

The prioritization of community health needs for the 2017-2019 time-frame was determined by Adventist Rehab's Operational Leadership Team. The Leadership Team took the following factors into consideration: incidence and prevalence of the need in the community, presence and size of disparities, changes over time, alignment with county priority areas, existing resources and partnerships, needed resources and gaps, and potential for measurable and achievable outcomes. This prioritization will guide Adventist Rehab's planning, development and resource allocation for community benefit activities, including the Implementation Strategy, for 2017-2019.

Final Prioritization

1. Traumatic Brain Injury
2. Stroke
3. Amputee
4. Spinal Cord Injury
5. Cardiovascular
6. Lymphedema
7. Cancer
8. Obesity
9. Diabetes
10. Neurology
11. Housing
12. Food
13. Education
14. Orthopedics

AHC Community Benefit Implementation & Reporting Process Overview



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:** AVP Rehabilitation; Associate VP of Operations**)**

Describe the role of Senior Leadership.
The senior leaders listed above play a large role in the community benefit planning for Adventist Rehabilitation. This leadership group played a lead role in completing the prioritization of needs process and provided input and approval on the implementation strategy prior to board approval for the 2014-2016 CHNA. Senior Leadership as a part of the Operational Leadership team, was presented with key data findings for the 2017-2019 CHNA. A sub group of these individuals including the AVP of Rehabilitation and the Associate VP of operations then reviewed the data in more detail and completed the prioritization process for the hospital.
The AVP of Rehabilitation acts as a champion for the implementation strategy initiatives and serves on the AHC Community Benefit Council on behalf of Adventist Rehabilitation. The CFO and Manager of Finance at Physical Health & Rehabilitation work closely with AHC finance and provide final approval of financials submitted.

ii. Clinical Leadership

1. **_X_Physician**
2. **_X_Nurse**
3. **___Social Worker**
4. **___Other (please specify)**

Describe the role of Clinical Leadership
Clinical leadership assists with the planning and implementation of community benefit activities including identifying needs in the community.

iii. Population Health Leadership and Staff

1. **_X_Population Health VP or equivalent (please list:** Sr. VP, Physician Networks & President, Adventist Medical Group**)**
2. **_X_Other population health staff (please list:** Director of Population Health Management**)**

Describe the role of population health leaders and staff in the community benefit process
The Sr. VP, Physician Networks & President, Adventist Medical Group is directly over the Center for Health Equity and Wellness which coordinates and manages AHC's community benefit efforts and reporting. He plays a large role in big picture community benefit planning including resource allocation and determining directions for community benefit investments. The Director of Population Health Management for AHC acts as a community benefit champion and is a member of AHC's Community Benefit Council.

iv. Community Benefit Operations

1. **_X_Individual (please specify FTE:** Cultural Diversity Liaison; Project Manager, Community Benefit; Research Assistant**)**
2. **_X_Committee (please list members:** Adventist HealthCare Community Benefit Council & Adventist HealthCare Community Partnership Fund Board; members listed below for both**)**
3. **_X_Department (please list staff:** Adventist HealthCare Center for Health Equity and Wellness**)**
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.

At Adventist Rehabilitation, the Cultural Diversity Liaison acts as a champion for Community Benefit and assists with recording and reporting community benefit activities. This individual is also a member of the Adventist HealthCare Community Benefit Council (described more below)as a representative of Adventist Rehabilitation.

The Adventist HealthCare Center for Health Equity and Wellness coordinates the implementation and reporting of community benefit for the entire hospital system. This includes compliling the Community Health Needs Assessments and the annual Community Benefit Reports, as well as acting as the administrators for CBISA. The Center for Health Equity and Wellness also conducts a large number of community benefit initiatives including health education and screenings. This department includes the Project Manager, Community Benefit and the Research Assistant listed above. These individuals take the lead role in CHNA development, implementation strategy coordination with each of the hospitals, and community benefit reporting.

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 4-6 times per year 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 - CHAIR
- Project Manager for Community Benefit, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- Research Assistant, Center for Health Equity and Wellness
- CFO, Shady Grove Medical Center
- Director of Case Management for SGMC and Washington Adventist
- Director of Population Health, Adventist HealthCare
- AVP, Rehabilitation at Adventist Rehabilitation
- Cultural Diversity Liaison at Adventist Rehabilitation
- Manager, Business Development at Behavioral Health and Wellness Rockville
- Project Accountant, Adventist HealthCare
- Senior Tax Accountant, Adventist HealthCare
- Financial Services Project Manager, Adventist HealthCare
- PR Marketing Coordinator, Adventist HealthCare

The Community Partnership Fund provides funding for organizations whose activities support the Adventist HealthCare Mission, especially those that have poort access to care and poor health outcomes. Funding priorities for the fund include:

- Activities that address a priority area of need identified in our hospitals' Community Health Needs Assessment
- Activities that target populations in Adventist HealthCare's service area that are socially and economically disadvantaged or medically underserved
- Activities that align with Adventist HealthCare's community-based mission
- Activities that have a measurable impact on the community being served

The Community Partnership Fund Board is in charge of setting funding priorities, managing application processes (application, selection, etc.), and reviewing funding requests. Members include:

- CEO, Adventist HealthCare
- Chief Development Officer
- Director of Public Policy
- President, Adventist Behavioral Health
- Executive Director, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- Sr. VP/Chief HR Officer
- Vice President of Business Development
- Sr. VP/CQIO
- VP Public Relations/Marketing
- CMO, Shady Grove Medical Center
- VP, Mission Integration and Spiritual Care
- AVP, Rehabilitation

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	**_____yes**	**__X__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**	**__X__no**
Narrative	**_____yes**	**__X__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 2017.

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)
__X__ Schools
_____ 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	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	Shady Grove Medical Center collaborates with Healthy Montgomery (HM), which

Description	serves as the Local Health Improvement Coalition in Montgomery County. SGMC contributes $25,000 annually to support the infrastructure of HM. SGMC 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 SGMC to identify needs and set priorities. SGMC 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 __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

Several Adventist HealthCare representatives take part in Healthy Montgomery. Marilyn Lynk, Executive Director of the Center for Health Equity and Wellness sits on the steering committee. Additional staff members also participate in committees such as the Community Health Needs Assessment Committee and the Chronic Disease Cluster planning group.

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 links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)

(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? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)*

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.*

    i. *What were the measurable results of the initiative?*

    ii. *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

Initiative: Comprehensive Concussion Care (CHNA Implementation Strategy Initiative)

Identified Need Was this identified through the CHNA process?	The CDC estimates that there are more than 3.8 million sports-related concussions per year in the U.S. Data from the 2004 to 2009 college sports season shows sports-related concussions comprised 9.2% of all injuries sustained in women's soccer, 7.4% in football, 6.3% in field hockey, 5.5% in men's soccer and 4.1% in women's volleyball[10]. A high school sports-related injury surveillance study for the 2014-2015 school year found that concussions comprised 25% of injuries sustained during competitions and 17% of injuries sustained during practice sessions[11]. From 2006 to 2010, Montgomery County had the highest percentage of traumatic brain injury (TBI) related emergency department visits in the state as well as the fourth highest percentage of TBI related hospital discharges[12]. From 2010 to 2011, Adventist HealthCare Rehabilitation had a higher percentage (12.78 percent) of brain injury discharges than the region (11.4 percent) and the nation (10.73 percent)[13]. From January 2015 to the end of July 2016, Adventist HealthCare Rehabilitation served and discharged a total of 405 brain injury patients.
Hospital Initiative	Adventist HealthCare Rehabilitation Athletic Trainer and Montgomery County Student Athlete Concussion Program
Total Number of People within the Target Population	The target population includes 6,045 student athletes at 13 Montgomery County High Schools
Total Number of People Reached by the Initiative within the Target Population	The total number of people reached was 6,045. 100% of student athletes have been baseline tested.
Primary Objective of the Initiative	The primary objective of this initiative is to help improve concussion diagnoses and treatment among Montgomery County Public School student athletes. Adventist HealthCare Rehabilitation has partnered with the Montgomery County Public school system to provide baseline concussion testing in 13 of the 25 high schools. Baseline testing is a pre-season exam conducted by trained professionals to assess an athlete's cognitive functions including learning and memory skills, ability to concentrate and problem solving skills. In the event that the athlete suffers a concussion, the results from these tests can be used in comparison with similar post-injury tests. Adventist HealthCare Rehabilitation uses ImPACT™ (Immediate Post-Concussion Assessment Cognitive Test), a web-based, computerized tool used to measure memory, processing speed, reaction time, attention span and problem solving skills. It is not an IQ test. This test takes between 30 to 45 minutes and is considered one of the standard baseline tests for athletes.

[10] Datalys Center: Sports Injury Research and Prevention, 2004-2009

[11] National High School Sports-Related Injury Surveillance Study: 2014 – 2015 School Year Convenience Sample Summary Report. http://www.ucdenver.edu/academics/colleges/PublicHealth/research/ResearchProjects/piper/projects/RIO/Documents/Convenience%20Report_2014_15.pdf

[12] Department of Health and Mental Hygiene, 2006-2010.

[13] Patient Outcomes Report. Adventist Rehabilitation Hospital of Maryland. 2011. http://www.adventistrehab.com/app/files/public/213/pdf-ARHM-Patient-Outcomes.pdf

	In addition to the baseline testing, Adventist HealthCare Rehabilitation has assisted with implementing an athletic trainer program at each of the 13 schools. This has included training and placing an athletic trainer in each of the schools to assist with timely on-site injury prevention and management. Additional details are described below.
	
	Specific objectives for the initiative include:
	1. By the end of 2015, provide comprehensive concussion care to at least 60 community members in need of concussion care services.
	2. By the end of the 2014-2015 school year, complete ImPact™ baseline testing for 100% of student athletes at 13 Montgomery County High Schools.
	3. By the end of the 2016-2017 school year, place trainers in 13 of the 25 Montgomery County High Schools to aide in the development of an injury management and prevention program for student athletes.
	
	Strategies for this initiative include:
	• Increasing knowledge and awareness of concussion risks; concussion identification, care, and management in the community and the Montgomery County Public School system
	• Implementing ImPact™ baseline testing for student athletes in 13 Montgomery County high schools (with each student baseline tested every 2 years)
	• Maintaining and making available baseline test results to students, parents, and students' health care providers at no cost
	• Providing retests following a concussion at no cost (analysis and treatment are an additional cost)
	• Providing follow-up testing and analysis for students as needed at a reasonable rate
	• Serving as a resource on concussion education for students, parents, and coaches
	• Training and placing full-time athletic trainers in 13 Montgomery County high schools
	  ○ Trainers attend all 'home' athletic events as well as 'away' varsity football games
	  ○ Trainers perform functions within the six domains of athletic trainers as established by the National Athletic Trainers Association: prevention; clinical evaluation and diagnosis; immediate care; treatment, rehabilitation, and reconditioning; organization and administration; and professional responsibilities.
	  ○ In addition, trainers assist in implementing school and system wide responsibilities related to the health and safety of student athletes.
	• Providing American Heart Association CPR/AED recertification for athletic staff at 13 Montgomery County high schools

Single or Multi-Year Initiative Time Period	This is a **multi-year** initiative that began in the fall of 2013 and will continue into 2017 and 2018 with the potential to continue for an additional 3 years thereafter (contingent on agreement renewal with Montgomery County Public Schools).
Key Collaborators in Delivery of the Initiative	**Key partners involved in this initiative include:** • Montgomery County Public Schools ○ Churchill, Clarksburg, Einstein, Kennedy, Richard Montgomery, Northwest, Paint Branch, Poolesville, Rockville, Springbrook, Watkins Mill, Wheaton, Wooton

	• Johns Hopkins Medical Center

Impact/Outcome of Hospital Initiative	**Baseline Concussion Testing**
	• Baseline testing was coordinated with school personnel for 13 Montgomery County high schools for the 2015-2016 and the 2016-2017 school years
	• ImPact™ baseline testing was completed at 13 Montgomery County high schools
	  ○ A total of 6,045 student athletes were baseline tested for the 2015-2016 school year
	  ○ A total of 2,927 student athletes were baseline tested for the 2016-2017 school year (through October 2016)
	
	Athletic Trainer Program
	• 13 certified athletic trainers were present for the 2015-2016 athletic season in the 13 Montgomery County high schools, and are currently present for the 2016-2017 school year
	• For the 2015-2016 school year:
	  ○ 923 injuries were evaluated and documented
	  ○ 191 concussions were diagnosed or suspected
	• For the 2016-2017 school year (thus far through October 2016):
	  ○ 418 injuries have been evaluated and documented
	  ○ 56 concussions have been diagnosed or suspected
	• CPR/AED recertification was provided by Physical Health & Rehabilitation staff:
	  ○ 211 coaches were recertified during the 2015-2016 school year
	  ○ 92 coaches have been recertified during the 2016-2017 school year (thus far through October 2016)

Evaluation of Outcomes	The Maryland State Board of Education established The Traumatic Brain Injury/Sports-Related Concussion Task Force in 2012 to research existing best practices regarding the prevention and treatment of TBI/concussions and to propose prevention, recognition, and management recommendations for schools in Maryland. In 2013, the Task Force submitted seven recommendations[14], some of which include: using the public health Levels of Prevention Model to implement prevention strategies; using educational programs to train coaches, athletic trainers, school nurses, teachers, counselors, student-athletes; promoting educational opportunities related to the evaluation and management of concussions; and improving communication with student-athletes, parents/guardians, schools, athletic departments and health care providers. Adventist HealthCare Rehabilitation's Comprehensive Concussion Care initiative has been working towards the continued implementation of the Task Force's recommendations in Montgomery County high schools by raising awareness of concussion risks, teaching ways to identify, treat and manage concussions, providing baseline testing for every student-athlete, making test results available for students and family, placing trained full-time athletic trainers at all 13 Montgomery County high schools, and much more. The Comprehensive Concussion Care program has been successfully working towards the improvement of concussion diagnoses and treatment in the 13 Montgomery County high schools.

[14] Maryland State Department of Education. Report of the Traumatic Brain Injury/Sports-Related Concussions Task Force, January 2013. http://www.marylandpublicschools.org/w/ConcussionTaskForceReport_012013.pdf

Continuation of Initiative	Adventist HealthCare Rehabilitation will continue this initiative into 2017 and 2018, at which point the contract with Montgomery County Public Schools will be up for renewal, for a potential additional 3-year term.	
A. Total Cost of Initiative for Current Calendar Year B. What amount is from Restricted Grants/ Direct offsetting	**A. Total Cost of Initiative** **Total estimated costs (2016): $667,500** • Salary for 13 athletic trainers (athletic trainer contracts include baseline testing as well): $575,000 • Benefits for athletic trainers: $90,000 • CPR Expenses & Salary: $2,500	**B. Direct offsetting revenue from Restricted Grants** **Total estimated revenue and funding from Montgomery County Public Schools:** $260,000

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 Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
Asthma	Montgomery County has lower asthma prevalence (9.9%) than Prince George's County (14.3%) or the state (13.5%). Prince George's County has a much higher ER rate due to asthma (52.8 per 10,000) compared to Montgomery County (17.4 per 10,000). Both counties have lower ER rates than the state (68.3 per 10,000).	Support other organizations that provide services related to asthma. Refer patients to other Adventist HealthCare entities or community organizations as appropriate.	Montgomery County has established the Asthma Management Program which focuses on Latino children. This intervention program provides education, support and follow-up care. Other resources include the American Lung Association in Maryland, Asthma and Allergy Foundation of America (Maryland Chapter), and the Maryland Asthma Control Program.	Adventist HealthCare Rehabilitation does not directly address Asthma because it is not a specialty area of the hospital. Sufficient resources and expertise are not available to meet these needs. Additional resources are available in the community.
Influenza	Influenza activity level across Maryland for 2016 flu season was minimal. Historically, the rate of ED visits due to immunization-preventable pneumonia and influenza in Montgomery County was much higher among younger adults (18-24 years old) and Blacks than among any other adult age or racial group.	Support other organizations that provide services related to influenza. Refer patients to other Adventist HealthCare entities or community organizations as appropriate.	Adventist HealthCare Shady Grove Medical Center offers annual flu shot clinics in Montgomery County beginning in early September and continuing through January. Flu shot clinics are held at community centers, congregations, subsidized apartment complexes, and at Adventist HealthCare Shady Grove Medical Center. The Montgomery County Health Department has immunization outreach and education services for county residents. An Annual campaign is offered to residents for flu prevention. Other local health care providers, pharmacies, WIC providers, schools, child care providers, and clinics provide flu vaccinations in addition to outreach	Adventist HealthCare Rehabilitation does not directly provide influenza services as they fall outside the scope of the hospital as a rehabilitation center. Influenza services are already provided by the acute care hospitals in the Adventist HealthCare System, Adventist HealthCare Shady Grove Medical Center and Adventist HealthCare Washington Adventist Hospital, as well as by several other organizations in Adventist HealthCare Rehabilitation's service area.

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
			and education.	
HIV/AIDS	Prince George's County has higher HIV/AIDS incidence rates (48.8 per 100,000) than Montgomery County (21.9 per 100,000) or the state (24.6 per 100,000). In both counties, Blacks are disproportionately burdened by HIV/AIDS.	Support other organizations that provide services related to HIV/AIDS. Refer patients to other Adventist HealthCare entities or community organizations as appropriate.	HIV case management from the Montgomery County Health Department helps to provide dental care, counseling, support groups, and home care services as needed. Education and outreach to at-risk populations is also provided. The Montgomery County Health Department also provides clinical services, lab tests, and diagnostic evaluations. The Maryland AIDS administration educates public health care professionals.	Adventist HealthCare Rehabilitation does not provide HIV/AIDS services as they fall outside the scope of the hospital as a rehabilitation center. HIV/AIDS services are already provided by other entities in the Adventist HealthCare network, as well as by several other organizations in Adventist HealthCare Rehabilitation's service area.
Population Health • Maternal and Infant Health • Behavioral Health • Senior Health	**Maternal and Infant Health:** In both Montgomery County and Prince George's Counties, blacks and Hispanics were most likely to receive late or no prenatal care at Asians and whites. Although infant mortality is generally decreasing, blacks continue to experience the highest rates of infant mortality in Maryland as well as in Montgomery County. **Behavioral Health:** In Montgomery County, 10.5 percent of the adult residents	Support other organizations that provide services related to maternal and infant health, behavioral health, and senior health. Refer patients to other Adventist HealthCare entities or community organizations as appropriate.	**Maternal and Infant Health:** Adventist HealthCare Shady Grove Medical Center and Adventist HealthCare Washington Adventist Hospital offer a full spectrum of services for expectant mothers, new mothers, and infants. Child birth and education classes are offered as well as lactation consultants. Free post-partum support groups are available as well. The Montgomery County Health Department works with Holy Cross, Adventist HealthCare Washington Adventist Hospital, and Adventist HealthCare Shady Grove Medical Center to provide prenatal services to low-	**Maternal and Infant Health:** Adventist HealthCare Rehabilitation does not provide maternal and infant services as they fall outside the scope of the hospital as a rehabilitation center. A full spectrum of maternal and infant services are already provided by Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare Washington Adventist Hospital and several other organizations in Adventist HealthCare Rehabilitation's service area.

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	have been diagnosed with an anxiety disorder and nearly 15 percent have been diagnosed with a depressive disorder. Among the youth, 12-17 year olds, 10.6% were diagnosed with major depressive episodes in 2013. **Senior Health:** In both Montgomery and Prince George's Counties, 6.7 percent of seniors live below the poverty line with higher percentages among minority seniors and women. In Montgomery County, 13.7 percent of the population is over age 65 and 87.5 percent of residents over the age of 65 have some type of health insurance. These rates are comparable to the State of Maryland. Rates of hospitalization for dementia/Alzheimer's for Montgomery County (142.7 per 100,000) were lower than rates in Maryland (194.1 per 100,000).		income and uninsured residents. To address teen pregnancy, school nurses work in accordance with Maryland state regulations providing Montgomery County Public School (MCPS) students with education and referrals that promote healthy lifestyle choices. The Teen Parent Support Program provides peer group education on raising children, healthy relationships, and prevention of repeat teenage pregnancy. Additional services and resources include the WIC program, safety net clinics, mental health care for pregnant women and new mothers at risk for depression, home visitation services to first time parents and well-baby care programs. **Behavioral Health:** Montgomery County Crisis Center providers 24 hour telephone or walk-in services for children and adolescents. Many additional organizations provide assessment and care services such as: Children's National Medical Center, Affiliated Community Counselors, Inc., City of Rockville Youth and Family	**Behavioral Health:** Adventist HealthCare Rehabilitation does not provide behavioral health services because these services are already provided by a neighboring specialty care hospital within its hospital system, Adventist HealthCare Behavioral Health and Wellness Services. In addition to Adventist Behavioral Health, there are many organizations that provide behavioral health services within the Adventist HealthCare Rehabilitation service area. **Senior Health:** Adventist HealthCare Rehabilitation does not directly provide senior care community outreach services as they fall outside the scope of the hospital as a rehabilitation center. Many older adults and seniors are served by various programs at Adventist HealthCare Rehabilitation, although these are not specifically/exclusively offered to seniors. Senior health services are already provided by other entities in the Adventist HealthCare network, as well as by several other organizations in

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
			Services, and Community Connections. The Mental Health Association and the National Alliance on Mental Illness provide support, education, and advocacy. **Senior Health:** The Montgomery County Department of Aging offers nutrition programs, runs community senior centers, and heads several multicultural health initiatives. The Jewish Council for the Aging has information and referral services, adult day care services, a senior help line, and Connect-A-Ride. Local community senior centers provide education classes, social activities, and health screenings. Additionally available are hospital-based programs including support groups, senior resource programs, and a variety of education services. Health promotion services focus on fall prevention, end of life health decisions, and overall health issues. Support groups for family caregivers, respite care, and in-home services are also available. This area also has all levels of care available for seniors such as acute care, skilled nursing care, assisted living	Adventist HealthCare Rehabilitation's service area.

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
			facilities, and home health care services.	
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. **Housing Quality** – 51.6 percent of renters in Montgomery County spend 30% or more of household income on rent. In 2016, an annual survey found there were 981 homeless people in Montgomery County and 544 in Prince George's County. **Education:** Montgomery County performs better than the state baseline with regard to percentage of students who graduate high school within 4 years. While the overall graduation rate is higher than the state, there are disparities in graduation rates among racial and ethnic groups. **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	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, a central food bank in Montgomery County, provides food assistance directly to individuals from 14 locations across the county. Manna works with local farms and orchards to provide fresh fruits and vegetables to their clients. Several local food programs deliver boxes of food to their clients, including Germantown HELP and Manna Food Center. Whether they offer delivery, transportation, or programs directed to children in need, these organizations have worked to overcome access challenges to deliver food and other services to those who need it. **Housing Quality:** Adventist HealthCare Rehabilitation supports and partners with a non-profit organization in Montgomery County 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 a program to provide permanent housing	Adventist HealthCare Rehabilitation does not directly address many of the social determinants of health as they fall outside the specialty areas of the hospital and Adventist HealthCare Rehabilitation does not have the resources or expertise to meet those needs. Instead Adventist HealthCare Rehabilitation supports and partners with other organizations in the community that specialize in addressing needs related to food access, housing quality, education, and transportation.

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale				
Focus Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	(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.		for families throughout the county. **Education:** 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:** A number of public transportation options are available in Montgomery County including Ride On, Park and Ride, Metrobus, Metrorail, MetroAccess, Call "N" Ride, AMTRAK, MARC, and taxis. Many of these options offer free of discounted fares for low income individuals.	

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?

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. Adventist HealthCare Rehabilitation's community benefit operations/activities are aligned with many of these initiatives. For example, the Adventist HealthCare Rehabilitation initiative to build a comprehensive concussion screening and treatment program provides services to student athletes at high schools across Montgomery County. The initiative includes baseline testing every two years, where tests are offered at a discounted rate or free of charge for students with economic difficulties. Athletic trainers are also placed at high schools, and attend all home games and away varsity football games. A Concussion Clinic is also provided to community members. With Montgomery County having a high percentage of traumatic brain injury-related emergency department visits, these initiatives help to promote the health of students in our community (while also promoting physical activity) and provide health services to those who may not otherwise have access to them.

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.

In 2014, 10.4 percent of Montgomery County adults and 11.4 percent of Prince George's County adults reported being unable to afford to see a doctor (Figure 26). When stratifying the data, disparities can be seen across different ages, races, and ethnicities. For instance, the percentage of Hispanic adults unable to afford to see a doctor is nearly twice that of the overall county numbers in Montgomery, and nearly three times the overall numbers in Prince George's (Figure 27).

Additionally, 8.19 percent of non-institutionalized Montgomery County residents and 10.9 percent of Prince George's County residents do not have health insurance (American Community Survey, 2015). This leads to untreated conditions and adverse health outcomes, which often result in emergency room visits.

Adventist HealthCare Physical Health & Rehabilitation is committed to providing access to quality patient care. As a member of Adventist HealthCare, we are the only specialty provider of inpatient rehabilitation care in the county. We are also CARF accredited for our Amputee, Brain Injury, Spinal Cord and Stroke programs, which indicates that our programs and services have demonstrated that they substantially meet internationally recognized standards of care.

In addition to our inpatient care, we also offer support groups for our patients and their families as they return to their lives outside of our facility. Our support groups, which include amputee, brain injury, aphasias, and Parkinson's, in addition to cognitive game nights, a cultural diversity group, and a Spanish language brain injury support group, meet monthly and are open to all of our patients.

In providing this care, our expenses outweigh the revenue associated with providing the care detailed above. Accordingly, to provide a continuum of quality care and narrow the gap in availability of providers to the uninsured / underinsured, we subsidize our physician practices.

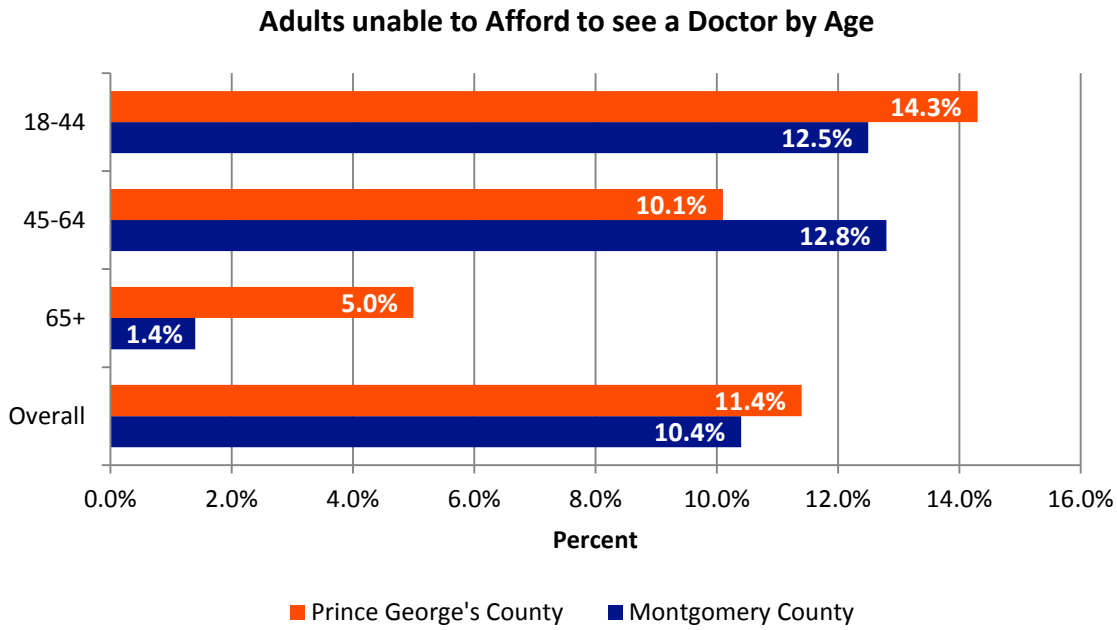


Figure 26. Percentage of Adults unable to Afford to see a Doctor by Age, Montgomery & Prince George's Counties, 2014 (www.HealthyMontgomery.org; www.pgchealthzone.org)

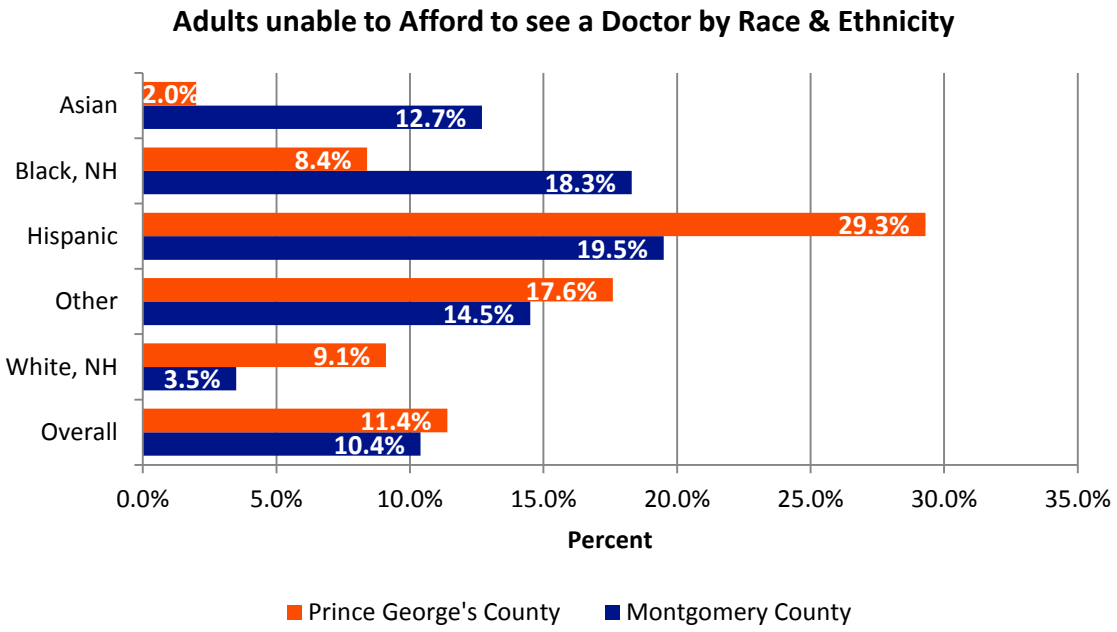


Figure 27. Percentage of Adults unable to Afford to see a Doctor by Race & Ethnicity, Montgomery & Prince George's Counties, 2014 (www.HealthyMontgomery.org; www.pgchealthzone.org)

2. **If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	Amount	Explanation of Need for Service
Hospital-Based physicians	$0.00	N/A
Non-Resident House Staff and Hospitalists	$70,337	As the only non-acute inpatient rehabilitation hospital in Montgomery County, the services our physicians provide are critical to meeting patient demand in Montgomery and surrounding counties, especially those with needs for inpatient/outpatient physical therapy, occupational therapy, and speech therapy.
Coverage of Emergency Department Call	$0.00	N/A
Physician Provision of Financial Assistance	$0.00	N/A
Physician Recruitment to Meet Community Need	$444,184	Our recruitment of quality physicians is in direct response to patient need for our therapy services, both on the inpatient and outpatient spectrum. We actively recruit physicians who specialize in physical therapy, occupational therapy and speech therapy. This furthers our mission of demonstrating God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	$0.00	N/A

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
- besides English, in what language(s) is the Patient Information sheet available;
- 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 Rehabilitation is committed to providing medically necessary health care services for all patients admitted to our facility. Inpatient and outpatient rehabilitation services are provided to all patients regardless of their individual ability to pay for such services. For those patients without medical insurance or personal resources, Adventist Rehab has a Financial Assistance Policy that they may be eligible to receive. Adventist HealthCare Rehabilitation 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. The Financial Assistance Policy as well as the Patient Information Sheet is available in both English and Spanish.

Prior to admission, a nurse liaison reviews each case. If it is determined that a patient does not have the financial means to pay for their services the patient is reviewed for eligibility for Medical Assistance by an outside contractor experienced in qualifying patients for Medicaid and other governmental programs. Patients are also informed about the Hospital Financial Assistance Policy. Applications are reviewed for approval in accordance with the Adventist HealthCare Financial Assistance Policy.

Upon admission, a disclosure statement is reviewed with each patient that explains how their hospital costs will be covered. Any out of pocket expenses are reviewed with the patient as well.

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 Rehabilitation is committed to providing medically necessary health care services for all patients admitted to our facility. Inpatient and outpatient rehabilitation services are provided to all patients regardless of their individual ability to pay for such services. For those patients without medical insurance or personal resources, Adventist Rehab has a Financial Assistance Policy that they may be eligible to receive. The Policy is designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs.

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

(Formerly known as Charity Care Policy)

Effective Date	01/08	Policy No:	AHC 3.19.0
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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

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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%

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

(Formerly known as Charity Care Policy)

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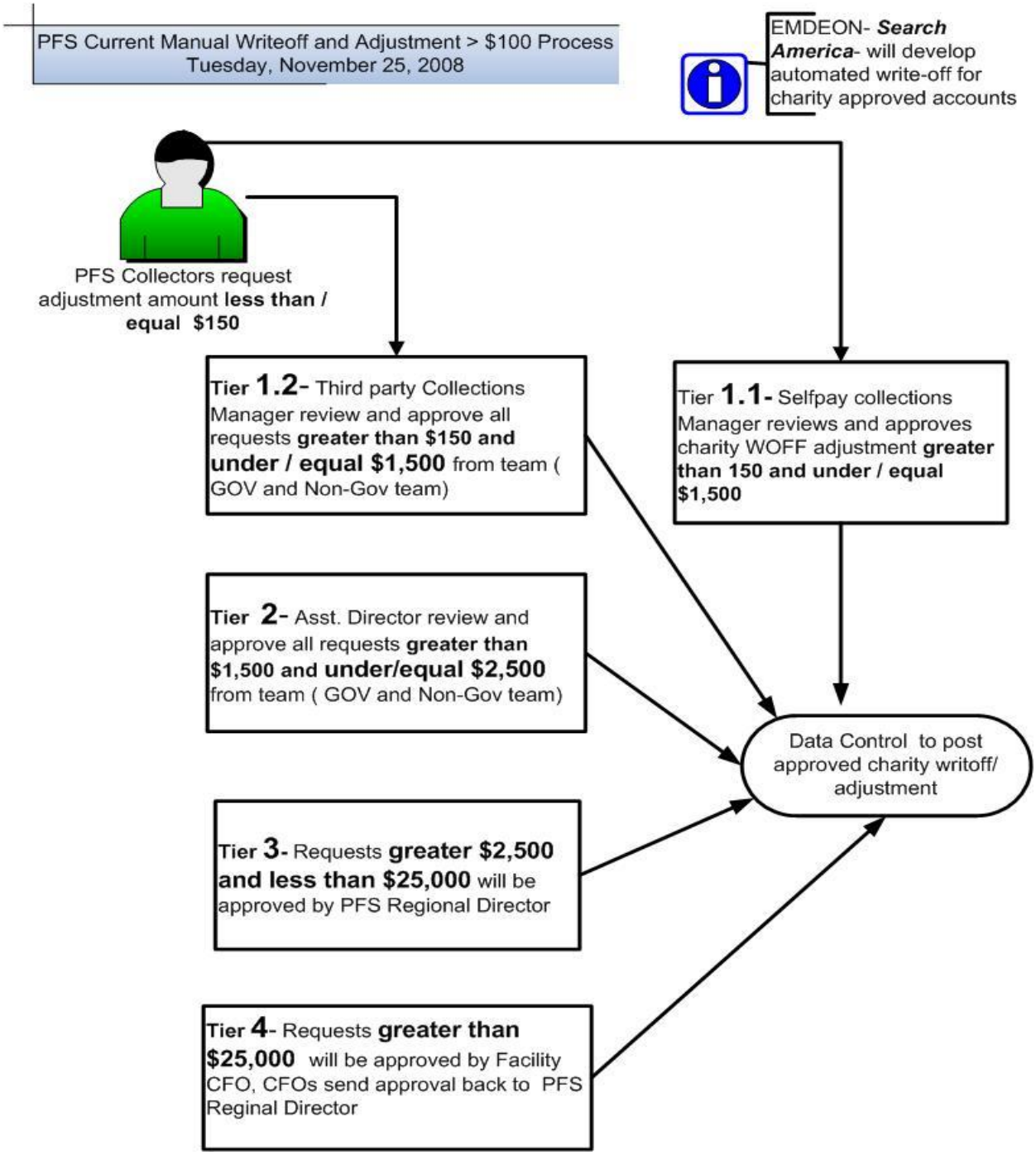

Appendix IV

Patient Information Sheet

Maryland Hospital Patient Information

Hospital Financial Assistance Policy

Adventist Healthcare Physical Health and Rehabilitation is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. This hospital provides care to all patients regardless of their ability to pay.

In compliance with Maryland law, Adventist Healthcare Physical Health and Rehabilitation 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.

Adventist Healthcare Physical Health and Rehabilitation 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 speak with a Patient Access representative for a referral.

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

Maryland Hospital Información para el paciente

Política de Asistencia Financiera del Hospital

Salud Adventista Salud Física y Rehabilitación está comprometida a satisfacer las necesidades de atención médica de su comunidad a través de un ministerio de sanación física, mental y espiritual. Este hospital proporciona atención a todos los pacientes independientemente de su capacidad de pago.
En cumplimiento con la ley de Maryland, Adventist Healthcare Physical Health and Rehabilitation tiene un Política y programa de asistencia financiera. Es posible que tenga derecho a recibir servicios hospitalarios de costo gratuito o a costo reducido. Esta facilidad excede la ley de Maryland proporcionando asistencia financiera basada en la necesidad del paciente, nivel de ingresos, tamaño de la familia y recursos financieros. La información sobre la política y el programa de asistencia financiera se puede obtener de cualquier Representante de Acceso a Pacientes y de la Oficina de Facturación.

Derechos de los pacientes

Como parte de la misión de Adventist HealthCare, los pacientes que cumplan con los criterios de asistencia financiera pueden recibir asistencia del hospital para pagar su factura.
Los pacientes también pueden ser elegibles para Maryland Medical Assistance - un programa financiado conjuntamente por gobiernos estatales y federales. Este programa paga el costo total de la cobertura de atención médica para individuos de bajos ingresos que cumplan con criterios específicos (ver información de contacto a continuación). Los pacientes que creen que han sido referidos erróneamente a una agencia de recaudación tienen el derecho de solicitar asistencia del hospital.

Obligaciones de los pacientes

Los pacientes con la capacidad de pagar su factura tienen una obligación
Para pagar el hospital de manera oportuna. Salud Adventista Salud Física y Rehabilitación hace todo lo posible para facturar correctamente cuentas de pacientes. Los pacientes tienen la responsabilidad de proporcionar información demográfica y de seguro correcta. Los pacientes que crean que pueden ser elegibles para recibir asistencia bajo la política de asistencia financiera del hospital, o que no pueden pagar la factura en su totalidad, deben comunicarse con un Consejero Financiero o
El Departamento de Facturación (ver información de contacto a continuación). Al solicitar asistencia financiera, los pacientes tienen la responsabilidad de proporcionar información precisa,
Completar la información financiera y notificar al Departamento de Facturación
Si su situación financiera cambia. Los pacientes que no cumplan con sus obligaciones financieras pueden ser referidos a una agencia de cobro.

Información del contacto

Para hacer los arreglos de pago de su factura, por favor llame al (301) 315-3660 para ayuda.

Para solicitar asistencia con su factura, llame a la Oficina de Facturación al (301) 315-3660.

Para informarse sobre la Asistencia Médica, por favor hable con un representante de Paciente para una referencia.

**** Nota: Los servicios médicos proporcionados durante su estancia no se incluyen en el estado de cuenta del hospital y se facturarán por separado.***

Appendix V

Hospital Mission, Vision, and Value Statements

Vision

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.

Mission

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

Values

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.