COMMUNITY BENEFIT NARRATIVE

Effective for FY2017 Community Benefit Reporting

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, MD 21215

December 15, 2017

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 (CY2016):	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients (CY2016):	Percentage of the Hospital's Patients who are Medicaid Recipients (CY2016):	Percentage of the Hospital's Patients who are Medicare Beneficiaries (CY2016):
232	11,838	20783 20782 20912 20903 20901 20904 20910 20740 20737 20706 20705	**Prince George's Hospital Center** 20706, 20737 **Holy Cross of Silver Spring** 20904, 20910, 20901, 20783, 20903, 20705, 20706, 20782, 20912, 20740 **Medstar Montgomery General** 20904 **Suburban Hospital** 20904, 20910	17.5% of overall patients were uninsured. Of these patients: 8.35% were from PG County 6.63% were from Montgomery County 2.18% were from outside of Maryland *Source: review of hospital discharge data*	27.7% *Source: review of hospital discharge data*	22.0% *Source: review of hospital discharge data*

			Union of Cecil County 20740, 20910, **Doctors Community Hospital** 20706, 20737 **Greater Laurel Hospital** 20705, 20904, 20706, 20740			

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

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

County	Percentage
Prince George's	46.33%
Montgomery	40.80%
District of Columbia	5.23%

Figure 1. Washington Adventist Hospital discharges by county, 2015

Approximately 85.0 percent of discharges come from our Total Service Area, which is considered Washington Adventist Hospital's Community Benefit Service Area "CBSA" (see Figure 2). Within that area, 60.0 percent of discharges are from the Primary Service Area including the following zip codes/cities:

20737 – Riverdale, 20740 – College Park, 20782 – Hyattsville, 20783 – Hyattsville, 20901 – Silver Spring, 20902 – Silver Spring, 20903 – Silver Spring, 20904 – Siler Spring, 20906 – Silver Spring, and 20910 – Silver Spring, 20912 – Takoma Park, and 88888 – Homeless.

We draw 25.0 percent of discharges from our Secondary Service Area including the following zip codes/cities:

20002 – Washington, 20011 – Washington, 20012 – Washington, 20705 – Beltsville, 20706 – Lanham, 20707 – Laurel, 20708 – Laurel, 20710 – Bladensburg, 20712 – Mount Rainier, 20720 – Bowie, 20721 – Bowie, 20722 – Brentwood, 20743 – Capitol Heights, 20747 – District Heights, 20770 – Greenbelt, 20774 – Upper Marlboro, 20781 – Hyattsville, 20784 – Hyattsville, 20785 – Hyattsville, 20850 – Rockville, 20853 – Rockville, 20866 – Burtonsville, 20874 – Germantown, and 20905 – Silver Spring (see Figure 2).

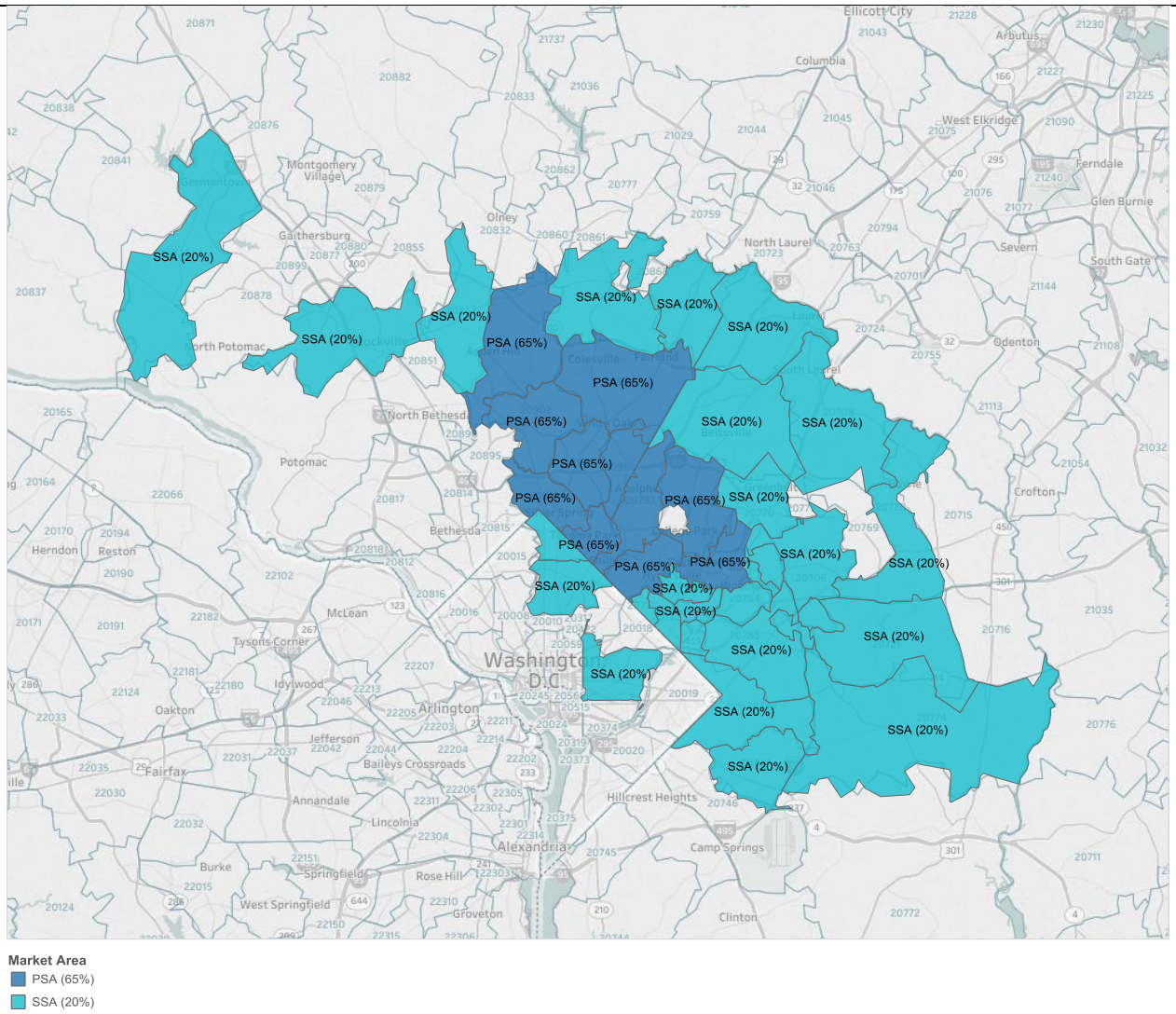

Figure 2. Map of Washington Adventist Hospital's Primary and Secondary Service Areas based on 2015 inpatient discharges

There are many different factors that can impact health which can include, but aren't limited to: education, the physical environment (e.g. availability of healthcare services and grocery stores), and income. Income can be considered a large barrier to health and wellness as income can affect a family's ability to pay for necessities such as 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. Over 100,000 deaths in the U.S. can be prevented annually if individuals receive the recommended clinical preventative care[1]. A study by the CDC on the relationship between income and healthcare coverage found that a majority of adults are not receiving recommended clinical preventative care; however, those with insurance are more likely to receive care than the uninsured while individuals with higher

[1] Fox, J. B., & Shaw, F. E. (2014). Relationship of Income and Health Care Coverage to Receipt of Recommended Clinical Preventive Services by Adults — United States, 2011–2012. *Morbidity and Mortality Weekly Report (MMWR),63*(61), 666-670. Retrieved December 16, 2016, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6331a2.htm.

income are most likely to receive recommended preventative care.[2] Therefore, the criteria used to identify vulnerable populations within Washington Adventist Hospital's CBSA are median household income and insurance status (see Figure 3).

Washington Adventist Hospital CBSA			
Location	**Zip Codes**	**Median Household Income (2015)**	**Percent Uninsured (2015)**
District of Columbia	20002	$74,303	6.60%
	20011	$62,281	10.70%
	20012	$80,991	6.30%
	Overall	$70,848	5.80%
Montgomery County	20850	$107,170	7.10%
	20853	$100,965	11.50%
	20866	$101,358	10.60%
	20874	$81,769	11.40%
	20901	$97,454	14.20%
	20902	$85,044	19.60%
	20903	$58,342	30.80%
	20904	$72,458	13.40%
	20905	$116,141	9.10%
	20906	$71,423	16.50%
	20910	$77,986	7.70%
	20912	$69,721	16.00%
	Overall	$99,435	10.30%
Prince George's County	20705	$74,022	14.20%
	20706	$70,754	15.40%
	20707	$75,742	11.70%
	20708	$64,134	13.50%
	20710	$42,226	19.60%
	20712	$47,048	25.80%
	20720	$133,641	5.30%
	20721	$120,994	5.80%
	20722	$60,900	21.90%
	20737	$56,672	27.80%
	20740	$59,633	10.90%
	20743	$57,671	12.60%
	20747	$60,421	9.70%
	20770	$62,909	16.00%
	20774	$93,216	7.60%
	20781	$67,000	24.20%
	20782	$64,562	21.70%
	20783	$60,958	38.70%
	20784	$58,564	19.00%

[2] Fox, J. B., & Shaw, F. E. (2014). Relationship of Income and Health Care Coverage to Receipt of Recommended Clinical Preventive Services by Adults — United States, 2011–2012. *Morbidity and Mortality Weekly Report (MMWR),63*(61), 666-670. Retrieved December 16, 2016, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6331a2.htm.

	20785	$60,883	13.70%
	Overall	$74,260	13.80%
Homeless*	88888	N/A	N/A
Maryland	*Overall*	$74,551	9.00%

*Note: Household income by zip code values are compared to the overall county median household income.
Income: Green indicates the location's income is equal to or above the county value. Red indicates the location's income is below the county value (i.e. a potentially vulnerable population.)
Insurance status: Green indicates the location's uninsured percentage is below the county value. Red indicates the location's uninsured percentage is above the county value (i.e. more uninsured without the zip code location than the county overall.)
*Homeless data unavailable; refer to Section: *Social Determinants of Health, Housing*

Figure 3. Median household income and percentage uninsured by zip code, 2015
(Source: Median Household Income in the Past 12 Months 15 ACS 5-Year Estimates; Selected Characteristics of Health Insurance Coverage 2015 ACS 5-Year Estimates)

Median Household Income within the CBSA

Median Household Income
Montgomery County: $99,763
Prince George's County: $79,184
Source: US Census Bureau, 2016 1-Year ACS Estimates

Household income directly influences a family's ability to pay for healthcare services and health insurance. Throughout the CBSA of Adventist HealthCare Washington Adventist Hospital and across racial and ethnic groups, Hispanics and Blacks have the lowest household income while non-Hispanic whites have the highest. However, in the state of Maryland overall, Asians have the highest median household income (see Figure 4).

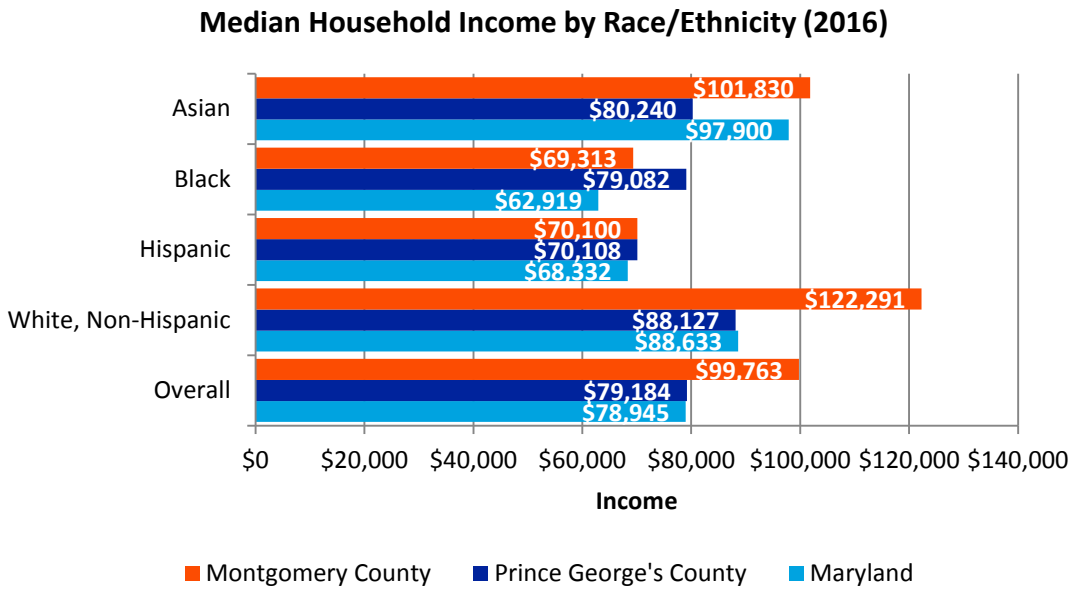

Figure 4. Median Household Income, Prince George's County, Montgomery County, and Maryland by Race and Ethnicity 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

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

Overall, the state of Maryland experienced the highest percentage of residents living below the poverty level (9.7 percent) while Prince George's County experienced the least (6.7 percent). However, income disparities are evident when broken down by racial and ethnic groups. Asians make up the highest percentage of residents living below the poverty level (12.3 percent) in Prince George's County while there are more Hispanics living below the poverty level in Montgomery County (10.7 percent). The fewest number of residents living below the poverty level is seen among whites in Montgomery County (5.3 percent) compared to Blacks in Prince George's County (8.6 percent) (see Figure 5).

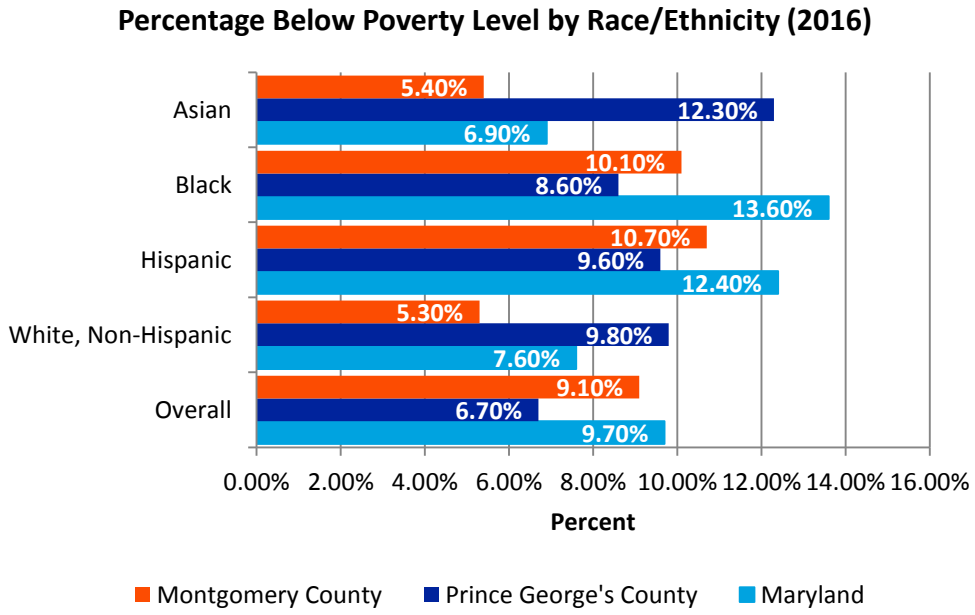

Figure 5. Poverty Status by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

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

Approximately 6.5 percent of all civilian non-institutionalized Montgomery County residents and 10.3 percent of Prince George's County residents are uninsured. In comparison, 6.1 percent of Maryland residents overall are uninsured (see figure 6).

Throughout Montgomery County, Prince George's County, and Maryland, whites are uninsured at lower rates than other racial groups. Hispanics are uninsured at significantly higher rates in both Montgomery (19.1 percent) and Prince George's Counties (28.7 percent) compared to all other racial and ethnic groups. Asians have the second highest rates of uninsured residents (Montgomery County: 10.2 percent; Prince George's County: 6.5 percent) (see Figure 6).

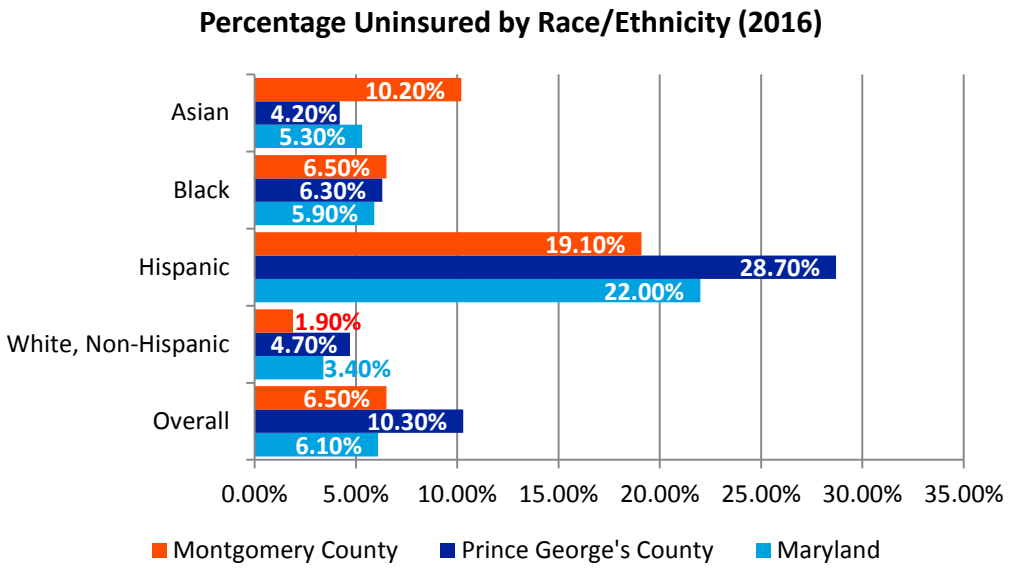

Figure 6. Percentage uninsured by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

Percentage of Medicaid recipients by County within the CBSA.

Percentage of Medicaid Recipients by County within the CBSA:
Montgomery County: 10.2% (105,935)
Prince George's County: 15.7% (141,765)
Source: U.S. Census Bureau, 2016 1-Year ACS Estimates

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

According to the Maryland Department of Health's 2015 Vital Statistics Report, Montgomery County residents have a the higher life expectancy (84.6 years) than Prince George's County residents (79.9 years). The life expectancy of all Maryland residents overall is 79.7 years. Whites have a higher life expectancy in Montgomery County (84.5 percent), Prince George's County (80.5 percent), and Maryland (80.3 percent) than Blacks (see Figure 7).

Life Expectancy	Montgomery County (in years)	Prince George's County (in years)	Maryland (in years)
Overall	84.6	79.9	79.7
Race/Ethnicity			
Black	82.7	79.3	77.3
White	84.4	80.5	80.3

Figure 7. Percentage uninsured by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland 2013-2015
(Source: Maryland Department of Health, *Maryland Vital Statistics Annual Report 2015*)

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 630 per 100,000 population in Prince George's County. These rates are lower than the mortality rate for Maryland overall (786.4 per 100,000). Non-Hispanic whites have the highest death rates in both counties and the state of Maryland overall while Hispanics have the lowest rates (see figure 8).

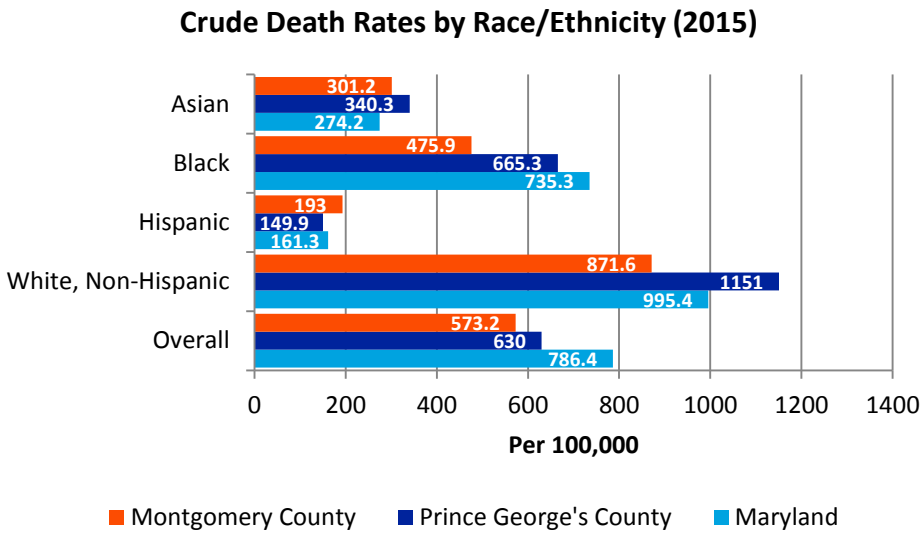

Figure 8. Crude Death Rate by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland, 2015
(Source: Maryland Department of Health, *Maryland Vital Statistics Annual Report 2015*)

Infant Mortality Rate

In 2015, Montgomery County had lower infant mortality rates (5.3 per 1,000 live births) than both Prince George's County (8.9 per 1,000 live births) and Maryland (6.7 per 1,000 live births). Blacks in Montgomery County, Prince George's County and the state overall are disproportionally affected by high infant mortality rates compared to all other racial and ethnic groups. The highest rate of infant deaths is among Blacks for Montgomery County (8.1 per 1,000 live births), Prince George's County (13.2 per 1,000 live births), and Maryland (11.3 per 1,000 live births). Overall, the lowest infant mortality rates are among non-Hispanic whites (see Figure 9).

Infant Mortality Rates by Race and Ethnicity (2015)			
Race/Ethnicity	**Maryland**	**Prince George's County**	**Montgomery County**
Overall	6.7	8.9	5.3
White, Non-Hispanic	4	*	2.2
Hispanic	4.4	2.6	7.5
Black	11.3	13.4	8.1
Asian	4.6	*	4
*Rates based on <5 events are not presented			

Figure 9. Infant Mortality Rates by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland, 2015)
(Source: Maryland Department of Health, Maryland Vital Statistics Annual Report 2015)

Access to Healthy Food

Healthy Eating Behaviors

In Maryland, 72.4 percent of adults consume less than five servings of fruits and vegetables daily. This proportion is higher than the Prince George's County average of 70.7 percent. Montgomery County has the lowest proportion of adults not consuming at least five servings of fruits and vegetables each day (66.7 percent) (see Figure 10).

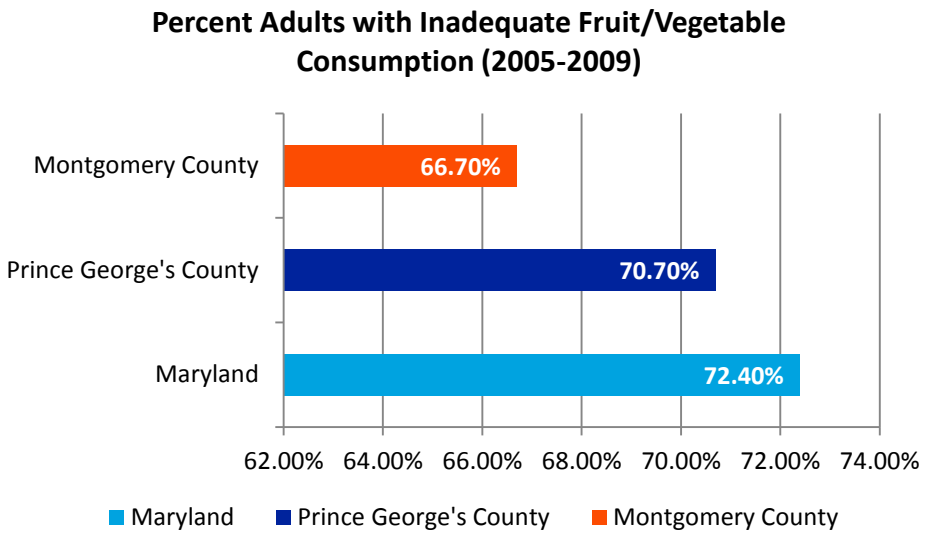

Figure 10. Adults Consuming Less than 5 Servings of Fruits and Vegetables Each Day, Prince George's County, Montgomery County, and Maryland
(Source: Community Commons, Community Health Needs Assessment, 2005-2009)

Fruit and vegetable consumption also varies by race and ethnicity. Blacks (32.5 percent) are more likely to consume fruits and vegetable at least five times a day than whites (28.6 percent) in Prince George's County whereas whites (33 percent) are more likely to consume more fruits and vegetables than Blacks (25.8 percent) in Montgomery County (see Figure 11).

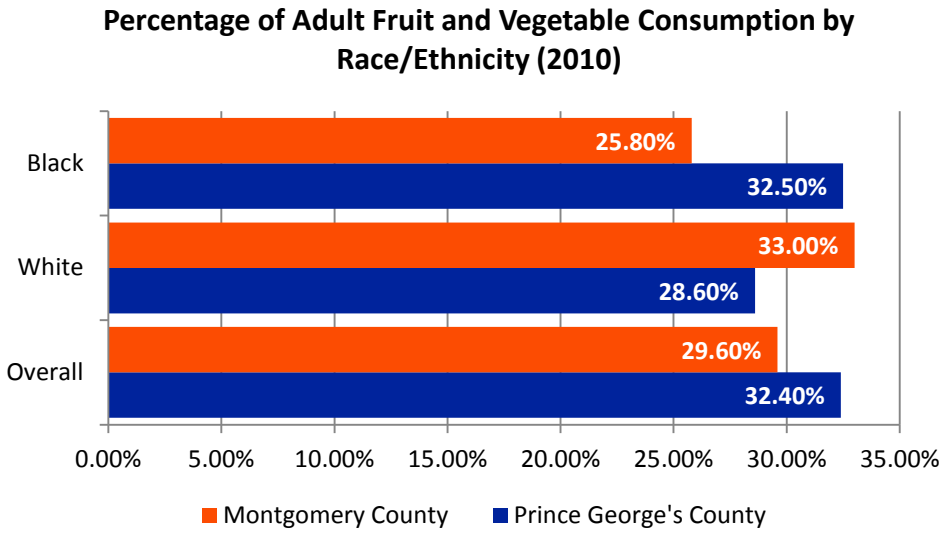

Figure 11. Percentage of Adults Consuming at Least Five or More Times a Day, Prince George's County and Montgomery County, 2010
(Source: Healthy Montgomery, 2017 & PGC Health Zone, 2017)

Food Insecurity Rates

Food insecurity is the USDA's measure for the lack of access to food necessary for a healthy life, and limited or uncertain availability of nutritionally sufficient foods.[3] In 2015, 14.4 percent of Prince George's County experienced food insecurity which is more than twice as much as the food insecurity rate in Montgomery County (6.3 percent). Although lower than Prince George's County, the state of Maryland still experienced food insecurity rates (11.4 percent) higher than that of Montgomery County.

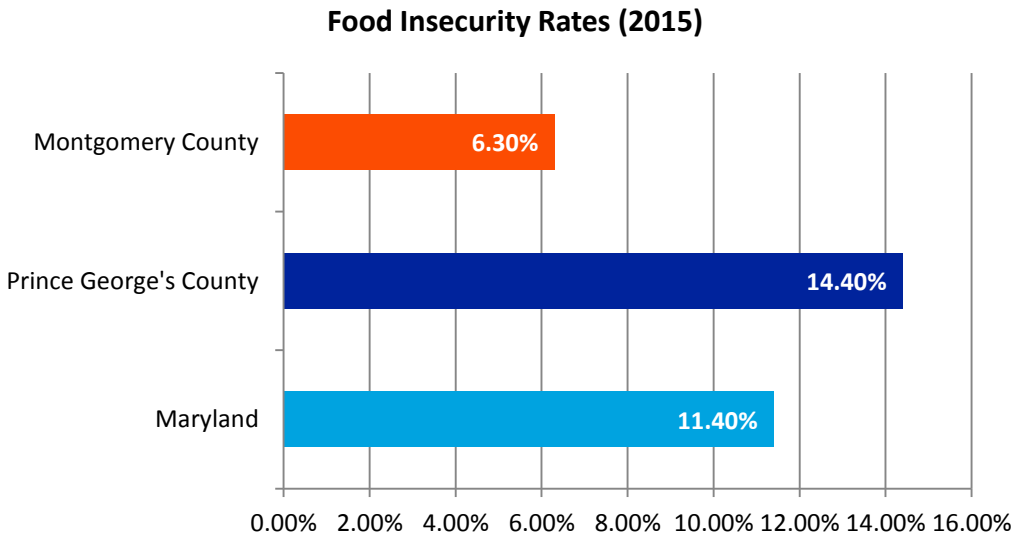

Figure 12. Food Insecurity Rates, Prince George's County, Montgomery County, and Maryland, 2015
(Source: Feeding America, *Map the Meal Gap*, 2015)

Healthy Food Access

A measure of healthy food access and of the environmental influences on healthy behaviors is access to grocery stores. Grocery stores, supermarkets and other similar food retailers serve as sources of fresh and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. The state of Maryland overall has 21.39 grocery stores per 100,000 population and Montgomery County has a similar rate of 21.1 grocery stores per 100,000 population. However, Prince George's County has a slightly lower rate of 18.3 grocery stores per 100,000 population (see Figure 13).

[3] Feeding America (2017). Map the Meal Gap. Retrieved from: http://map.feedingamerica.org

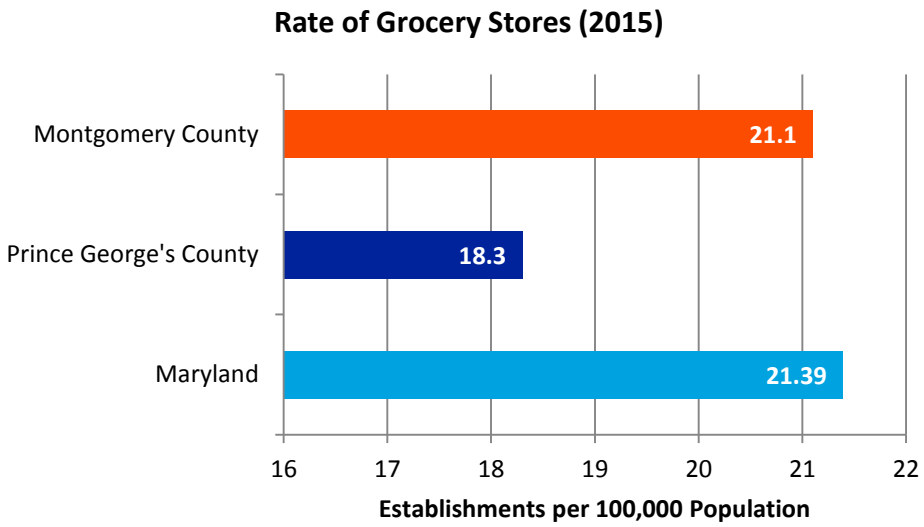

Figure 13. Number of Grocery Stores per 100,000 Population, Prince George's County, Montgomery County, and Maryland, 2015
(Source: Community Commons, Community Health Needs Assessment, 2015)

Access to fast food restaurant options has increased nationwide over the past few years to fulfill a niche for cheap and fast dining options despite often providing unhealthy foods. In 2015, there were 86.6 fast food restaurants per 100,000 population in Maryland. Prince George's County had more fast food restaurants at 88.6 establishments per 100,000 population. However, Montgomery County has fewer fast food restaurants than both Prince George's County and the state of Maryland overall at 82.32 establishments per 100,000 population (see Figure 14).

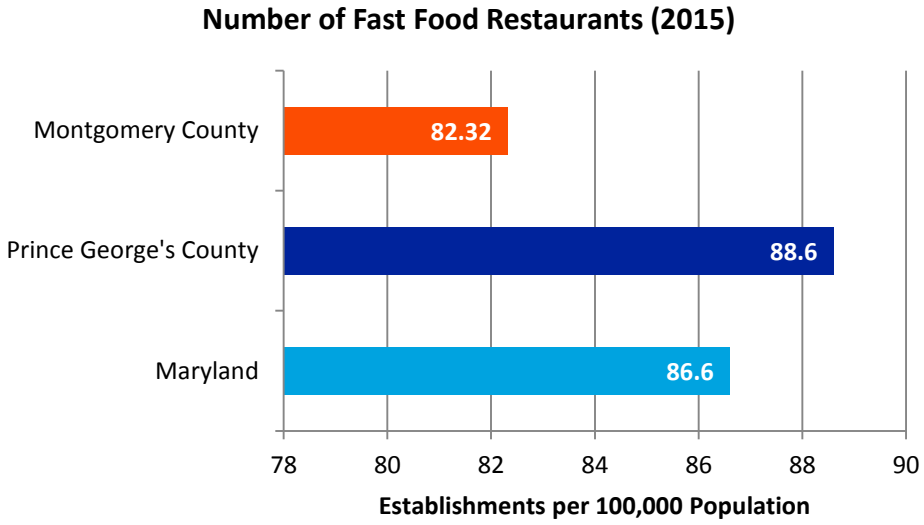

Figure 14. Number of Fast Food Restaurants per 100,000 Population, Prince George's County, Montgomery County, and Maryland 2015
(Source: Community, Commons, Community Health Needs Assessment, 2015)

Transportation

The majority of residents in both Montgomery and Prince George's Counties drive alone to work (65.3 percent and 65.5 percent, respectively), or utilize public transportation (15.5 percent and 15.6 percent, respectively) (see Figure 15).

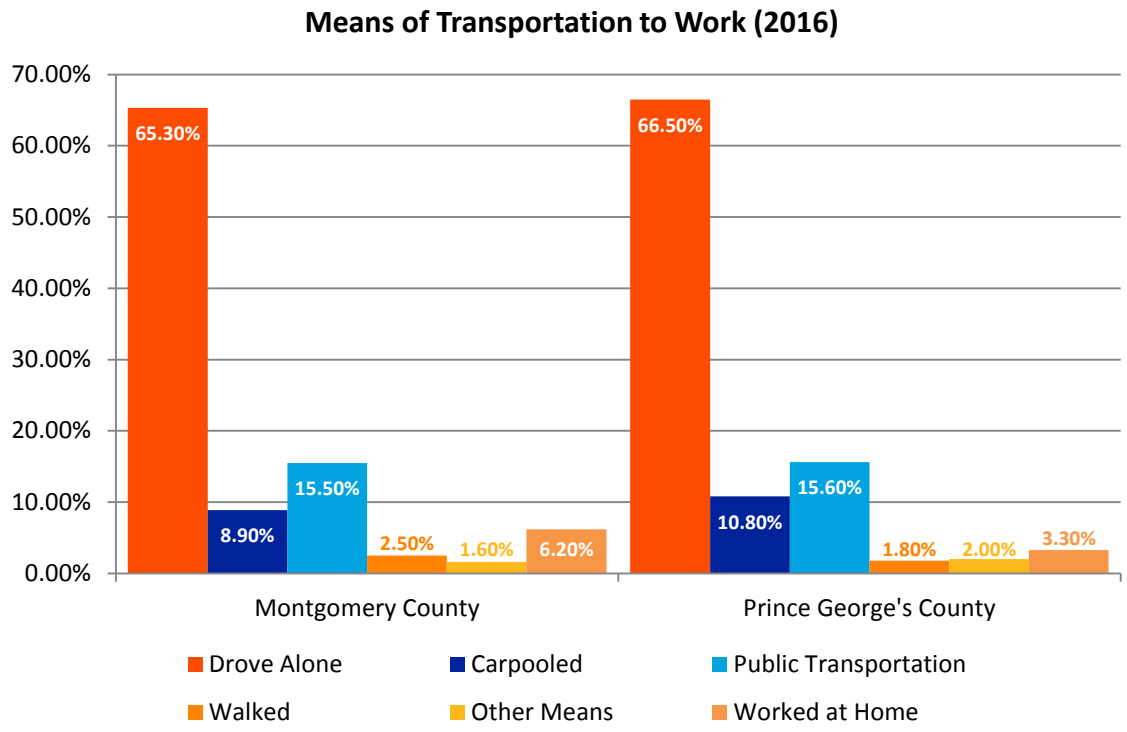

Figure 15. Means of Transportation to Work, Prince George's and Montgomery Counties, 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

The mean travel time to work for all residents in Montgomery County is about 34.5 minutes while the mean travel time for all Prince George's County residents is 36.5 minutes (see Figure 16).

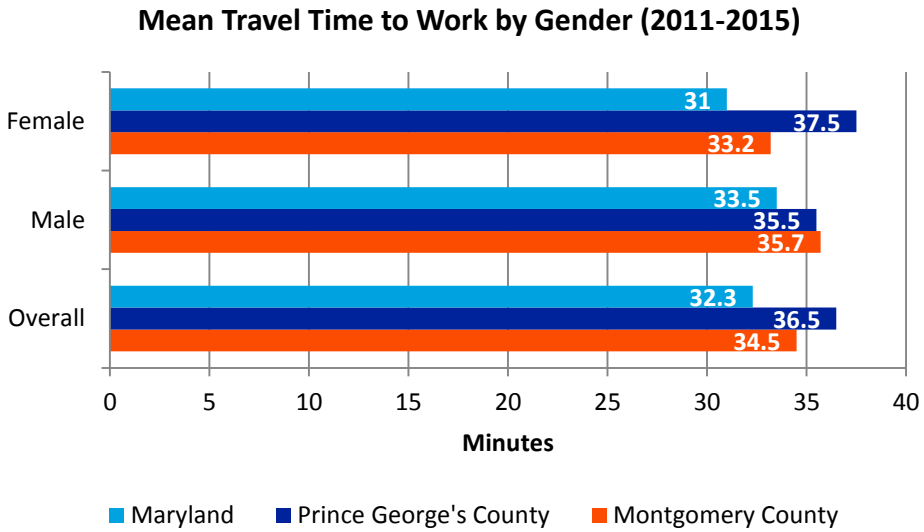

Figure 16. Mean Travel Time to Work by Gender, Prince George's County, Montgomery County, and Maryland, 2011-2015
(Source: Healthy Montgomery, 2017, PGC HealthZone, 2017)

Pedestrian Safety

The 2015 rate of pedestrian injuries in both Montgomery and Prince George's Counties are the same at 43.4 injuries per 100,000 population. The rate of pedestrian injuries for both counties has increased from 2014 as well (see Figure 17).

County	SHIP Objective	SHIP 2013 County Measure	SHIP 2014 County Measure	SHIP 2015 County Update	SHIP 2015 Maryland Update	Maryland SHIP 2017 Target
Montgomery	Reduce rate of pedestrian injuries	35.6	41.4	43.4	47.1	35.6
Prince George's		37.2	39.8	43.4		

Figure 17. Rate of Pedestrian Injuries per 100,000 Population, Prince George's County, Montgomery County, and Maryland, 2015 (Source: Maryland, SHIP, 2015)

The pedestrian death rate in Montgomery County has steadily increased from 2012 from 7 deaths in 2012 to 16 deaths in 2015 (see Figure 18-A). Comparatively, the pedestrian death rate in Prince George's County decreased from 24 deaths to 21 deaths in 2015 despite a sharp increase (30 deaths) in 2014 (see Figure 18-B). The traffic fatalities among occupants of all vehicle types in Prince George's County in 2015 (75 deaths) is more than double the number of traffic of fatalities among occupants of all vehicle types in Montgomery County (31 deaths) (see Figures 18-A and 18-B).

From 2012 to 2014, non-Hispanic white individuals in Montgomery County experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (see Figure 18-A).

Montgomery County Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
	Hispanic	2	5	4	1
	White Non-Hispanic	11	12	13	15
	Black, Non-Hispanic	7	6	4	6
	Asian, Non-Hispanic/Unknown	0	0	0	1
	All Other Non-Hispanic or Race	3	3	4	3
	Unknown Race and Unknown Hispanic	7	1	3	5
Occupants (All Vehicle Types)	**Total**	**30**	**27**	**28**	**31**
	Hispanic	0	1	1	0
	White Non-Hispanic	4	6	4	4
	Black, Non-Hispanic	2	4	1	5
	Asian, Non-Hispanic/Unknown	0	1	1	0
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	1	1	4	7
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	**Total**	**7**	**13**	**11**	**16**
Total	Hispanic	2	6	5	1

	White, Non-Hispanic	15	18	17	19
	Black, Non-Hispanic	9	10	5	11
	Asian, Non-Hispanic/Unknown	0	1	1	1
	All Other Non-Hispanic or Race	3	3	4	3
	Unknown Race and Unknown Hispanic	8	2	7	12
	Total	**37**	**40**	**39**	**47**

Figure 18-A. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Prince George's County Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
Occupants (All Vehicle Types)	Hispanic	5	7	3	0
	White Non-Hispanic	7	8	8	13
	Black, Non-Hispanic	36	35	47	35
	All Other Non-Hispanic or Race	0	3	1	6
	Unknown Race and Unknown Hispanic	15	17	9	21
	Total	**63**	**70**	**68**	**75**
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	1	0	4	0
	White Non-Hispanic	4	1	6	4
	Black, Non-Hispanic	14	10	12	6
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	5	6	8	11
	Total	**24**	**17**	**30**	**21**
Total	Hispanic	6	7	7	0
	White Non-Hispanic	11	9	14	17
	Black, Non-Hispanic	50	45	59	41
	All Other Non-Hispanic or Race	0	3	1	6
	Unknown Race and Unknown Hispanic	20	23	17	32
	Total	**87**	**87**	**98**	**96**

Figure 18-B. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Maryland Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
Occupants (All Vehicle Types)	Hispanic	20	22	14	1
	White Non-Hispanic	234	192	176	203
	Black, Non-Hispanic	90	83	93	118
	American Indian, Non-Hispanic/Unknown	2	0	1	0

	Asian, Non-Hispanic/Unknown	4	1	1	2
	All Other Non-Hispanic or Race	12	18	10	18
	Unknown Race and Unknown Hispanic	46	32	38	68
	Total	**408**	**348**	**333**	**410**
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	3	5	6	1
	White Non-Hispanic	49	54	57	43
	Black, Non-Hispanic	35	42	27	26
	Asian, Non-Hispanic/Unknown	0	1	1	0
	All Other Non-Hispanic or Race	2	2	0	3
	Unknown Race and Unknown Hispanic	14	13	18	37
	Total	**103**	**117**	**109**	**110**
Total	Hispanic	23	27	20	2
	White Non-Hispanic	283	246	233	246
	Black, Non-Hispanic	125	125	120	144
	American Indian, Non-Hispanic/Unknown	2	0	1	0
	Asian, Non-Hispanic/Unknown	4	2	2	2
	All Other Non-Hispanic or Race	14	20	10	21
	Unknown Race and Unknown Hispanic	60	45	56	105
	Total	**511**	**465**	**442**	**520**

Figure 18-C. Maryland Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Education

Graduation and Educational Attainment

In 2015, 89.83 percent of Montgomery County high school students graduated within four years. The four-year graduation rate for Montgomery County is higher than that of the state (87.61 percent). Despite both Maryland and Montgomery County reaching the Healthy People 2020 high school graduation rate goal of 87 percent[4], Prince George's County (81.44 percent) did not (see Figure 19).

[4] 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

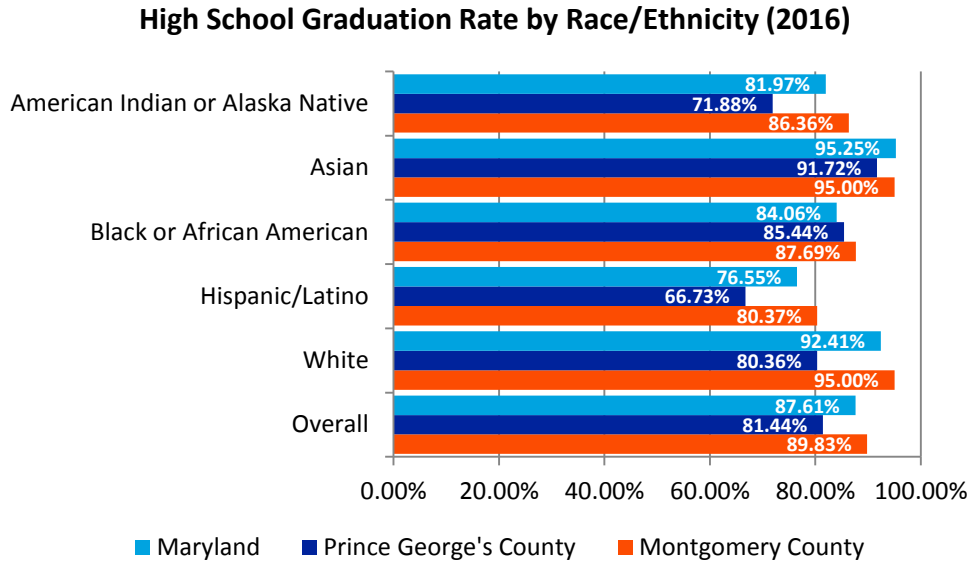

Figure 19. High School Graduation Rates by Race/Ethnicity, Prince George's County, Montgomery County, and Maryland. 2016 (Source: 2017 Maryland Report Card)

Racial and ethnic disparities in education are more evident at the higher level. The overall percentage of adults aged 25+ in Montgomery County with a bachelor's degree or higher is 59.2 percent. This is higher than both the state (39.3 percent) and Prince George's County (31.9 percent). However, when stratified by race and ethnicity, whites have the highest percentage in Montgomery County (71.6 percent), but more Asians over 25 have a bachelor's degree or higher in both Prince George's County (51.8 percent) and Maryland (62.5 percent) (see Figure 20).

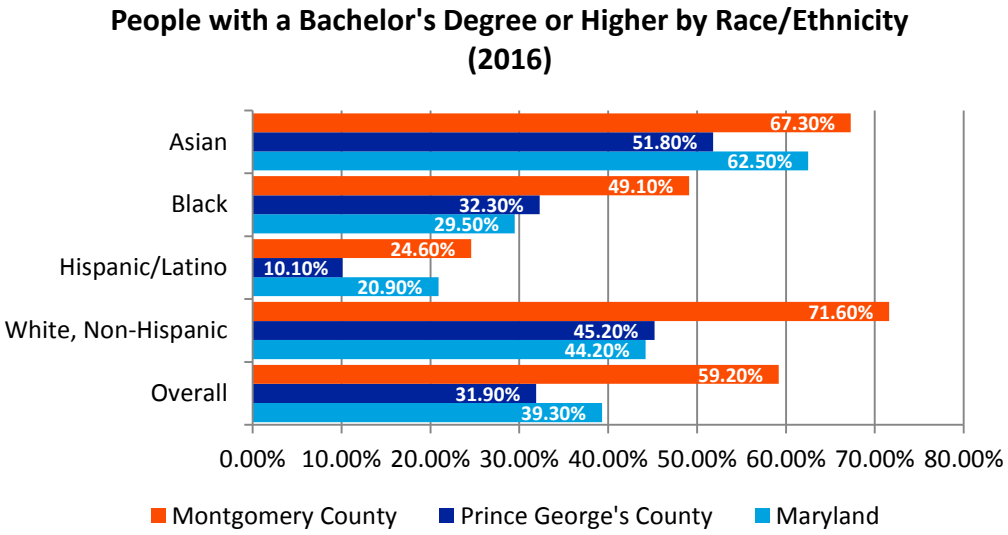

Figure 20. People with a Bachelor's Degree or Higher by Race/Ethnicity, Prince George's County, Montgomery County, and Maryland, 2016 (Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

English and Algebra Proficiency

The Maryland High School Assessment (HSA) indicates that at least 95 percent of white students and 93.6 percent of Asian 12th grade students proficient in English compared to 73.7 percent of Hispanic and about 75 percent of Black students in Montgomery County. There are racial and ethnic disparities among 12th graders in English proficiency in Prince George's County as well as 89.2 percent of white students tested proficient in English compared to 63.6 percent of Hispanic students. More Asian 12th grade students tested proficient in English in the state compared to Black students with the lowest proficiency overall (64.8 percent) (see Figure 21).

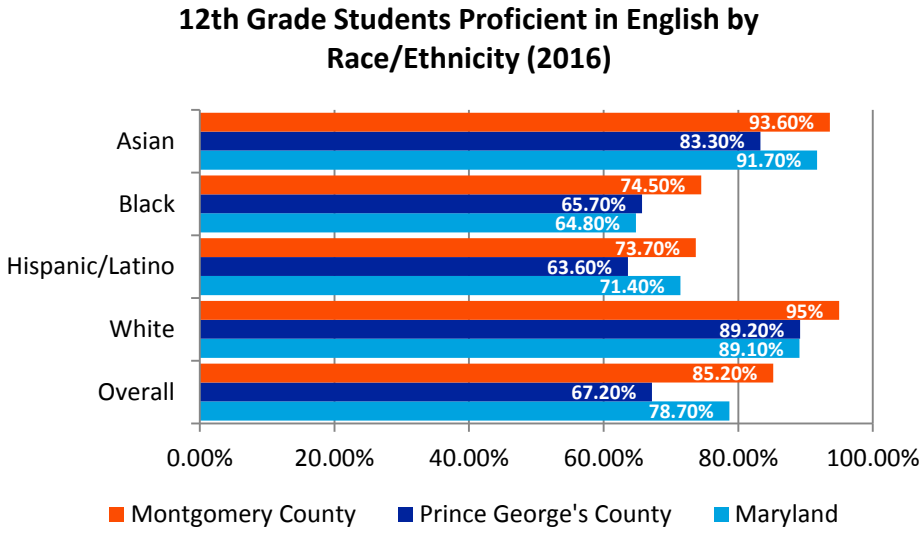

Figure 21. 12th Grade Students Proficient in English by Race/Ethnicity, Prince George's County, Montgomery County, Maryland, 2016 (Source: 2017 Maryland Report Card)

A similar trend can be seen in algebra proficiency among 12th grade high school students. Asians and whites hold the highest algebra proficiency across the board in Montgomery County (95 percent for both), Prince George's County (86.1 percent and 87.7 percent, respectively), and Maryland (95.5 percent and 94.2 percent, respectively). Black students had the lowest proficiency in algebra in both Montgomery County (77.6 percent) and Maryland (69.1 percent) while Hispanic students held the lowest proficiency in Prince George's County (64.8 percent) (see Figure 22).

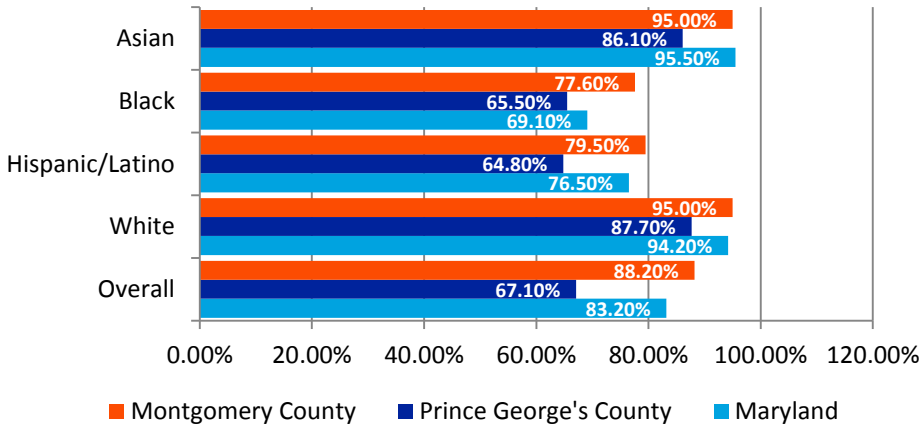

Figure 22. 12th Grade Students Proficient in Algebra by Race/Ethnicity,
Prince George's County, Montgomery County, Maryland, 2016
(Source: 2017 Maryland Report Card)

Readiness for Kindergarten

The percentage of children entering kindergarten ready to learn in Montgomery County increased from 48 percent in 2014 to 49 percent in 2015 and is higher than the overall Maryland readiness score, but significantly lower than the Maryland 2017 target of 85.5 percent readiness. Hispanic children were among those least likely to be prepared for kindergarten in Montgomery County (28 percent) and Prince George's County (22 percent). Asian and white children were more likely to enter kindergarten ready to learn for both counties (see Figure 23).

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	Percentage of children who enter kindergarten ready to learn	34%	38%	Asian–46%; AA-45% Hispanic-22% White-59%	45%	85.5%
Montgomery		48%	49%	Asian–58%; AA-40% Hispanic-28% White-68%		

Figure 23. Percentage of Children Entering Kindergarten Ready to Learn,
Prince George's County and Montgomery County, 2015
Notice: Race/Ethnicity data for 2015 is unavailable
(Source: Maryland SHIP, 2015)

Housing Quality

Housing Quality

The condition of a person's home and neighborhood environment is a crucial determinant of health status. Across the U.S., a disproportionate percentage of minority households experience severe or moderate housing problems. The majority of both severe and moderate housing problems are experienced by American Indians or Alaskan Natives followed by Blacks (see Figure 24).

At the local level, 17 percent of households in Maryland, 17 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 in 2017: overcrowding; high housing costs; and lack of kitchen or plumbing facilities.[5]

[5] University of Wisconsin – Population Health Institute. (2017). Compare counties. *County Health Rankings*. Retrieved from: http://www.countyhealthrankings.org/app/maryland/2017/compare/snapshot?counties=24_031%2024_033

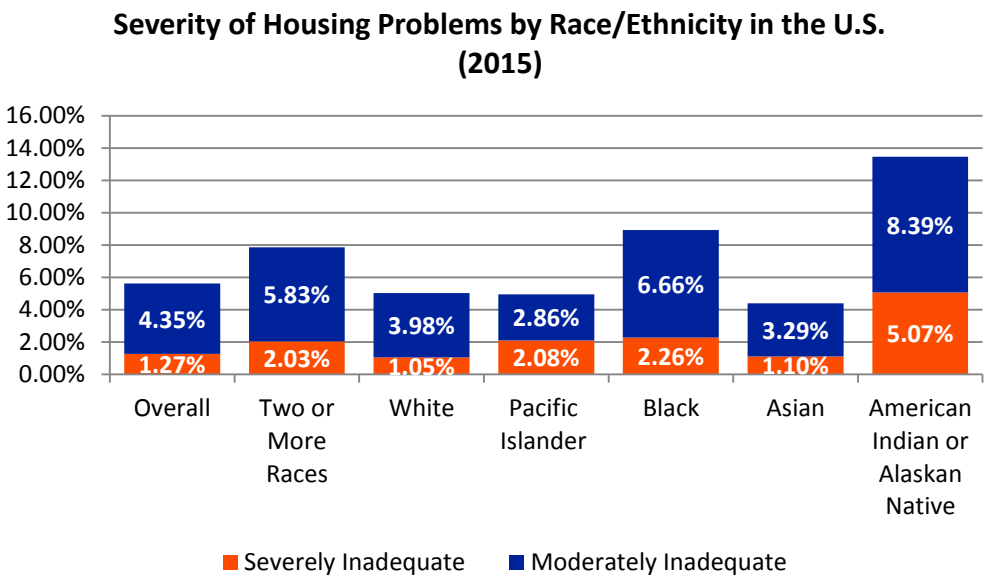

Figure 24. Severity of Housing Problems by Race/Ethnicity in the U.S., 2015
Note: Physical problems include plumbing, heating, electrical and upkeep
(Source: U.S. Census Bureau, American Housing Survey, 2015)

Montgomery County Housing Statistics

- Renters spending 35 percent or more of household income on rent: 50.0 percent
- Homeowner vacancy rate: 0.8 (2015)
- Housing units in multi-unit structures: 34.2 percent
- Housing units: 390,563
- Homeownership rate: 64.7 percent
- Median value of owner-occupied housing units: $474,900 (2015)
  (Source: U.S. Census Bureau, ACS, 2016 1-Year Estimate & U.S. Census Bureau, ACS 2015 1-Year Estimate)
- 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: 49.1 percent (2016)
- Homeowner vacancy rate: 1.7 (2015)
- Housing units in multi-unit structures: 32.7 percent
- Housing units: 332,569
- Homeownership rate: 60.7 percent
- Median value of owner-occupied housing units: $272,200 (2015)
  (Source: U.S. Census Bureau, ACS, 2016 1-Year Estimate & U.S. Census Bureau, ACS 2015 1-Year Estimate)
- 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.

A Point-in-Time Enumeration survey by the Metropolitan Washington Council on Governments indicates a steady decrease in homeless people in Montgomery and Prince George's Counties from 2015 through 2017 (see Figure 25). Montgomery County had the third largest reduction in the number of persons experiencing homelessness from 2016 to 2017[6].

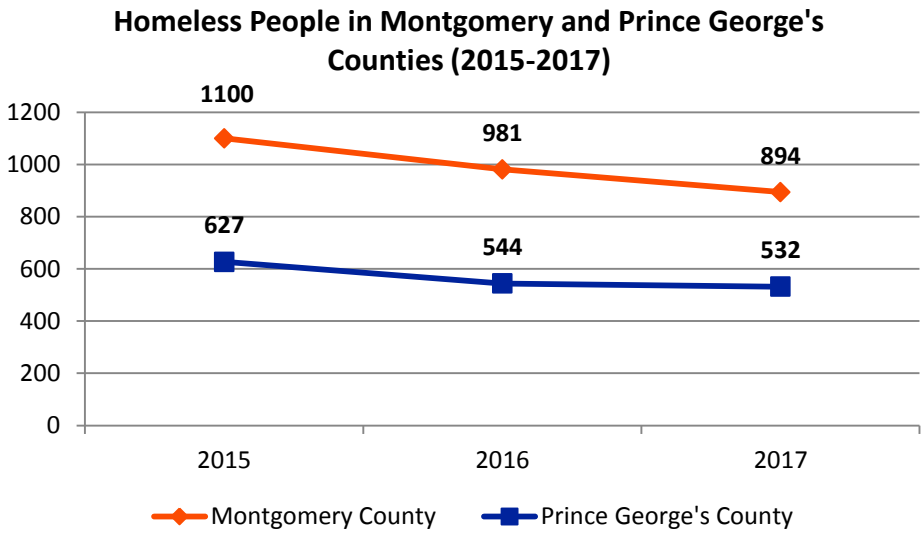

Figure 25. Number of Homeless People in Montgomery County and Prince George's County, 2015-2017 (Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

In 2017, the homeless population in Montgomery County included 86 homeless families comprised of 106 adults and 172 children (see Figure 26-A). The 103 homeless family units in Prince George's County consisted of 124 adults and 214 children (see Figure 26-B).

[6] Metropolitan Washington Council on Governments. (2017). *Homelessness in metropolitan Washington: Results and analysis from the annual point-in-time (PIT) count of persons experiencing homelessness*. Retrieved from: https://www.mwcog.org/documents/2017/05/10/homelessness-in-metropolitan-washington-results-and-analysis-from-the-annual-point-in-time-pit-count-of-homeless-persons-homelessness/

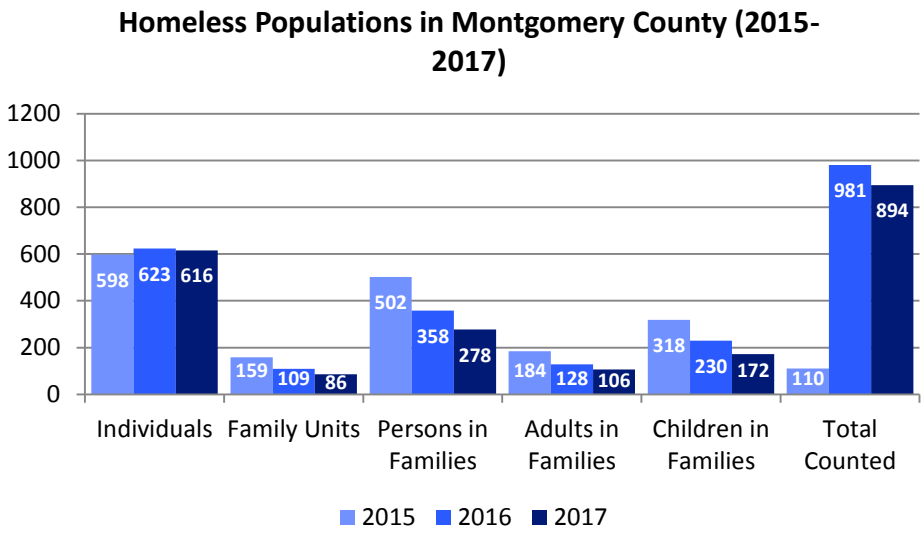

Figure 26-A. Homeless Populations in Montgomery County, 2015-2017
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

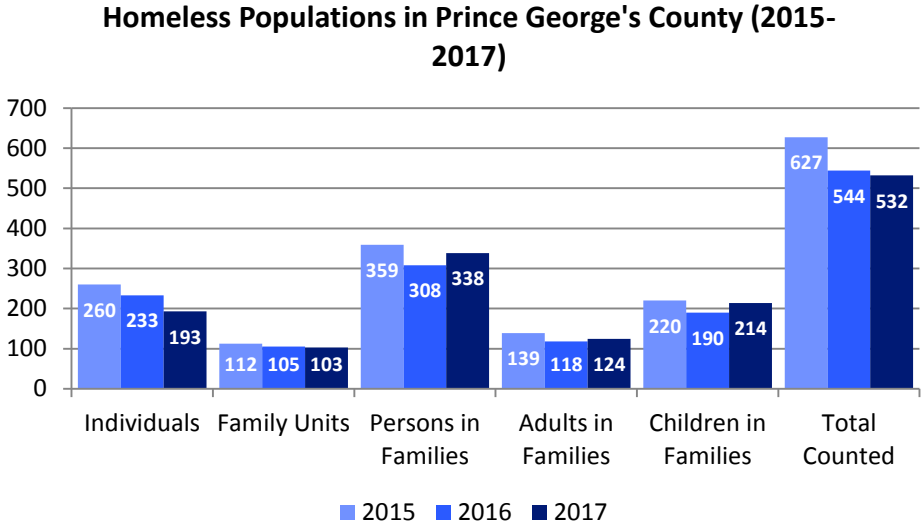

Figure 26-B. Homeless Populations in Prince George's County, 2015-2017
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

Among the already vulnerable homeless population, there are numerous subpopulations and individuals with various health, mental, and physical issues. In 2017, Montgomery County had 159 chronically homeless individuals, 175 individuals with a severe mental illness, and 162 with a chronic health problem. Prince George's County had 29 chronically homeless individuals, 54 individuals with a severe mental illness, and 65 individuals with a chronic health problem (see Figure 25).

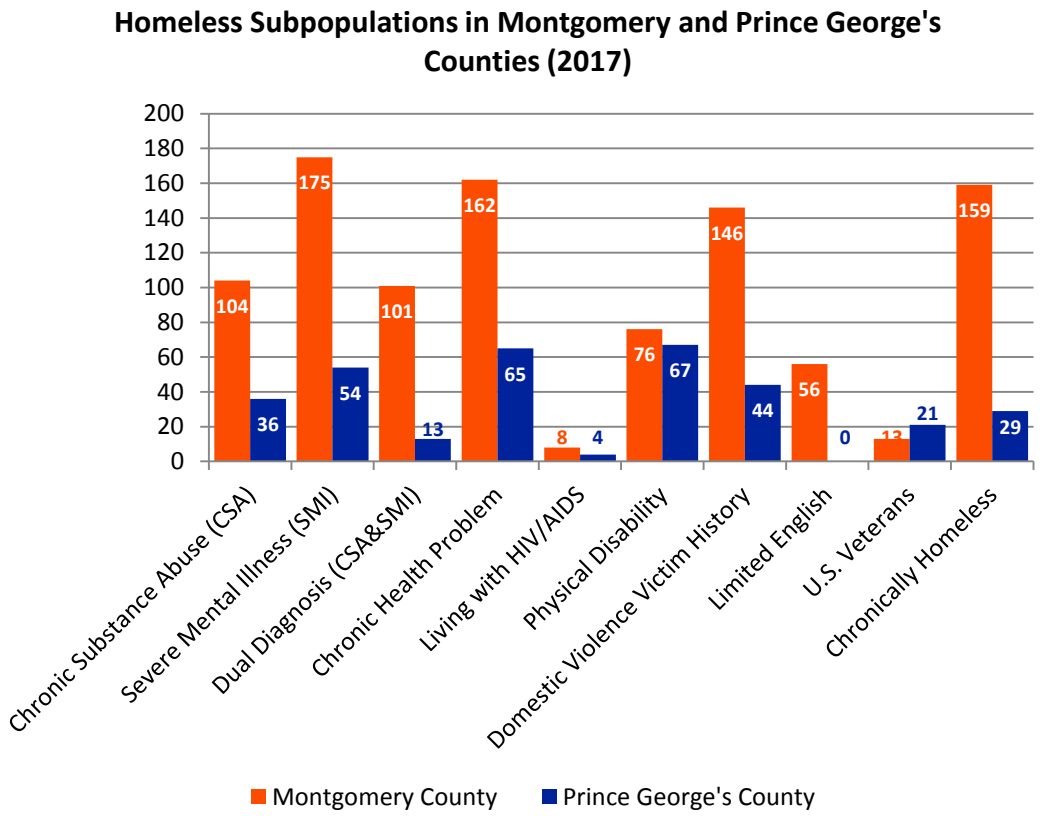

Figure 27. Adult Homeless Subpopulations in Montgomery County and Prince George's County (2017)
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

Exposure to Environmental Factors that Negatively Effect 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 C 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 (898lbs) of carcinogens released into the air.[9]

[7] Healthy Communities Institute. (2017). Annual ozone air quality, 2013-2015. *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. (2017). Annual ozone air quality, 2013-2015. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeId=1260

[9] Healthy Communities Institute. (2017). Recognized carcinogens released into air. 2016. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=389&localeTypeId=2&localeId=1260

Available detail on race, ethnicity, and language within CBSA
See SHIP County profiles for demographic information of Maryland jurisdictions.
http://ship.md.networkofcare.org/ph/county-indicators.aspx

Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	1,043,863	908,049	6,016,447
Age, %*			
Under 5 Years	6.4%	6.6%	6.1%
Under 18 Years	23.4%	22.5%	22.4%
65 Years and Older	14.5%	12.3%	14.6%
Race/Ethnicity, %*			
White	60.9%	26.5%	59.3%
Black or African American	19.5%	65.0%	30.7%
Native American & Alaskan Native	0.7%	1.1%	0.6%
Asian	15.5%	4.6%	6.6%
Native Hawaiian & Other Pacific Islander	0.1%	0.2%	0.1%
Hispanic	19.1%	17.8%	9.8%
Language Other than English Spoken at Home, % age 5+**	39.6%	22.5%	17.2%
Median Household Income†	$99,763	$79,184	$78,945
Persons below Poverty Level, %†	9.10%	6.70%	9.70%
Pop. 25+ Without H.S. Diploma, %**	91.2%	85.6%	89.4%
Pop. 25+ With Bachelor's Degree or Above, %**	57.9%	31.1%	37.9%

Sources:
**U.S. Census Bureau. (2016).QuickFacts. Retrieved from:*
https://www.census.gov/quickfacts/fact/table/MD,princegeorgescountymaryland,montgomerycountymaryland/HSD310215#viewtop
*** indicates data is from 2011-2015*
†U.S. Census Bureau. (2016). American Community Survey. Poverty status in the past 12 months 2016 1-Year ACS Estimates. Retrieved from:
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S1701&prodType=table

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these instructions?**

   _X_Yes
   ___No

   Provide date here. 12/28/2016 **(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).
   https://www.adventisthealthcare.com/app/files/public/3950/2017-CHNA-WAH.pdf

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

   _X_Yes 5/15/2017 **(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.
   https://www.adventisthealthcare.com/app/files/public/4203/2017-CHNA-WAH-ImplementationStrategy.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. **Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?** *(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)*

   a. **Are Community Benefits planning and investments part of your hospital's internal strategic plan?**

      _X_ **Yes**
      ___**No**

      If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.
      As a part of Adventist HealthCare, Washington Adventist Hospital (WAH) is dedicated to Community Benefit which aligns with the system's core mission and values. The Strategic Plan for WAH as well as all of Adventist HealthCare (AHC) is based on six pillars of success: People, Quality and Safety, Patient Experience, Finance, Growth, and Population Health. Each of these pillars is centered on measurable objectives and targets, and is led by an overarching council with several committees reporting up to it. Included within the Population Health pillar are the hospital's community benefit efforts. The strategic plan also outlines system-wide community benefit infrastructure and the areas of focus as determined by the CHNA process. The strategic plan is not a publicly available document.

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:** President's Council**)**

Describe the role of Senior Leadership.
The senior leaders above, as well as the other members of the President's Council play a role in the community benefit planning for Washington Adventist Hospital. The President's Council, which includes the CEO, CFO, and several others, played a lead role in completing the prioritization process for the 2014-2016 CHNA as well as the 2017-2019 CHNA. For the 2017-2019 CHNA, the President's Council was presented with the key data findings. A sub-committee of the group then reviewed the data in more detail and completed the prioritization process for the hospital. This group, the CHNA Committee, which includes the VP of Business Development, also took the lead in the hospital's implementation strategy development, and currently takes the lead on monitoring the progress of each of the initiatives.

The CFO also works closely with finance to review and provide final approval of the financials spreadsheet that is submitted with this report.

ii. Clinical Leadership

1. **___Physician**
2. **___Nurse**
3. **___Social Worker**
4. **_X_Other (please specify:** Director of Case Management**)**

Describe the role of Clinical Leadership
The Director of Case Management assists with planning and implementation of community benefit activities and plays a large role in community building as well. She also serves on the Community Benefit Council.

iii. Population Health Leadership and Staff

1. **_X_Population Health VP or equivalent (please list:** SVP of Population Health/Post-Acute Care Services**)**
2. **_X_Other population health staff (please list:** Director for Population Health Management**)**

Describe the role of population health leaders and staff in the community benefit process
The SVP of Population Health is directly over the Center for Health Equity and Wellness which coordinates and manages AHC's community benefit efforts and reporting. She 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 as well as the CHNA committee.

iv. Community Benefit Operations

1. **__the Title of Individual (please specify FTE)**
2. **_X_ Committee (please list members:** Community Benefit Council, Community Partnership Fund, CHNA Committee**)**
3. **_X_ Department (please list staff:** Center for Health Equity & Wellness, Finance**)**
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.

The Adventist HealthCare **Center for Health Equity and Wellness** (CHEW) coordinates the implementation and reporting of community benefit for the entire hospital system. This includes compiling 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. CHEW organizes and leads the CHNA committee, the Community Benefit Council and the Community Partnership Fund. CHEW includes an Executive Director, Director of Operations, Manager for Health Equity and Cultural and Linguistic Programs, Data Coordinator, Program Assistant for Health Equity, Coordinator for Cultural and Linguistic Programs, and several clinical and non-clinical community health educators and program coordinators.

The **Finance** department completes the financial spreadsheet for the annual community benefit reports. They also work closely with CHEW to ensure complete and accurate community benefit tracking and reporting. Members of the department also sit on the Community Benefit Council as well as the Community Partnership Fund. Finance department members include the Financial Reporting Manager, IT Accountant, and two Project Accountants.

WAH has a **CHNA committee** that led the CHNA prioritization process as well as the implementation strategy development. The group currently meets regularly and monitors the progress of each of the implementation strategy initiatives.

Adventist HealthCare has a **Community Benefit Council** with representatives from each of the 4 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
- Manager, Health Equity and Cultural and Linguistic Program, Center for Health Equity and Wellness
- Coordinator, Data Management, Center for Health Equity and Wellness
- Director of Operations, 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
- AVP, Behavioral Health and Wellness Operations
- IT Accountant, Adventist HealthCare
- Financial Reporting Manager, Adventist HealthCare
- PR Marketing Coordinator, Adventist HealthCare
- VP, Mission Integration and Spiritual Care

The **Community Partnership Fund** provides funding for organizations whose activities support the Adventist HealthCare Mission, especially those that have poor 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
- VP Public Relations/Marketing
- VP, Mission Integration and Spiritual Care
- VP Development, Chief Development Officer (WAH)
- Director, Government Relations
- Financial Reporting Manager
- VP of Business Development (WAH)
- AVP, Rehabilitation
- Sr. VP/CQIO
- Executive Director, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- SVP of Population Health/Post-Acute Care Services
- AVP, Behavioral Health and Wellness Services
- CMO, SGMC

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, members of the Finance and Center for Health Equity and Wellness departments meet 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.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

__X__yes _____no

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

AHC's population health strategy is focused on achieving six overarching goals and as such has defined various initiatives targeted at meeting these goals. These goals include: (1) Improving Care Transitions by improving communication between providers, patients, caregivers, and community supports in order to provide appropriate, effective, efficient and safe care; (2) Developing and expanding infrastructure that facilitate greater physician alignment by optimizing the integration between hospital-based and community providers and building clinical integration and communication structures between community-based physicians; (3) Improving access to appropriate care for underserved populations by expanding primary care networks and partners, developing programs to foster patient engagement among underserved populations, and improving coordination of care between providers; (4) Reducing ED overutilization by identifying the underlying needs of high utilizers and facilitating patient linkages to primary care and specialty providers; (5) Improving the management of high-risk populations including those with behavioral health issues by increasing touch points for targeted patients as well as outpatient and community-based services for underserved populations; and (6) Establishing a robust and enhanced community delivery network by developing a comprehensive, coordinated and integrated care continuum. In particular, community benefit investments will be utilized for goal 3.

Community benefit investments will be utilized for chronic disease management in the community as well as health equity and wellness approaches in addressing community health needs, predominantly for the underserved. AHC's Center for Health Equity and Wellness (the Center) is essential to AHC's execution of population-based care by providing community-based health education and wellness classes, disease prevention and management programs, and health screenings (e.g., blood pressure, BMI, body composition, carbon monoxide) that are culturally/linguistically appropriate (e.g., bilingual health educators) and aligned with community health needs. AHC and the Center will leverage existing partnerships with Montgomery County Department of Health and Human Services (HHS), Primary Care Coalition of Montgomery County (PCC), and local safety net clinics resulting in several highly successful collaborations that will continue to help to ensure that underserved populations have access to and receive primary care services. For instance, WAH will participate in the HHS Maternal Partnerships

Program to provide obstetric and gynecologic services for uninsured women in Montgomery County. Also, WAH will provide breast cancer screening and navigation for low-income women through partnerships with PCC, Women's Cancer Control Program of Montgomery County, Maryland Cancer Crusade, and private foundations.

There are several community-based programs and initiatives in AHC's plan to help people understand their health risks and self-manage diabetes including: healthy cooking and nutrition classes, evidence-based Diabetes Self-Management Program/Education, informal diabetes education to individuals in a group medical appointment, peer-led support groups to encourage healthy lifestyles, and community health education and screening. WAH will continue to provide a free, community-based Stanford Model Diabetes Self-Management Program (DSMP) to people living with type-2 diabetes. WAH will provide these programs to improve community health especially in populations that are likely to experience socioeconomic disadvantages and barriers to accessing health care. These programs align with community health needs identified in the WAH Community Health Needs Assessment (CHNA).

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X__ Other hospital organizations
__X__ Local Health Department
__X__ Local health improvement coalitions (LHICs)
__X__ Schools
_____ Behavioral health organizations
__X__ Faith based community organizations
__X__ Social service organizations
__X__Post-acute care facilities

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 indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	Healthy Montgomery
Name of Key Collaborator	Healthy Montgomery Steering Committee Co-Chairs: • Mr. George Leventhal, Council Member, Montgomery County Council • Ms. Sharon London, Vice President, ICF International Additional Committee Members can be found here: http://www.healthymontgomery.org/index.php?module=htmlpages&func=display&pid=5000
Title	*See previous row*
Collaboration Description	Adventist HealthCare collaborates with Healthy Montgomery (HM), which serves as the Local Health Improvement Coalition in Montgomery County. AHC contributes $50,000 annually to support the infrastructure of HM. AHC worked with HM to complete a 2016 Community Health Needs Assessment, which helped to inform our CHNA, and the website maintained by HM provides current data which was utilized by AHC to identify needs and set priorities. AHC was also represented on the HM Steering Committee, which sets the direction for the group.

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

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

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

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Several Adventist HealthCare representatives take part in Healthy Montgomery as members of the steering committee as well as additional committees and planning groups. Healthy Montgomery is the LHIC for Montgomery County.

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/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.*
      (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. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposed of the collaboration.*

   h. *Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.*

Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

i. *Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:*

ii. *Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:*

iii. *The number of people served by the initiative.*

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)*

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? If not, why? 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 amount, if any, was provided through a restricted grant or donation?

Table III
Initiative: Parent and Family Education Programs

Identified Need Was this identified through the CHNA process?	According to the World Health Organization (WHO), breastfeeding is one of the most effective ways to ensure child health and survival[10]. WHO also recommends that infants should be exclusively breastfed for the first six months of life in order to achieve optimal growth. Healthy People 2020 set a target goal of 60.6% to increase the proportion of infants who are breastfed at 6-months[11]. Currently, the national rate is at 51.8%[12]. In Maryland, breastfeeding at 6-months is 66.5%. Despite the recommendations, breastfeeding remains low in many communities, primarily the Black community. In 2012, the percentage of Black Babies who were breast fed at 6-months was 35.3%, which is significantly lower when compared to White (55.8%) and Hispanic (51.4%) babies[13]. The need to promote and support breastfeeding in racial/ethnic communities was identified previously as well as in the 2016 CHNA under Maternal and Child Health.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Parent and Family Education Program
Total Number of People Within the Target Population	WAH primarily serves Montgomery and Prince George's County. Montgomery County has an estimated 204,763 women of childbearing age (15 to 44 years old). Prince George's County has an estimated 190,401 women of childbearing age[14].
Total Number of People Reached by the Initiative Within the Target Population	*An exact count of unique individuals across all of the programs listed below is unknown. Where available, unique individuals are listed below in addition to encounters.* • 113 encounters at Hecho de Pecho • 402 individuals and 537 encounters on the Warm Line **Total Encounters: 650**
Primary Objective of the Initiative	The primary objective for this initiative is to reduce infant mortality rate disparities and increase breastfeeding support programs and services for mothers in Montgomery and Prince George's County. Adventist HealthCare Washington Adventist Hospital has implemented a series of initiatives to improve access to breastfeeding support programs and services. These initiatives are listed below. **Hecho de Pecho:** Through Hecho de Pecho, Adventist HealthCare Washington Adventist Hospital provides a free, weekly, breastfeeding support group for Spanish-speaking mothers. It is a safe space for mothers to share their experiences and participate with other mothers in a cordial and informative meeting to promote breastfeeding. While the focus of each session is to

[10] World Health Organization. (2017). 10 facts on breastfeeding. Retrieved from http://www.who.int/features/factfiles/breastfeeding/en/
[11] Centers for Disease Control and Prevention. (2017). Healthy People 2020 Objectives for the Nation. Retrieved from https://www.cdc.gov/breastfeeding/policy/hp2020.htm
[12] Centers for Disease Control and Prevention. (2017). Breastfeeding report card: Progressing toward national breastfeeding goals United States 2016. Retrieved from https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf
[13] Centers for Disease Control and Prevention. (2017). Percent of Women Engaging in Breastfeeding Practices in United States by Race 2012. Retrieved from https://www.cdc.gov/breastfeeding/resources/us-breastfeeding-rates.html
[14] U.S Census Bureau. (2016). American Community Survey 1-Year Estimates

	address questions and concerns of the attendees, a curriculum and interactive activities are planned for each session as well. Refreshments are provided at each meeting and mothers are encouraged to bring their baby, older children, or a support person. **Warm Line:** Through the Warm Line, Adventist HealthCare Washington Adventist Hospital and Shady Grove Medical Center provide telephone assistance for breastfeeding questions and concerns, as well as evidence-based information for breastfeeding mothers and families. The Warm Line is staffed by an IBCLC (International Board Certified Lactation Consultant) and is available 7 days a week/365 days a year at (240) 826-6667. ***The Warm Line is an AHC program that is a joint effort between Shady Grove Medical Center and Washington Adventist Hospital. The description and outcomes for this program have been listed on the reports for both hospitals. The costs and offsetting revenue for these programs have been split accordingly between the two reports.*
Single or Multi-Year Initiative Time Period	Hecho de Pecho was initiated in 2015, and is a multi-year initiative. The Warm Line is an ongoing multi-year initiative.
Key Collaborators in Delivery of the Initiative	There are currently no collaborators on this initiative.

Impact/Outcome of Hospital Initiative	**Hecho de Pecho**
	
	• Hecho de Pecho met 11 times in 2017. Sessions were held monthly for approximately 2 hours.
	• There were a total of 113 encounters. Of these, 40 encounters were mothers and 73 were babies, children, and support persons.
	• Beginning in fall 2016, a process improvement project was initiated for Hecho de Pecho utilizing the Baldrige model.
	  ○ Two evaluation metrics were put into place:
	  ▪ Mothers in attendance at each session – target set at 9
	  • Each session ranged from 1-6 mothers with an average of 4 mothers per session. The numbers have held steadily between 3 and 6 with the exception of January (1), April (2), and October (2).
	  ▪ Participants in attendance at each session – target set at 20
	  • Each session ranged from 3 to 19 participants, with an average of 10 at each session. The number of participants increased significantly during the summer months, from May (9) to June (18) and July (19). The number of participants decreased slightly from August to November with a range of 6- 14.
	
	Warm Line
	A total of 402 individuals have called into the warm line and received breastfeeding support from January through November 2017. There have been a total of 537 calls/encounters.

Evaluation of Outcomes	Maryland SHIP measures show infant death rates among Blacks in Montgomery have fluctuated in recent years. Currently, the infant mortality rate for Black babies is 8.8 per 1,000 live births. In Prince George's County, infant mortality among black residents has increased from 2014, 8.0 per 1,000 live births to 13 per 1,000 in 2015[15]. The SHIP measures also show that Black residents in Montgomery County and Prince George's County experience higher rates of babies with low birth weight (approximately 10.0% and 10.7%, respectively) than their racial counterparts. The Parent Education initiatives at Adventist HealthCare Washington Adventist Hospital have been working towards the reduction of infant mortality and babies with low birth weight by targeting the specific populations most affected.	
Continuation of Initiative	Hecho de Pecho and the Warm Line will be continued into 2018. Efforts will continue for Hecho de Pecho to increase attendance and reach. A new Spanish speaking part time coordinator has recently been hired to coordinate parent and family education and outreach for the WAH community.	
A. Total Cost of Initiative for Current Calendar Year B. What amount is from Restricted Grants/ Direct offsetting revenue	**A. Total Cost of Initiative** **Hecho de Pecho Total Estimated Costs: $2,735** **Warm Line Total Estimated Costs: $2,559**	**B. Direct offsetting revenue from Restricted Grants** **Hecho de Pecho: $0.00** **Warm Line: $0.00**

Initiative: Building Community Capacity around Diabetes & Obesity – The Stanford Model

Identified Need Was this identified through the CHNA process?	Primary data collected as part of Adventist HealthCare Washington Adventist Hospital's CHNA ranked obesity and diabetes in the top 10 among 26 identified community health concerns. Obesity was ranked 2nd, while diabetes was ranked 4th. In Montgomery County, 17.9% of adults are obese and 52.9% are overweight or obese[16]. For Prince George's County that percentage is even higher with 65.7% of adults being overweight or obese[17]. The most disproportionately affected groups in both counties are Blacks and Hispanics and range from 45 to 64 years old[18]. Additionally, females are more likely to be obese in Prince Georges County at 71.5% when compared to 64.9% of males. The opposite is true for

[15] Maryland Department of Health and Mental Hygiene (2016). Maryland vital statistics: Infant mortality in Maryland, 2015. Retrieved from https://health.maryland.gov/vsa/Documents/Infant_Mortality_Report_2015.pdf
[16] Healthy Montgomery. (2017). Adults who are Overweight and Obese. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=56&localeId=1259
[17] PGC Health Zone. (2017). Adults who are Overweight or Obese. Retrieved from http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=56&localeId=1260
[18] Maryland BRFSS Data (2014).

	Montgomery County where more males (63.4%) are overweight or obese than females (51.5%). Moreover, in Montgomery County the groups with the highest prevalence of diabetes included Asians (9.3%), males (7.7%), and those that were 65 years of age or older (19.2%)[19]. In Prince George's County, the highest prevalence of diabetes included those in the "other" race/ethnicity category (14.9%), females (12.5%), and those 65 years of age or older (35.8%). From the CHNA, it was also discovered that Black and American Indian/Alaska Native populations in Montgomery County had the highest rates of age-adjusted ER and hospitalization visits due to diabetes complications and uncontrolled diabetes. Montgomery county also ranked in the top half of all counties in Maryland for: • Percentage of adults with diabetes • Age-adjusted death rate due to diabetes • Age-adjusted ER and hospitalization rates due to diabetes, short and long-term complications of diabetes, and uncontrolled diabetes, • Overall ER rate due to diabetes Additionally, Prince Georges County was rated in the bottom half of all counties in Maryland for all the measures except for ER visit due to diabetes. The need was identified in the 2016 CHNA findings.
Hospital Initiative	Building Community Capacity around Diabetes & Obesity – The Stanford Model
Total Number of People Within the Target Population	Adventist HealthCare Washington Adventist Hospital serves both Montgomery and Prince George's County. According to the U.S. Census Bureau, there are an estimated 1,043,863 people living in Montgomery County. Of those individuals, 52.9% of adults are overweight or obese and 7.4% have been diagnosed with diabetes. In Prince George's County there are approximately 908,049 people[20], 65.7% of adults are overweight or obese, and 12.5% have diabetes.
Total Number of People Reached by the Initiative Within the Target Population	*An exact count of unique individuals across all of the programs listed below is unknown. Where available, unique individuals are listed below in addition to encounters.* • 15 community members were trained as DSMP facilitators, with 60 encounters • 45 individuals attended a DSMP workshop with 202 encounters • 371 encounters for community health screenings and education **Total People Reached: 60+** **Total Encounters: 633**
Primary Objective of the Initiative	The primary objective of this initiative is to increase access to education and resources for individuals living with diabetes. This initiative aims to increase the availability of diabetes education as well as build capacity in the community through the training of community members.

[19] Maryland BRFSS Data (2014).
[20] U.S Census Bureau. (2016). American Community Survey 1-Year Estimates

	Diabetes Self-Management Program (DSMP): Developed by Stanford University, the DSMP is an evidence-based workshop that is designed to be highly interactive and build participants' skills and confidence in managing their chronic condition and maintaining a healthy and active lifestyle. One workshop takes place over six weeks and includes a total of six, 2.5-hour sessions held weekly. Each workshop is led by two trained instructors and offered free to community members who are either living with diabetes or taking care of someone living with diabetes. Initially led by trained Adventist HealthCare employees, this fall the program expanded to include lay and clinical community members as instructors. Adventist HealthCare in partnership with Health Quality Innovators (HQI) facilitated a free train-the-trainer session for interested community members. For those community members that are clinicians, Adventist HealthCare has also offered them the opportunity to earn hours towards becoming a Certified Diabetes Educator (CDE) through the facilitation of DSMP workshops. Following the completion of the train-the-trainer session, as well as the facilitation of a DSMP workshop in the community, each of the clinical leaders will also receive a stipend to cover the costs of their CDE exam. **Community Health Screenings and Education:** Partnering with groups such as community centers, residence communities, schools, non-profit organizations, and faith-based organizations, among others, SGMC offers free body fat and BMI screenings in the community. These screenings are offered at various events, locations, and times. Screenings are conducted by health educators that provide each individual with an overview of their results and what they mean as well as a brief counseling session, if desired, to discuss health behaviors, lifestyle, and additional resources. ***The Diabetes Self-Management Program is an AHC program that is a joint effort between Shady Grove Medical Center and Washington Adventist Hospital. The description and outcomes for this program have been listed on the reports for both hospitals. The costs and offsetting revenue for these programs have been split accordingly between the two reports.*
Single or Multi-Year Initiative Time Period	This is a **multi-year** initiative. The Stanford Model was initiated in 2015 and currently has no end date.
Key Collaborators in Delivery of the Initiative	**Key collaborators and partners for the implementation and initiative include:** • Adventist HealthCare Faith Community Network • Adventist HealthCare Faith Community Nurse Network • Health Quality Innovators (HQI) • Montgomery County Health and Human Services Office of Aging

Impact/Outcome of Hospital Initiative	**Diabetes Self-Management Program (DSMP)**
	
	• Four 6-week workshops were completed in 2017. Workshops took place at Rockville Senior Center, Takoma Park Community Center, The Oaks at Four Corners, and Mid-County Recreation Center.
	  ○ 45 individuals attended the workshops, with a total of 202 encounters
	  ○ Participant Demographics (approximately 34 of the 45 individuals provided demographic information):
	  ▪ Age Range (n= 27): 43-85
	  ▪ Gender (n= 33): Female- 24, Male- 9
	  ▪ Race (n= 21): White- 11, Black- 7, Asian- 3,

- Ethnicity (32): Hispanic- 13, Non-Hispanic- 19
- Health Insurance (n= 33):
  - Medicare only- 2
  - Medicaid only- 19
  - Private Insurance only- 2
  - Medicare and Medicaid- 5
  - Medicare and Private- 5
- Education (n= 32):
  - 8th grade or less- 5
  - High school diploma- 5
  - Some college/technical school- 6
  - College degree- 6
  - Graduate and/or professional degree- 9
- Among the participants (n= 32):
  - 3 had pre-diabetes
  - 4 had Type 1 diabetes
  - 13 had Type 2 diabetes
  - 7 had no diabetes
  - 5 did not know if they had diabetes or not

- Of the 45 participants, 13 completed both a pre and post assessment and had the following outcomes:
  - 6 reported increase in fruit and vegetable consumption
  - 5 reported increase in exercise frequency
  - 2 reported increase in blood sugar testing
  - 5 reported increase in checking of feet

- DSMP Expansion:
  - As an initial step in expanding the DSMP program to include community facilitators, and informational session was held in July to introduce the program as well as the CDE component.
  - In partnership with Health Quality Innovators (HQI), Adventist HealthCare held a 4 day DSMP train-the-trainer course in November for lay and clinical community members. A total of 15 community members completed the training and were certified as DSMP facilitators.
  - Working with community partners including the faith community, senior centers, and community centers among others, 6 workshops have been confirmed thus far for the first half of 2018. Additional workshops are anticipated to be scheduled for the second half of the year.

Community Health Screenings and Education

- Within WAH's service area, the following screenings and corresponding health education were provided between January and early December:
  - Body Mass Index (handheld device): 277
    - Normal- 36.1% (100)
    - Underweight- 3.2% (9)
    - Overweight- 30.3% (84)
    - Obese- 30.3% (84)
  - Waist-to-hip Ratio: 94
    - Low Risk: 46.8% (44)

	▪ Moderate Risk: 28.7% (27) ▪ High Risk: 24.5% (23)	
Evaluation of Outcomes	Montgomery County has met the HP2020 target for adults who are obese, however, Prince George's County has not. Additionally, Prince George's County has not met HP2020 targets for adults who engage in regular physical activity. According to Maryland SHIP indicators, Montgomery County emergency department (ER) visit rates due to diabetes (primary diagnosis) has increased over the years from 98.2 per 100,000 in 2013 to as high as 100.00 per 100,000 in 2015. These county-wide rates are significantly lower than the SHIP 2017 target, 186.3 ED visits per 100,000. However, among minority groups in Montgomery county the rates are much higher. The Chronic Disease- Faith Community initiatives at Adventist HealthCare Washington Adventist Hospital will continue to work towards meeting HP2020 and Maryland SHIP targets.	
Continuation of Initiative	Each of the initiatives described above will be continuing into 2018. In order to better meet the needs of the community and increase capacity, the DSMP program has been expanded as described above to include community facilitators and the CDE component.	
C. Total Cost of Initiative for Current Calendar Year D. What amount is from Restricted Grants/ Direct offsetting revenue	**A. Total Cost of Initiative** **Diabetes Self-Management Program:** $13,340.78 **Community Health Screenings and Education:** $1,000	**B. Direct offsetting revenue from Restricted Grants** **Diabetes Self-Management Program:** $6,840.78 **Community Health Screenings and Education:** $0.00

Initiative: Food Access - Hungry Harvest Produce Rx & Long Branch Healthy Food Access Program

Identified Need Was this identified through the CHNA process?	In Montgomery and Prince George's County, access to affordable nutritious food was identified through the CHNA, as both, a health concern and a needed resource in the community. 6.3% of the population in Montgomery County and 14.4% of the population in Prince George's County experienced food insecurity in 2015[21,22]. Child food insecurity was 13.3% in Montgomery County and 13.6% in Prince Georges County. 66.7% of the adult population consumes less than five servings of fruits and vegetables daily in Montgomery County[23]. Additionally, in Montgomery County, the differences in fruit and vegetable consumption differ among racial and ethnic groups. A higher percentage of White (33%) and Asian (31%) residents consume five or more servings of fruits and vegetables daily when compared to the county as a whole[24]. Through our primary survey data, various challenges to healthy eating and access to food in the community were identified such as the high cost of healthy foods, small number of farmer's markets, and too many fast food restaurants. In our primary survey data, obesity and diabetes were also ranked in the top 10 identified community health concerns. In Montgomery County, 20.3% of adults are obese and 57.4% are overweight or obese. In Prince George's County, the percentage is even higher with 34.2% of adults being obese and 68.3% being considered overweight or obese. Moreover, 7% of adults in Montgomery County and 11.5% of adults in Prince George's County have been diagnosed with diabetes. The need was identified in the 2016 CHNA findings.
Hospital Initiative	Food Access: Hungry Harvest Produce Rx and Long Branch Healthy Food Access Program **Hungry Harvest Rx and the Long Branch Healthy Food Access Program are a joint effort between Shady Grove Medical Center and Washington Adventist Hospital. The description and outcomes for this program have been listed on the reports for both hospitals. Persons reached as well as outcomes are reported as combined totals. The costs and offsetting revenue for these programs have been split accordingly between the two hospitals.*
Total Number of People Within the Target Population	Adventist HealthCare Washington Adventist Hospital serves both Montgomery and Prince George's County. The estimated population in Montgomery County is 1,043,863 and in Prince George's County the estimated population is 908,049[25]. According to the most recent data from Feeding America, 65,527 residents and 31,940 children in Montgomery County are food insecure[26]. In Prince George's County, 130,759 residents and 27,750 children are also food insecure. Additionally, in 2016, only 29.6% of adults living in Montgomery County and 32.4% in Prince George's County consumed the recommended amount of fruit and vegetables.

[21] Healthy Montgomery. (2017). Food Insecurity Rate. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=2107&localeId=1259
[22] PGC Health Zone. (2017). Food Insecurity Rate. Retrieved from http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=2107&localeId=1260
[23] Healthy Montgomery. (2015). Food Insecurity Rate. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=2107&localeId=1259
[24] Healthy Montgomery. (2017). Adult Fruit and Vegetable Consumption. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=37&localeId=1259
[25] U.S. Census Bureau. (2017). American Fact Finder.
[26] Feeding America (2017). Map the meal gap. Retrieved from http://www.feedingamerica.org/research/map-the-meal-gap/2015/MMG_AllCounties_CDs_MMG_2015_1/MD_AllCounties_CDs_MMG_2015.pdf

Total Number of People Reached by the Initiative Within the Target Population	**Program Reach:** • 43 individuals participated in the Long Branch Healthy Food Access Program • 264 individuals were enrolled in the Hungry Harvest Rx Program and received fresh produce deliveries **Total People Reached: 307**
Primary Objective of the Initiative	The primary objective for this initiative is to provide health resources to vulnerable populations in order to improve health behaviors and outcomes such as diabetes management (HbA1c), BMI, and weight. Adventist HealthCare Washington Adventist Hospital implemented a series of initiatives to address food insecurity, obesity, diabetes management, and healthy eating. These initiatives (listed below) are offered to participants free of charge. **Long Branch Healthy Food Access Program (LBHFAP)** LBHFAP is for individuals with diabetes living in the Takoma Park and Long Branch communities. Each participant receives 3-months of active intervention followed by 9-months of maintenance. Throughout the active intervention, community health workers (CHWs) work with participants to develop a tailored food access and healthy living plan, assess eligibility for assistance programs (i.e. SNAP and WIC), enroll interested participants in Manna's nutrition education program, and provide referrals to PCP's if participants do not already have one. During the active intervention, participants also receive weekly food deliveries from Hungry Harvest, Manna, and Crossroads Community Food Network. Participants are also provided the opportunity to take part in monthly education sessions such as cooking, nutrition, or physical activity classes. **Hungry Harvest Produce Rx** In partnership with Hungry Harvest, Shady Grove Medical Center provides produce prescriptions to patients who are at or below 250% of the federal poverty level and are in need of food assistance. Program participants receive free fresh produce deliveries from Hungry Harvest every 2 weeks for 2 months. Hungry Harvest partners with medical professionals, hospitals, and community care organizations to offer the Produce Rx program. Across their partnerships they have seen very positive outcomes for program participants including increased produce consumption by 55%; reduced BMI, weight, blood pressure and blood sugar; and reduced health care costs of $300 per person per quarter.
Single or Multi-Year Initiative Time Period	**Multi-Year Initiative** The Long Branch Healthy Food Access Program is a 3-year pilot program spanning from spring 2017 to December 2019. Hungry Harvest Produce Rx is a multi-year initiative that is ongoing.
Key Collaborators in Delivery of the Initiative	**Key collaborators and partners for the implementation and initiative include:** • Community Health and Empowerment through Education and Research (CHEER) • Manna Food Center • Hungry Harvest • Crossroads Community Food Network • Mobile Med

	• Primary Care Coalition of Montgomery County

Impact/Outcome of Hospital Initiative	**Long Branch Healthy Food Access Program (LBHFAP)**
	
	• Beginning in Spring 2017, the LBHFAP has served 43 low-income, food insecure residents of the Takoma Park and Long Branch communities who have uncontrolled diabetes.
	• Food Assistance: The first cohort consisted of 43 participants. Each participant received an average of 7.8 packages of food. Of the 43 participants, 38 accessed food from more than one service option. The number of distributions for each service include:
	  • WAH Food Donation- 42
	  • Manna Food Pick Up- 50
	  • Hungry Harvest Delivery- 151
	  • Crossroads Delivery- 35
	  • Crossroads Pick up- 61
	• Nutrition & Fitness Classes: 30 participants from the first cohort participated in nutrition and fitness activities. Participants engaged in an average of 1.87 nutrition/fitness activities. Of the 30 participants, 11 participated in more than one of the activity. Activities and number of participants included:
	  • CHEER Zumba- 19
	  • Nutrition Education- 8
	  • CHEER Walking- 7
	  • Cooking Demonstration- 22
	• Additional Findings: While the sample size is small, promising outcomes have been seen among program participants thus far:
	  • 57% of participants increased their intake of fruits and vegetables
	  • 50% reduced intake of salty snacks or butter and margarine
	  • Body Mass Index (BMI): 64% of participants reduced their BMI with an average weight loss of 5.5lbs
	  • HbA1c: Half of participants lowered their A1C with an average reduction of 0.75
	
	Hungry Harvest Produce Rx
	
	• In 2017, Adventist HealthCare enrolled 264 patients in the Hungry Harvest Produce Rx program.
	• Each participant received a total of 4 fresh produce deliveries (1 delivery every 2 weeks for 8 weeks) equaling 36 pounds of fresh produce. This equates to approximately 1 additional cup of produce per day added to each individual's diet.
	• A total of 9,504 pounds of fresh produce were delivered to program participants.

Evaluation of Outcomes	According to the Maryland SHIP indicators, targets have been met for both counties for adults who are overweight and obese. However, targets are unmet for adults who are obese in both Montgomery (17.9%) and Prince George's County (30.7%). SHIP measures also show that food insecurity in Montgomery County and Prince George's County has declined slightly in 2014 to 2015 from 7% to 6.3% and 15.5% to 14.4%. However, only 29.6% of adults in Montgomery County consume the recommended amount of fruits and vegetables. Additionally, In Prince George's and Montgomery County, SHIP measures show that the percentage of adults living with diabetes has increased from 2014 to 2015 with 11.5% to 12.5% and 7.0% to 7.4%. The

	initiatives at Adventist HealthCare Washington Adventist Hospital and Shady Grove Medical Center have been working towards reducing obesity, food insecurity, and adequately managing diabetes diagnosis.	
Continuation of Initiative	The Long Branch Health Food Access Program is a pilot that has thus far seen positive outcomes. It will be continuing until December 2019. The Hungry Harvest Produce Rx program will be continuing in 2018 with an increased capacity to serve an increased number of patients.	
E. Total Cost of Initiative for Current Calendar Year F. What amount is from Restricted Grants/ Direct offsetting revenue	**A. Total Cost of Initiative** **Long Branch Healthy Food Access Program:** $22,000 **Hungry Harvest Produce Rx Program:** $15,000	**B. Direct offsetting revenue from Restricted Grants** **Long Branch Healthy Food Access Program:** $0.00 **Hungry Harvest Produce Rx Program:** $0.00

Initiative: Breast Cancer Screening

Identified Need Was this identified through the CHNA process?	In the United States, breast cancer is the leading cause of death among women[27]. Risk factors for breast cancer include age, genetic disposition, obesity, and alcohol. In Montgomery County, the breast cancer incidence rate is 130.1 per 100,000 women[28], whereas in Prince George's County the rate is 125.5 per 100,000 women[29]. For Montgomery County, the racial/ethnic groups with the highest incidence rate for breast cancer include American Indian/Alaskan Native, Black, and White women[30]. When compared to Prince George's County the group with the highest incidence rate is Black, with Whites having a much lower incidence rate, followed by Hispanic[31]. The Black age-adjusted mortality rate in Montgomery County is 25.6 per 100,000, which is much higher when compared to other racial groups[32]. Similarly, in Prince George's County, the black aged-adjusted death rate due to cancer is 29.1 compared to whites at 21.1[33]. The need was identified in the 2016 CHNA findings.

[27] Healthy Montgomery. (2017). Age-Adjusted Incidence Rates for Breast Cancer. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1259
[28] Healthy Montgomery. (2017). Breast Cancer Incidence Rate. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1259
[29] PGC Health Zone. (2017). Breast Cancer Incidence Rate. Retrieved from http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1260
[30] Healthy Montgomery. (2017). Breast Cancer Incidence Rate. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1259
[31] PGC Health Zone. (2017). Breast Cancer Incidence Rates. Retrieved from http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1260
[32] Healthy Montgomery. (2017). Age-Adjusted Mortality rate due to Breast Cancer. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=4949&localeId=1259
[33] PGC Health Zone (2016). Age-Adjusted Death Rate due to Breast Cancer. Retrieved from http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18904707

Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Breast Cancer Screening Program
Total Number of People Within the Target Population	According to the US Census Bureau, Montgomery County has a population of 274,789 women over the age of 40, whereas Prince George's County has 223,889 women over the age of 40[34]. The Breast Cancer Screening and Support Program specifically targets uninsured or underinsured women within this population.
Total Number of People Reached by the Initiative Within the Target Population	An exact count of unique individuals across all of the programs listed below is unknown. Where available, unique individuals are listed below in addition to encounters. • 714 screening and diagnostic services were provided to 517 unique individuals through the Breast Cancer Screening Program • 33 individuals participated in Look Good, Feel Better **Total People Reached: 550** **Total Encounters: 747**
Primary Objective of the Initiative	**The primary objectives for this initiative are:** • To implement strategies that address breast cancer needs in the uninsured or underinsured population served by Adventist HealthCare Washington Adventist Hospital. • To reduce the incidence, prevalence, and mortality rates of breast cancer in both Montgomery and Prince Georges County by increasing access to preventative breast care and follow-up treatment for uninsured and/or underinsured women over 40. • To decrease the intervals between screening, diagnosis and treatment through cancer navigation. **Breast Cancer Screening Program**: The Breast Cancer Screening Program provides free, comprehensive breast cancer services to women 40 years and over with limited or no health insurance in Montgomery County and Prince George's County. Patients are educated about the importance of breast health and given access to free mammograms and cancer treatment services. These services include mammograms, biopsies, ultrasounds, diagnostic and treatment services, and patient navigation to women in need. **Look Good Feel Better:** Through a partnership with the American Cancer Society, Adventist HealthCare brings quarterly Look Good, Feel Better sessions to the community it serves. The program is aimed at improving self-image appearance through free group, individual, and self-help beauty sessions that create a sense of support, confidence, courage and community. The two-hour sessions are led by a certified cosmetologist who teaches make-up tips, turban use, wig care, and beauty-related information to women undergoing cancer treatment. Participants are also given a free makeup kit.
Single or Multi-Year Initiative Time Period	The implemented initiatives are multi-year initiatives.

[34] U.S. Census Bureau. (2016). Sex by Age: American Community Survey 1-Year Estimates

Key Collaborators in Delivery of the Initiative	**Key collaborators and partners for the implementation and initiative include:** • Montgomery County Health and Human Services' Women's Cancer Control Program • Primary Care Coalition, Montgomery Cares • American Cancer Society

Impact/Outcome of Hospital Initiative	**Breast Cancer Screening Program**
	• A total of 714 breast cancer screening and diagnostic services were provided among 517 individuals
	  ○ Screening Mammograms: 414
	  ○ Diagnostic Services including Mammograms and Sonograms: 300
	• **Demographics:**
	  ○ Age
	  ▪ <40: 1.54% (11)
	  ▪ 40-49: 46.91% (335)
	  ▪ 50-64: 41.03% (293)
	  ▪ 65 and over**:** 10.5% (75)
	  ○ Race
	  ▪ White: 0.6% (4)
	  ▪ Black: 25.5% (182)
	  ▪ Asian: 3.6% (26)
	  ▪ Native Hawaiian/Pacific Islander: 0.0% (0)
	  ▪ Other: 70.2% (501)
	  ○ Ethnicity
	  ▪ Hispanic: 68.34% (488)
	  ▪ Non-Hispanic: 31.65% (226)
	• **Time to Follow-Up:** Screening to Diagnostic Mammogram (January-October 2017)
	  ○ The screening to diagnostic mammogram patient call back time frame has increased since the start of the year with 14-days in January and increasing to 27-days in October. Although, there was a notable decline in both May and August.
	  ○ Monthly Average for the year: 23.8 days (compared to 25.7 days in 2016)
	  ○ WAH continues to work toward the American Society of Clinical Oncology standard of 15-days followed by "world class" status which is reached at 5-days.
	Look Good, Feel Better
	• Look Good Feel Better was held 6 times in 2017.
	• There were a total of 33 participants for the year.

Evaluation of Outcomes	The Healthy People 2020 target for breast cancer is 20.7 deaths per 100,000 females[35]. Neither Montgomery County nor Prince George's County have met this HP 2020 target, with a mortality rate of 23.7 per 100,000 and 27.0 per 100,000. According to the National Cancer Institute, recent trends show breast cancer incidence rates in both counties to be increasing[36,37]. The

[35] Healthy People 2020 (2015). Cancer. Accessed: http://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
[36] Healthy Montgomery (2017). Breast cancer incidence rate. Retrieved from http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1259
[37] PGC Health Zone (2017). Breast cancer incidence rate. Retrieved from http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=180&localeId=1260

	Breast Cancer Screening Program at WAH has been targeting specific populations with health care access barriers and providing them with the necessary screenings and diagnostic services. Additionally, the breast cancer initiative at WAH has been navigating the patients in their cancer screening, diagnosis and follow-up processes in order to lower the call back rate to the 15-day standard set by the American Society of Clinical Oncology.	
Continuation of Initiative	The Breast Cancer Screening Program will be continuing at least through June 2018 at which time the current contract with Montgomery County will be ending. It has not yet been determined if the program will continue or in what capacity beyond June 2018.	
G. Total Cost of Initiative for Current Calendar Year H. What amount is from Restricted Grants/ Direct offsetting revenue	**C. Total Cost of Initiative** **Breast Cancer Screening Program Total Estimated Costs (January – October 2017):** $251,845 **Look Good Feel Better Total Estimated Costs:** $576.00	**D. Direct offsetting revenue from Restricted Grants** **Breast Cancer Screening Program (January-June 2017 for Montgomery County HHS; January-October Primary Care Coalition):** $46,649 **Look Good Feel Better:** $0.00

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**

Cardiovascular Health	**Heart Disease –** Heart disease was ranked as the number one cause of death in United States by the CDC. The death rate from heart disease was higher in Prince George's County (172.5 per 100,000) than in Maryland (169.9 per 100,000). Although on the decline in Maryland and Montgomery County due to improvements in treatment, it remains the leading cause of death in Montgomery County, killing blacks (123.4 per 100,000) at a higher rate than whites (114 per 100,000).
	Stroke – One of the top five leading causes of death in the United States. Mortality rates in Montgomery County have met the HP 2020 target, but health disparities between racial/ethnic groups persist. Black residents have the highest stroke death rate in the County at 27.96/100,000 compared to whites at 24.7, Asian/Pacific Islanders at 22.4, and Hispanics at 20.8. Prince George's County, which has a stroke mortality rate of 35.1/100,000, has not met Healthy People 2020 goal of 34.8.
		Provide cardiovascular community outreach, to include the following screenings to community: blood pressure, glucose and A1C.
		
		Provide free cardiovascular educational materials, blood pressure screenings and body composition screenings (BMI, weight, % body fat, % muscle) at health fairs, churches, senior centers, and various community locations.
			WAH provides free screenings, health education, and lectures in the community around cardiovascular health. Regular blood pressure screenings and education are provided at several community locations. Additional screenings, education, and lectures are provided at health fairs and locations such as senior centers, low-income housing units, and community centers. Screenings offered include blood pressure, body mass index, body fat percentage, and waist to hip ratio.	**Community Heart Health Screenings**
				Washington Adventist Hospital provides free heart health screenings at community events/activities each year. Heart health screenings include:
				• Blood pressure
				• Body Composition
				  ○ Body mass index (BMI)
				  ○ Waist-to-hip ratio
				
				There were a total of 723 blood pressure screenings in the WAH CBSA:
				• Normal- 32.5% (235)
				• Prehypertension- 35.8% (259)
				• Stage 1 Hypertension- 26.4% (191)
				• Stage 2 Hypertension- 4.4% (32)
				• Hypertensive Crisis- 0.8% (6)
				
				**data based off systolic blood pressure interpretation*
				
				There were 277 BMI readings:
				• Normal- 36.1% (100)
				• Underweight- 3.2% (9)
				• Overweight- 30.3% (84)
				• Obese- 30.3% (84)
				
				There were 94 Waist to Hip screenings:
				• Low Risk: 46.8% (44)
				• Moderate Risk: 28.7% (27)
				• High Risk: 24.5% (23)

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
Influenza	Nationally, in 2016, the percentage of adults who received an influenza vaccination by age group was 62.3% for adults aged 65 and over, 42.2% for ages 50-64, and 30.6% for those aged 18-49. In Maryland, mortality due to influenza and its complications is decreasing although disparities still exist among racial groups. Blacks across the state have a higher mortality rate due to influenza and its complications when compared to Whites. Blacks in Montgomery County visit the ER at a much higher rate than Whites for issues related to flu. Neither Montgomery nor Prince George's County met the Healthy People 2020 or SHIP 2017 targets for vaccination rates. However, there has been an increase in the number of people receiving flu vaccinations across Montgomery County, Prince Georges County, and Maryland.	Provide influenza vaccinations to the community throughout the fall flu season in a variety of locations, which include locations that have elderly adults with limited mobility (e.g. senior living facilities and housing).	WAH provides both education and clinics in the community during flu season. • Flu Clinics: WAH provides free and low cost flu shot clinics throughout the county to children, adults, and senior centers at various locations including community centers, senior centers, faith-based organizations, and low-income housing units, among others. • Education and Outreach: WAH also provides health education on cold and flu prevention to community members at many of the locations listed above.	Document and track the number of influenza vaccinations provided to community members, and analyze provision of vaccine by variables such as age, ZIP code, and insurance or payment type. The total number of flu shots administered in the WAH region: **369**

2. **Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.**

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale	
Topic Area	**Rationale**
Asthma	WAH does not currently provide community outreach and educational programs specific to asthma due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.
Behavioral health	WAH does not directly address behavioral health due to a lack of resources. Behavioral health is being addressed by other organizations in the community including Adventist HealthCare Behavioral Health and Wellness Services, a specialty care hospital part of the Adventist HealthCare system. WAH also participates in the Nexus Montgomery Regional Partnership along with the other five hospitals operating in Montgomery County as well as community organizations such as the Primary Care Coalition. The aim of the partnership is to improve the health status of those most at risk of avoidable hospital use, including those with severe behavioral health conditions.
HIV	WAH does not currently provide community outreach and educational programs specific to HIV/AIDS due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.
Social Determinants of Health • Housing • Education	WAH does not currently provide community outreach and educational programs specific to housing and education due to limited financial resources, expertise, and a focus on areas that were identified as higher priority during the CHNA prioritization process.

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

The State's initiatives for improvement in population health include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. Also, in the context of the State's unique all-payer rate setting model, hospitals are tasked with improving quality, including decreasing 30-day readmissions. Adventist HealthCare Washington Adventist Hospital's community benefit operations/activities are aligned with many of these initiatives. For example, WAH's "Help Stop the Flu" initiative, in partnership with local safety-net clinics, reached over 300 people with flu vaccinations and/or education about the flu, in order to address high rates of flu in the population, as evidenced by high flu-related emergency department visits. Also, in efforts to reduce cancer-related mortality and survival, WAH offers free cancer screenings to community members. Also, free cardiovascular screenings (e.g. blood pressure and body composition) are offered at various health fairs, houses of worship, senior centers, etc., to reach populations that may not otherwise have access to these kinds of services. The Breast Cancer Screening program, which

provides free, comprehensive breast cancer services to women over 40 with limited or no insurance, serves many African American and Latino women from underserved areas. Hecho de Pecho, a Spanish mother-baby support group led by a Spanish-speaking lactation counselor, is WAH's initiative to provide breastfeeding support to combat the low breastfeeding rates and low/very low birth weights among Latinos. Patients at risk for diabetes, or with a diagnosis of diabetes, may be referred to a 6-week diabetes self-management program. These programs illustrate the integration of health care with various community resources, which, in turn, can lower readmission rates.

VI. PHYSICIANS

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

Adventist HealthCare Washington Adventist Hospital is committed to addressing access to care and has noted an increase in the number of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our service area. The lists included below in question VI.2 include physician specialties and services the hospital provides to ensure access to care for all in our community, including the uninsured.

Published reports by health care advocacy organizations have noted that the capital area, including Montgomery County and Prince George's County, has shortages in 8 of 30 physician specialty groups[38]. Shortages were identified among hematology/oncology, anesthesiology, diagnostic radiology, general surgery, and neurosurgery. A borderline physician supply was found in dermatology, physical medicine, radiation oncology, and vascular surgery. Across the state, medical specialists are projected to decrease from 40 per 100,000 state residents to 37 per 100,000 in 2015. However, the capital region is projected to be less significantly affected compared to other regions of the state due to lower retirement rates and higher rates of medical residents. Washington Adventist Hospital is augmenting this information by conducting a Medical Staff Development plan to determine physician specialty needs in the community and at the hospital.

By 2030, there is a projected physician shortage nationwide with only between 40,800 and 104,900 fewer physicians available. Projected primary care physician shortages will range between 7,300 and 43,100 physicians as well. The shortage of physicians in non-primary care specialties (e.g., surgery, psychiatry, and pathology) is also expected to range between 33,500 and 61,800 by 2030. The high demand, but short supply of physicians is attributed to a growing and aging population that is will also impact the pool of available physicians. One-third of currently active physicians will be over 65 years of age within the next decade so their retirement decisions will have the largest impact on physician supply.[39]

A Community and Physician Needs Assessment was conducted by the Advisory Board Company contracted by Washington Adventist Hospital to further define surpluses or deficits of physicians in the community it serves.

Adventist HealthCare Washington Adventist Hospital partners with local safety net clinics including Community Clinic, Inc., Mobile Medical Care, Inc., and Mary's Center, as well as individual physician practices to narrow the gap in availability of specialist providers to serve the uninsured cared for by the hospital. Washington Adventist Hospital has subsidized 4,000 visits to maternal-fetal specialists in 2015 to meet the needs of high-risk uninsured prenatal patients. The partnership with Community Clinic Inc. includes a Federally Qualified Health Center (FQHC) developed on the hospital's campus to serve uninsured patients.

[38] Maryland Hospital Association & MedChi the Maryland State Medical Society. 2008. Maryland Physician Workforce Study.
[39] HIS Markit. 2017. Association of American Medical Colleges. *2017 Update The Complexities of physician supply and Demand: Projections from 2015 to 2030*.

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	$9,828,266	Adults who do not have a primary care physician, and OB patients who do not have a designated OB physician are provided with 24/7 hospitalist coverage.
Coverage of Emergency Department Call	$1,654,267	Specialists are needed to cover Emergency Department Call to provide adequate specialty care to patients who present through Emergency Department.
Physician Provision of Financial Assistance	$0.00	N/A
Physician Recruitment to Meet Community Need	$5,832,915	Recruitment and employment of physicians enables greater success to recruit, retain, and develop physician practices, which in return reduce physician shortage in the community as identified.
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

In keeping with Adventist HealthCare's (AHC) mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Policy (FAP) provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need. AHC provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for financial assistance will be initiated prior to, or at the time of admission. The FAP identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual. AHC also contracts with a third party organization experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

AHC informs patients and persons of their eligibility for financial assistance according to the National CLAS standards and provides this information in both English and Spanish at several intervals and locations. The Hospital's Notice of Financial Assistance and Charity Care Policy is clearly posted in the emergency department, business offices, and registration areas as well as on the Adventist HealthCare website so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill.

As a standard process, plain language summaries of the FAP are provided during emergency department registration, during financial counseling sessions and upon request. The plain language summaries are also posted at all registration sites, in specialty area waiting rooms, and in specialty area patient rooms. Complete and current versions of the full FAP, plain language summary, and application form are posted on AHC hospital websites. All three documents, as well as the patient information sheet, are available in both English and Spanish.

The FAP policy applies to Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare Washington Adventist Hospital, Adventist HealthCare Behavioral Health & Wellness Services, and Adventist HealthCare Rehabilitation. It has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code. The FAP provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- Prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- Special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

Appendix II

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

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

It is part of Adventist HealthCare Washington Adventist Hospital's mission to provide necessary medical care to those who are unable to pay for that care. This policy requires patients to cooperate with and avail themselves of all available programs (including Medicaid, workers compensation and other state and local programs) that might provide coverage for medical services. The hospital considers Financial Assistance to any patient responsibility amount as long as the patient has followed our requirements.

The financial assistance application was most recently changed to match the Maryland State Uniform Financial Assistance Application.

Appendix III

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

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Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed:	02/09, 9/19/13, 10/10/17	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17	Page: 1 of 14	

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FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland, collectively referred to as AHC.

PURPOSE:

In keeping with AHC's mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George's County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's (or their guarantors') ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

DEFINITIONS:

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services**: treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
    - Places the health of the individual in serious jeopardy
    - Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
    - And may include, but are not limited to:
        - Emergency Department Outpatients
        - Emergency Department Admissions
        - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care**: a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount**: The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.
- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the

United States, this level is determined by the Department of Health and Human Services.

- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.

1.2. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:

1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See Attachment A for current FPL).

1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines

1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family's income), and/or

1.2.4. absence of other available financial resources to pay for urgent or emergent medical care

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:

1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).

1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:

1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and

1.5.4. The treatment plan was developed and provided by an AHC care team

1.6. **Considerations:**

1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistant applied to the patient payment liability portion of their medically necessary services

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the

appropriate staff based on medical necessity criteria established in this policy, and may or may not be approved for financial assistance.

1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:

1.7.1. Purposely providing false or misleading information by the patient or responsible party; or

1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)

1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or

1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or

1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.

1.8. **Special Considerations (Presumptive Eligibility)**: Adventist Healthcare make available financial assistance to patients based upon their "assumed eligibility" if they meet on of the following criteria:

1.8.1. Patients, *unless otherwise eligible for Medicaid or CHI*P, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.1.1. Households with children in the free or reduced lunch program;

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or non-emergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:

1.8.3.1. categorized as homeless or indigent

1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity

1.8.3.3. unresponsive during care and is discharged due to expiration

1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

1.8.3.5. a victim of a crime or abuse (other requirements will apply)

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section

and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form.

1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.

2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.

2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

3. Policy Application and Determination Period

3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**

3.2. Probable eligibility will be communicated to the patient within 2 business days of the submission of an application.

3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's (or guarantor's) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are

not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges.

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

4.6.1. AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.

4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.

4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within a reasonable period of time.

4.6.7. AHC provides options for payment arrangements.

4.6.8. AHC upholds and honors individuals' right to appeal decisions and seek reconsideration.

4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

4.7. **Individual Patient's Responsibilities**

4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.

4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.

5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.

5.1.3. The AHC hospital facility's PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.

5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

5.1.5. An individual will be informed about the AHC hospital facility's FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance**: Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.

7. **POLICY REVIEW AND MAINTAINENCE:**

7.1. This policy will be reviewed on a bi-annual basis

7.2. The review team includes Adventist Health entity CFOs and VP of Revenue Management for Adventist Health

7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.

7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

The following information can be found at Adventist HealthCare's Public Notice of Financial Assistance & Charity Care:

Document Title
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC's Financial Assistance Policy

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

Adventist HealthCare is committed to meeting the health care needs of our community through the ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance.

Availability of Financial Assistance: You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full your expected out-of-pocket expenses for emergency and other medically necessary care that Adventist HealthCare provides.

Eligibility: Adventist HealthCare provides financial assistance based upon need. To determine need, we review your household income and compare it to the Federal Poverty Level guidelines set by the U.S. Department of Health and Human Services. We also review the amount of charges for which you are responsible.

If you and/or the party responsible for payment has combined income equal to or below 200 percent of the federal poverty guidelines, you will have no financial responsibility for the care that Adventist HealthCare provides. If you fall between 200 percent and 600 percent of the guidelines, you may qualify for discounted rates for our care.

If you are eligible for financial assistance under this policy, Adventist HealthCare will not charge more for your emergency or other medically necessary care than the amounts we generally bill to individuals who have insurance for such care. In certain cases, we may presume you are eligible for financial assistance if you already qualify for certain types of governmental aid.

You may be ineligible for financial assistance if you have sufficient insurance coverage or we determine your income is enough to pay for care. Please see the links below for our full policy, which provides more explanation and details.

How to Apply for Aid

Obtain a free copy of our application:

- Call our Patient Financial Services Department (PFS) at **301-315-3660**
- Visit PFS at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue
  Gaithersburg, MD 20878
- Download at AdventistHealthcare.com/FinancialAssistance

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

☎ **If you need help with the application or have questions:**

- Call PFS at **301-315-3660**
- Visit us at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Mail or drop off your application with the required documentation to**:**
Adventist HealthCare
PFS Department, 5th Floor
810 W. Diamond Avenue
Gaithersburg, MD 20878

Translation Services: The Financial Assistance Policy, application form and this plain language summary is available in English or Spanish. Adventist HealthCare can provide assistance through a qualified bilingual interpreter upon request.

Additional Resources

HHS FPL Guidelines

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia financiera

Adventist HealthCare asume el compromiso de satisfacer las necesidades de atención médica de nuestra comunidad a través del ministerio de curación física, mental y espiritual. Todos los pacientes, independientemente de su raza, credo, sexo, edad, nacionalidad o situación financiera, pueden solicitar asistencia financiera.

Disponibilidad de la Asistencia financiera: Usted podría recibir asistencia financiera si no tiene seguro, si su seguro es insuficiente, o si pagar la totalidad de sus gastos de bolsillo por atención de emergencia y otra atención médicamente necesaria que Adventist HealthCare brinde le causaría dificultades económicas.

Elegibilidad: Adventist HealthCare proporciona asistencia financiera en base a la necesidad. Para determinar la necesidad, analizamos los ingresos de su hogar y los comparamos con las pautas del Nivel Federal de Pobreza establecido por el Departamento de Salud y Servicios Humanos de los EE. UU. También analizamos el monto de los cargos por los que es responsable.

Si usted o el responsable de realizar el pago tiene un ingreso combinado igual o menor que el 200 por ciento de las pautas federales de pobreza, no tendrá responsabilidad financiera por la atención que Adventist HealthCare proporciona. Si usted se encuentra entre el 200 por ciento y el 600 por ciento de lo establecido por las pautas, podría calificar para acceder a tarifas con descuento por nuestra atención.

Si usted es elegible para recibir asistencia financiera bajo esta política, Adventist HealthCare no le cobrará más por su atención de emergencia u otra atención médicamente necesaria que los montos que generalmente le facturamos a las personas que tienen seguro para dicha atención. En algunos casos, asumiremos que usted es elegible para recibir asistencia financiera si ya califica para recibir ciertos tipos de ayuda gubernamental.

Es posible que no sea elegible para recibir asistencia financiera si tiene cobertura de seguro suficiente o determinamos que sus ingresos son suficientes para pagar la atención. Visite los siguientes enlaces para consultar nuestra política completa, que tiene una explicación más detallada.

Cómo solicitar ayuda

Obtenga una copia gratuita de nuestra solicitud:

- Llame a nuestro Departamento de Servicios Financieros para Pacientes (PFS) al **301-315-3660**
- Visite PFS en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia financiera

- Descárguela en AdventistHealthcare.com/FinancialAssistance

☎ **Si necesita ayuda con la solicitud o tiene preguntas:**

- Llame a PFS al **301-315-3660**
- Visítenos en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Envíe su solicitud por correo o entréguela con la documentación requerida a:
Adventist HealthCare
Departamento de PFS, 5to piso
810 W. Diamond Avenue
Gaithersburg, MD 20878

Servicios de traducción: La Política de Asistencia financiera, el formulario de solicitud y el resumen en lenguaje sencillo están disponibles en inglés y español. Adventist HealthCare puede brindarle asistencia mediante un intérprete bilingüe calificado si lo solicita.

Recursos adicionales

Pautas del Nivel federal de pobreza de HHS

Appendix IV

Patient Information Sheet

Maryland Hospital Patient Information

Hospital Financial Assistance Policy

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

Patients' Rights

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

Patients' Obligations

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

Contact Information

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

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

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

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

Información del paciente de Maryland Hospital

Política de ayuda financiera del hospital

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

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

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

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

Derechos del paciente

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

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

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

Obligaciones del paciente

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

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

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

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

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

Información de contacto

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

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

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

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

Appendix V

Hospital Mission, Vision, and Value Statements

Adventist HealthCare Mission Statement: *We extend God's care through the ministry of physical, mental and spiritual healing.*

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

1. ***Respect:*** *We recognize the infinite worth of each individual.*
2. ***Integrity:*** *We are conscientious and trustworthy in everything we do.*
3. ***Service:*** *We care for our patients, their families, and each other with compassion.*
4. ***Excellence:*** *We do our best every day to exceed expectations.*
5. ***Stewardship:*** *We take ownership to efficiently and effectively extend God's care.*