

Reporting Requirements

Narrative Reporting Instructions:

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

129 Licensed Beds and 8600 inpatient admissions (including births).

2. Describe the community your organization serves. The narrative should address the following topics: *(The items below are based on IRS Schedule H, Part V, Question 4).*

- Describe the geographic community or communities the organization serves;
- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

See attachment "Profile of Charles County"

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done *(based on IRS Schedule H, Part V, Question 2).*

The following are examples of how community health needs might have been identified:

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
- Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
- Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
- Analyzed utilization patterns in the hospital to identify unmet needs;
- Surveyed community residents, and if so, indicate the date of the survey;
- Used data or statistics compiled by county, state, or federal government;
- Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);

b. In seeking information about community health needs, did you consult with the local health department?

Civista Medical Center, in partnership with the Charles County Department of Health, conducts a Needs Assessment of Charles County every five (5) years. The data included in this report was collected in 2006 and is scheduled to be repeated in FY 2011. Additionally, The Charles County Community Foundation, in cooperation with Civista Medical Center, Charles County Department of Health, The United Way of Charles County and the Charles County Government conducted a Priority Needs Assessment for Charles County in 2008. In April 2009, the Charles County Local Management Board conducted a Needs Assessment. The Maryland Physician data is from the Maryland Health Commission's 2007 report. The data from all of these reports is shared with all of the members of Partnerships for a Healthier Charles County of which Civista is a member.

4. Please list the major needs identified through the process explained question #3.

- 1. Leading causes of death (Highest mortality among African Americans)**
 - a. Malignant Neoplasm**
 - b. Diseases of the Heart**
- 2. Rising infant mortality rate**
- 3. Rising obesity rates**
- 4. Physician shortages in 83 specialties**

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

Civista Medical Center's Community Benefit Program consists of the following decision makers:

- The Board of Director's**
- Executive Management Team**
- Community Benefits Leadership Team (Health Promotions, Finance)**
- Community Benefits Reporters**

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

Civista Medical Center sponsors the following community initiatives:

- 1. Free cancer screening and education programs for prostate, breast, cervical and colorectal cancer; with outreach targeted to the uninsured and African American populations; Participation in the Tobacco Education Program**
- 2. Prenatal clinic**
- 3. WE CAN! (Ways to Enhance Children's Activity and Nutrition) program for 8-13 year olds**
- 4. Physician recruitment efforts**

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of

major Community Benefit program initiatives.

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

- a. Name of initiative:
- b. Year of evaluation:
- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or
- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Assessment of the success of initiatives will be provided with the 2011 Charles County needs Assessment Survey.

- 1. Prostate Cancer Screening September 2009: Focused outreach on areas of county that have a high African American population; Partnership with traditionally African American Groups such as the Bel Alton Alumni Association and Delta Zeta Sorority; Evaluation provided by the Charles County Department of Health**
- 2. Prenatal Clinic – ongoing: Civista provides the only prenatal clinic for uninsured and underinsured pregnant women; Clinical services, education and follow up are provided by Civista Medical Center staff and physicians. Clinic providers participate on the Charles County Fetal Infant Mortality Board for review and evaluation of outcomes.**
- 3. WE CAN! Childhood Obesity Program initiated in FY 2009; Free family education program for 8-13 year olds and their families; New initiative; Data is currently being collected and will be evaluated in partnership with the Charles County Department of Health.**
- 4. Physician Recruitment – Recruitment of physicians to Charles County concentrating in the high priority areas of the 83 specialties lacking; Physician recruiter retained by Civista; Evaluation by number of physicians successfully recruited and placed.**

8. 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.

See Attachment “Shortages by Region”

According to the Maryland Health Commission, 83 physician specialties are in shortage in the Southern Maryland area. Of particular lack in Charles County is Obstetrics and Gynecology. In early 2008, only 5 OB/GYN physicians were providing care at Civista– 3 of whom are employed by Civista Medical Center. The rising infant mortality rate in Charles County raised the recruitment of OB/GYN practitioners to priority one. To date, one additional physician has been added. Recruitment efforts for, Orthopedics, General Surgery, Infectious Disease has produced additional physicians. Ongoing efforts to recruit include for Neurology, Oncology, Primary Care, General Surgery, Orthopedics, ENT, and Gastroenterology.

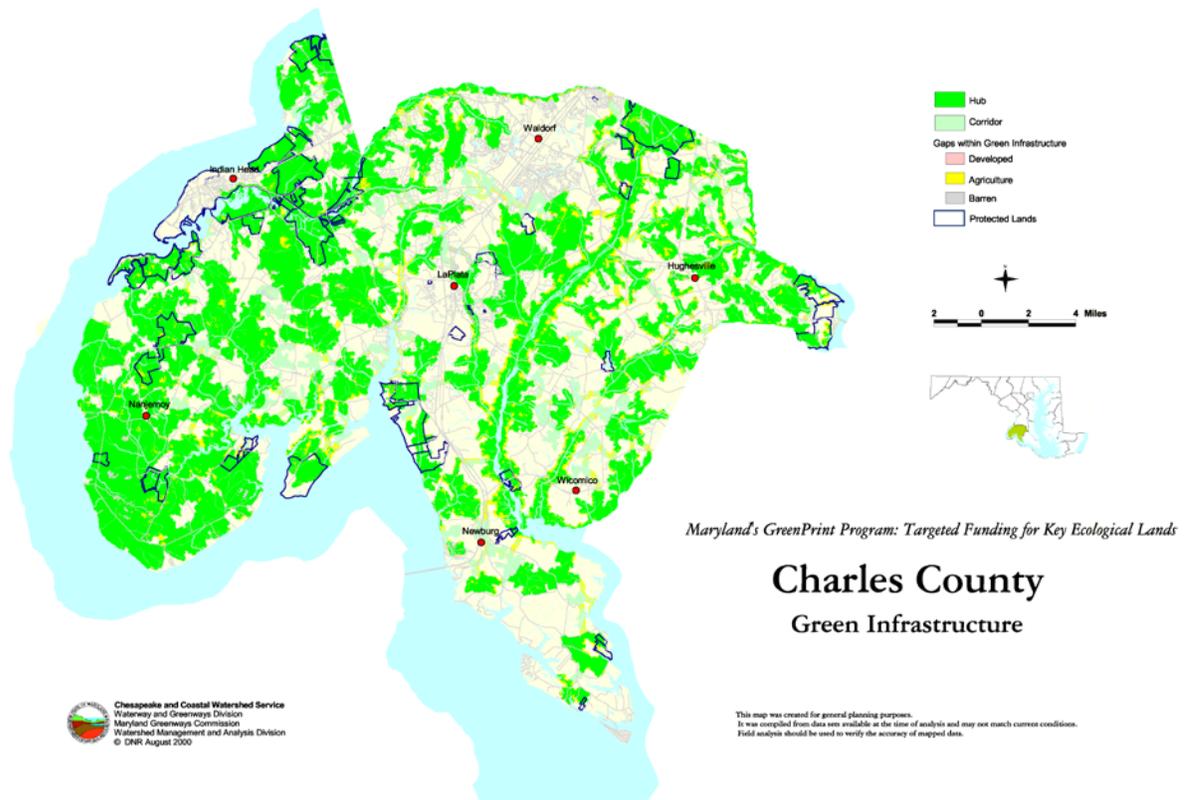
9. If you list Physician Subsidies in your data, please provide detail.

Attachment "2009 Workforce Development Costs"

Profile of Charles County

Charles County is mostly a rural county located on the Southern Maryland Peninsula, bordered by Prince George's County to the north, Calvert County to the east, and St. Mary's County to the south. Charles sits about 15 miles south of the Washington Capitol Beltway, 18 miles from Washington, D.C, and 54 miles southwest of Baltimore.

The northern part of the county is the “development district” where commercial, residential and business growth is focused, so that the remainder of the county can retain its rural character. The major communities of Charles County are La Plata, the county seat; Port Tobacco, Indian Head, and the planned community of St. Charles. The main commercial cluster is Hughesville-Waldorf-White Plains.



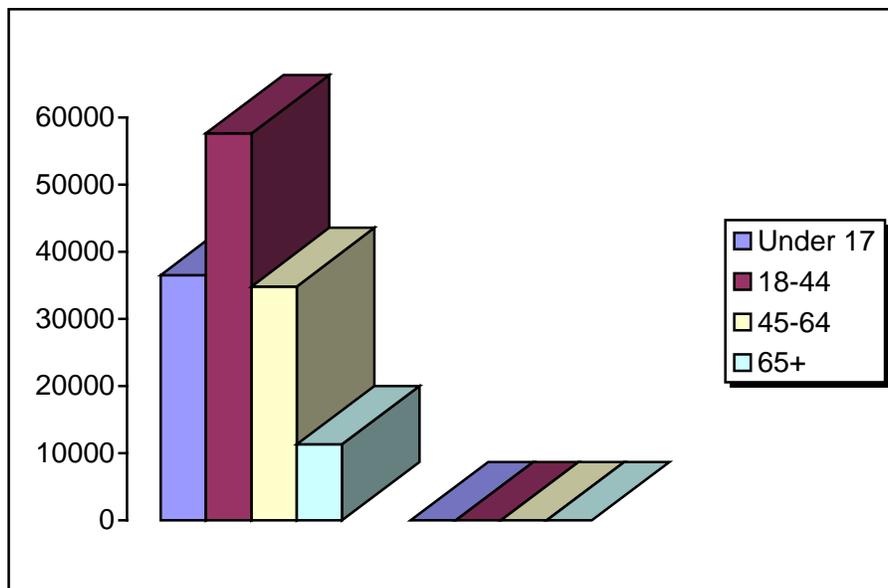
Source: 2003 dnr.maryland.gov

There are three nursing homes in Charles County, two are located in La Plata and one is located in Waldorf. In addition to the nursing homes there are two adult day care centers one in La Plata and one in Waldorf. These facilities provide care for the elderly citizens of Charles County, assisting family members by providing day time activities for those elderly citizens still in the home families. The County has one 98-bed hospital—Civista, located in the county's seat, La Plata.

Demographics

Charles County continues to experience rapid growth, expanding its population from 47,678 to 120,546 in the 2000 census. Current U.S. Census estimates are that the population now exceeds 140,444. This magnitude of growth can be seen in the change in population density, with an increase of 15% in the period from 2000 to 2005. While there are only 307 people per square mile over the total area of Charles County, there are 821 people per square mile of developed land. The population density is concentrated mainly in the northern end of the County. The census describes a population that is young, with a medium age of 35 years, and approximately 26% is under the age of 17, 41% is between the ages of 18-44, 25% is between the ages of 45-64; and 8% of the county's population 65 or over.²

Charles County Population by Age-group, 2006



Source: Maryland DHMH 2005 Vital Statistics Report

The average household size is 2.85 with the average family size 3.23. The marital status of the county for males is 15,962 never married, 28,913 now married, 1,467 separated, 924 widowed, and 5,680 divorced. For females 17,792 never married, 28,699 now married, 1,796 separated, 4,018 widowed, 5,563 divorced. All numbers refer to residents 15 years and over.¹³

In 2006 the types of households in Charles County included 54% married couples, 23% other families, 19% people living alone, and 4% other nonfamily households. The geographic mobility of residents in Charles County showed that 86% had been in the same residences, only 7% had moved to another residence in the county, 4% moved out of the county, 3% moved to another state, and 1% moved out of the country.¹³

Population:

Charles County Population Data

| Population Data | Charles County | Maryland |
|------------------|----------------|-----------|
| Population, 2000 | 120,546 | 5,296,486 |
| Population, 2006 | 140,416 | 5,615,727 |
| Male, 2006 | 48.7% | 48.4% |
| Female, 2006 | 51.3% | 51.6% |

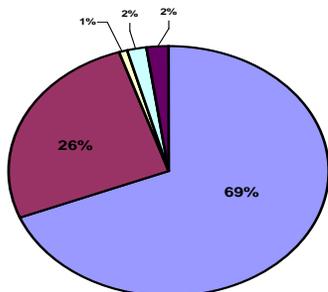
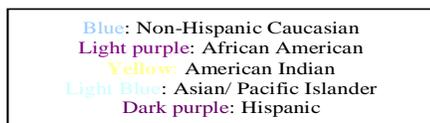
Source: 2006 Maryland Vital Statistics Report and US Census Bureau:
2006 American Community Survey

The minority population in the United States as well as Maryland continues to grow each year. In 2004, more than 32% of the total US population was racial or ethnic minorities. In 2004, the minority population in Maryland made up 39.6% of the population.¹

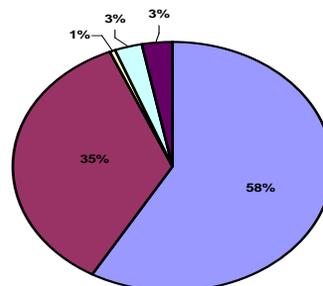
In 2004, racial and ethnic minorities made up 39.4% of the total county population. Charles County ranks fifth among the 24 Maryland jurisdictions in terms of the largest minority population. The county minority population is also significantly higher than the minority population in the other Southern Maryland jurisdictions: Calvert County with 16.3% and St Mary's County with 19%.¹

And the minority population within the county continues to grow each year. In 2005, the Charles County minority population comprised 41.5% of the total population (Refer to graph below). It remained the fifth highest percentage among the Maryland jurisdictions, but it exceeded the Maryland state average percentage of 40.3%.²

Race of Charles County Population, 2000 versus 2005



2000

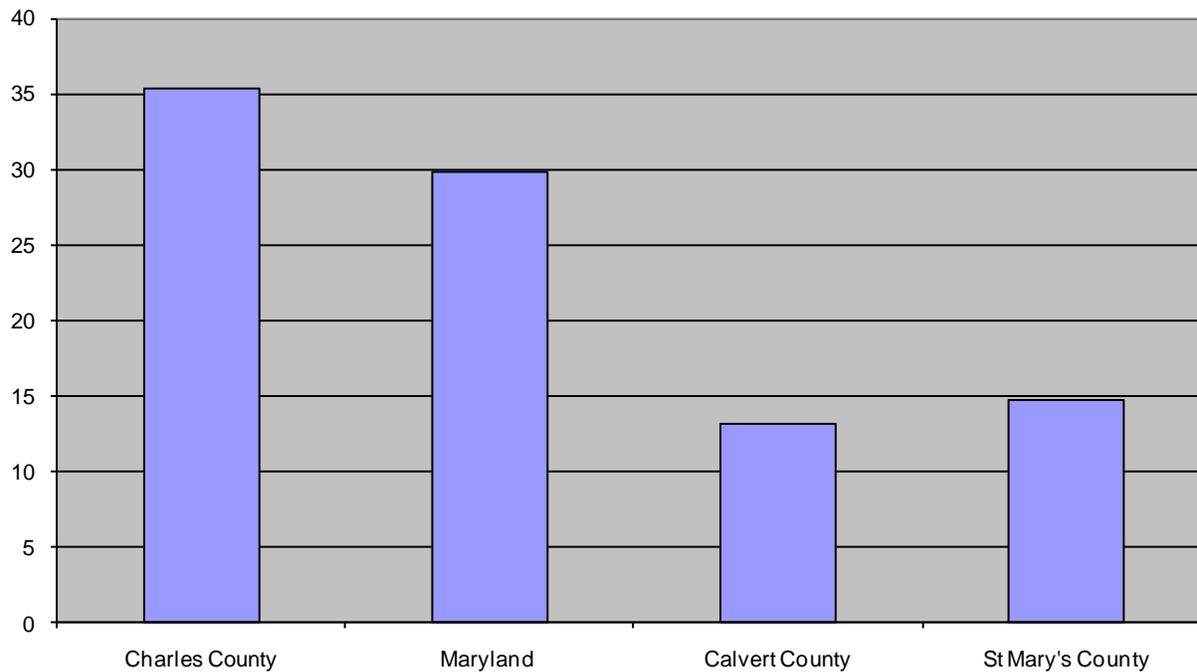


2005

Source: Maryland Department of Health and Mental Hygiene. 2005 MD Vital Statistics Report.

The African American population is the largest minority group within the state of Maryland as well as Charles County. African American comprised 75% of the Maryland minority population and approximately 85% of the Charles County minority population.

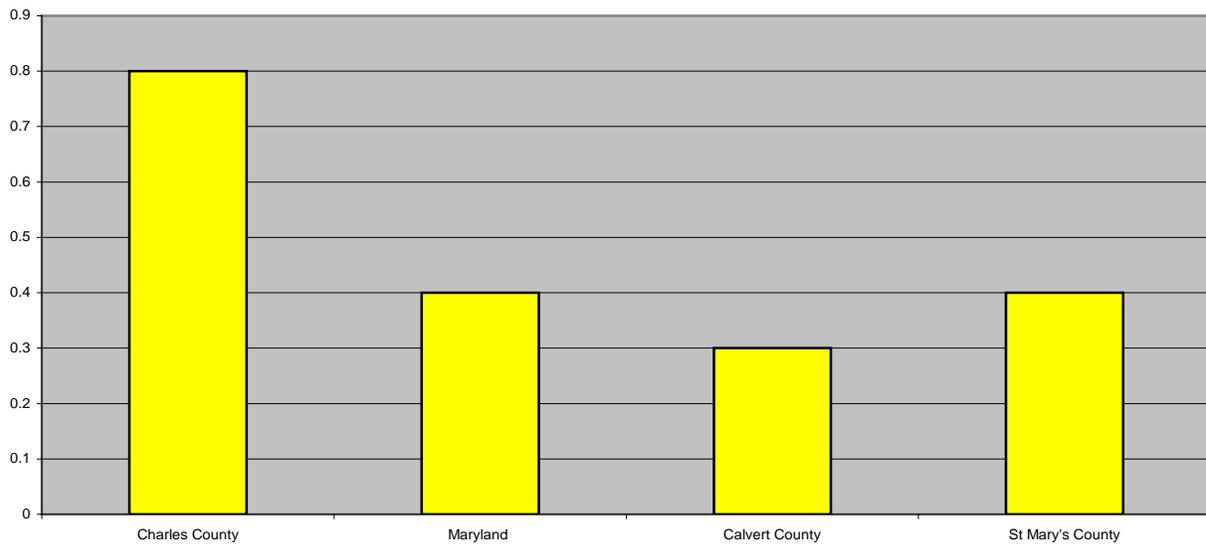
The African American population continues to grow within the county population. In 2005, they accounted for 35.4% of the total county population. This is the 4th highest percentage among the 24 Maryland jurisdictions. This percentage is much higher than the percent for the other Southern Maryland jurisdictions: Calvert County: 13.1% and St Mary’s County: 14.8%. These differences are statistically significant ($p > .05$). It is also greater than the Maryland state average of 29.9%, though the difference is not statistically significant ($p < .05$).¹

2005 African American Population: Percent of Total Population

Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Though the American Indian/ Alaskan Native population makes up a very small percentage of the total county population, Charles County has the highest proportion of this minority than any of the jurisdiction in the state of Maryland. American Indians and Alaskan Natives make up 0.8% of the total county population. This is double the Maryland state average of 0.4%. It is also much higher than the other Southern Maryland jurisdictions: Calvert County: 0.3% and St Mary's County: 0.4%.¹

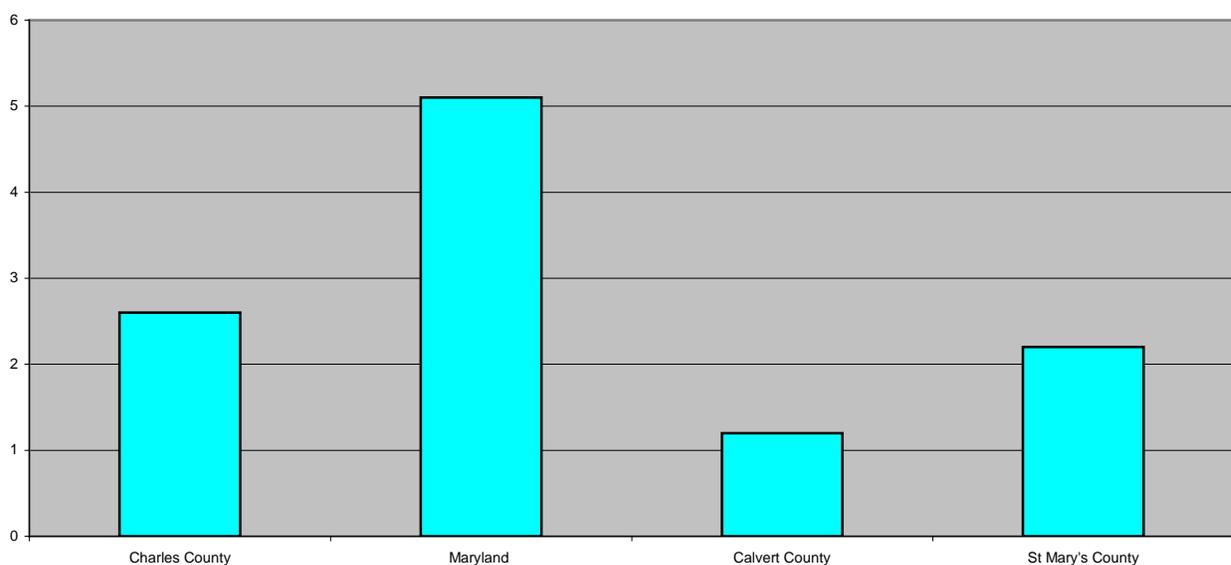
2005 American Indian/Alaskan Native Population: Percent of Total Population



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

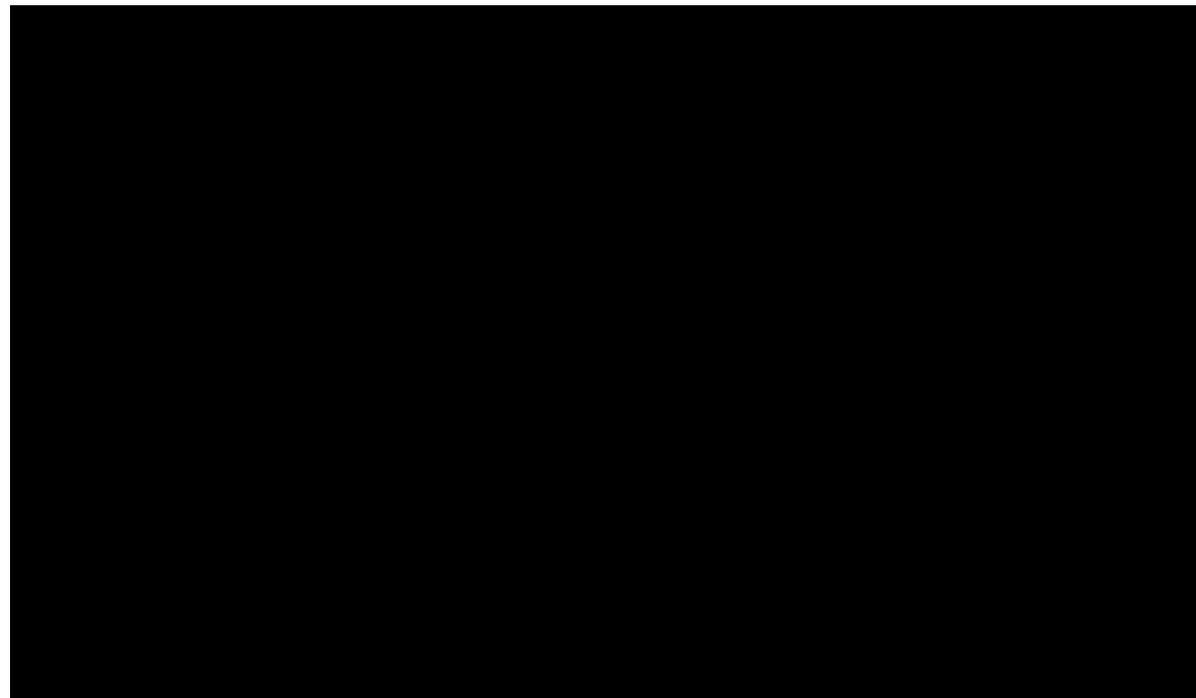
The presence of Asians and Pacific Islander continues to increase within Charles County as well. According to the 2005 Maryland Vital Statistics Report, Asians and Pacific Islanders made up 2.6% of the total Charles County population. This is the seventh highest percentage among the Maryland jurisdictions. This is the greatest percentage among the Southern Maryland jurisdictions: Calvert County: 1.2% and St Mary's County: 2.2%. It is however less than the Maryland state average of 5.1%, which may be skewed by the large presence of Asians and Pacific Islanders in large Maryland counties.¹

2005 Asian/Pacific Islander Population: Percent of Total Population



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

The Hispanic and Latino population is becoming a significant minority within Charles County. This minority now comprises 3.1% of the total county population. This percentage is the seventh highest among the Maryland jurisdictions; however, this is lower than the Maryland state average of 5.7%, which is high due to larger counties such as Montgomery County where Hispanics make up 13.6% of the total county population. The Charles County Hispanic population is the largest among the Southern Maryland jurisdictions: Calvert County 2.0% and St Mary's County 2.3%.¹



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

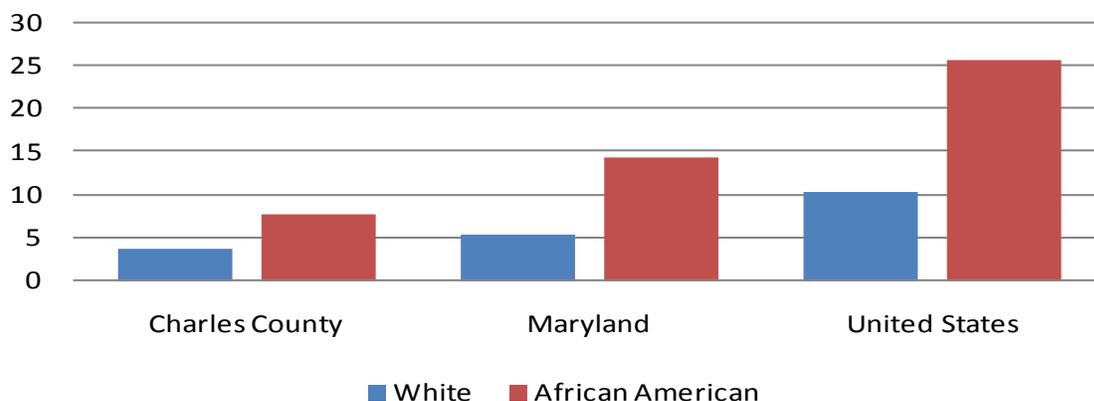
Socio-economic Characteristics:

Employment and economic indicators for the county are strong. In 2006 the employed population for 16 years and older was 108,609. The commute to work includes 56,379 vehicles driven alone, 8,084 vehicles used for carpooling, 5,459 individuals use public transportation (excluding taxicabs), 546 individuals walk, 348 individuals use other means, and 2,421 individuals work from home.¹³

Income:

In 2006, the mean household income was \$95,033.¹³ Charles County has a rate of 6.4% of all families who were living below the poverty level in 2006. African Americans were twice as likely to report that they were below the poverty level as Whites in the county. However, the rates of poverty in Charles County are significantly lower than the Maryland average rate and the United States rate. Poverty rates for Asians, American Indian/ Alaskan Native, and Hispanics could not be calculated due to small sample sizes.³

Percent Below Poverty Level in past 12 months, 2005



Source: 2005 American Community Survey, US Census Bureau

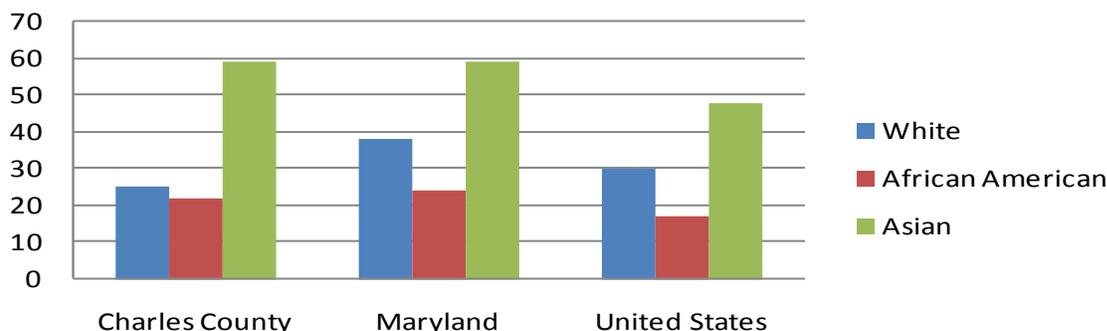
| Economic Indicators | Charles County | Maryland |
|--------------------------------|----------------|----------|
| Average Household Income, 2006 | \$95,033 | \$83,367 |
| Persons below poverty, 2006 | 6.4% | 7.8% |
| Homeownership rate, 2006 | 79.2% | 69.4% |
| In labor force, 2006 | 73.5% | 69.2% |

Source: 2006 Maryland Vital Statistics Report and US Census Bureau: 2006 American Community Survey

Educational Attainment:

Within Charles County, the number of individuals with a bachelor's degree or higher in the White and African American populations is less than the Maryland average. The percentage of college educated African American residents in Charles County is higher than the United States average and only slightly below the Maryland state average. For the Asian population, the Charles County percentage is exactly the same as the Maryland state average and higher than the United State average. Educational attainment statistics were not available for the American Indian/Alaskan Native and Hispanic populations due to small samples sizes.³

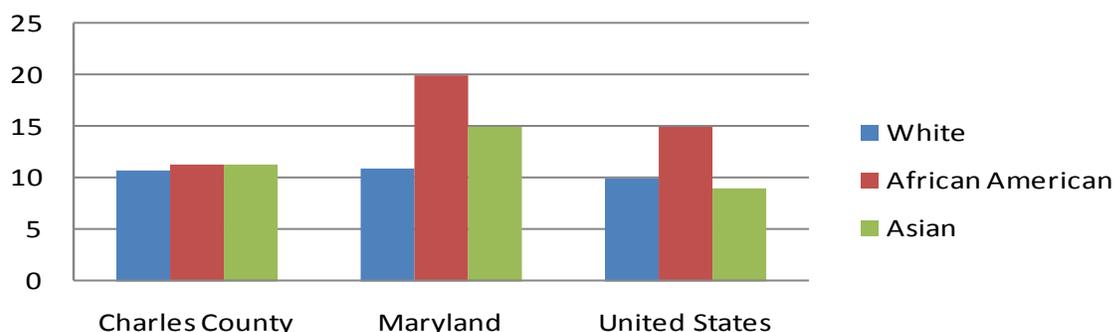
Percent of Bachelors Degree or higher within Racial and Ethnic Groups, 2005 (Ages 25 and over)



Source: 2005 American Community Survey, US Census Bureau

There are no visible racial disparities in the percentage of individuals who have less than a high school diploma. The percentage for Whites, African Americans, and Asians was approximately 11 percent.³ The rate among the White population was similar on a county, state, and national level. The rate for the African American population was less on a county level than the state and national averages. The rate for the Asian population was less than the national average though slightly higher than the state average.

Percent with Less than High School Diploma within Racial and Ethnic Groups, 2005 (Ages 25 and over)



Source: 2005 American Community Survey, US Census Bureau

Mortality:

All Cause Mortality:

From 1999-2003, Charles County like most jurisdictions within Maryland, has a lower all-cause mortality rate than the Maryland state average rate and the national rate. However, mortality rates are higher for African Americans than Whites in every Maryland jurisdiction as well as the state, and the nation.⁴

The Charles County African American all-cause mortality rate is the 4th lowest among the Maryland jurisdictions. It is actually lower than the White all-cause mortality rate for several Maryland jurisdictions such as Somerset County and Baltimore City.

When comparing the White and African American rates on a county level, there are no statistically significant differences in the all-cause mortality rates. The percent excess in the African American all-cause mortality rate compared to the White all-cause mortality rate in Charles County is the smallest in the state. The African American death rate is only 4.1% greater than the White death rate. This is significantly smaller than the Maryland state average excess of 30.8%.

Leading Causes of Death

| Cause of Death | Charles County Number, 2006 | Charles County Number, 2004-2006 | Charles County Rate 2004-2006* | Maryland Number, 2006 | Maryland Number, 2004-2006 | Maryland Rate 2004-2006* |
|--|-----------------------------|----------------------------------|--------------------------------|-----------------------|----------------------------|--------------------------|
| All Causes | 841 | 2568 | 862.2 | 43491 | 130426 | 789.0 |
| Cancers | 202 | 662 | 215.7 | 10336 | 30831 | 186.6 |
| Diseases of the Heart | 199 | 599 | 211.6 | 11191 | 34026 | 205.7 |
| Accidents | 46 | 126 | 33.5 | 1424 | 4187 | 25.0 |
| Chronic Lower Respiratory Diseases | 46 | 127 | 46.3 | 1827 | 5618 | 34.9 |
| Cerebrovascular Diseases | 34 | 128 | 46.8 | 2358 | 7535 | 45.9 |
| Diabetes mellitus | 31 | 95 | 32.3 | 1230 | 4025 | 24.5 |
| Septicemia | 17 | 65 | 21.0 | 964 | 3105 | 18.9 |
| Influenza & Pneumonia | 17 | 68 | 25.8 | 1091 | 3429 | 20.8 |
| Certain conditions originating in the perinatal period | 17 | 39 | ** | 365 | 1101 | ** |
| Alzheimer's Disease | 12 | 41 | 17.1 | 908 | 2767 | 16.9 |
| Intentional self-harm (suicide) | 12 | 39 | 9.9 | 485 | 1441 | 8.5 |

*All rates calculated per 100,000 population

**Rates not available

Source: 2006 Maryland Vital Statistics Report

Diseases of the Heart:

From 1999-2003, Charles County had lower heart disease death rates for African Americans and for Whites than the Maryland state average rate and the United States rate. The Charles County African American heart disease mortality rate was the 11th lowest in the state. On the county

level, the Charles County African American heart disease death rate was higher than the White heart disease death rate, though there was not a statistically significant difference ($p < .05$).⁴

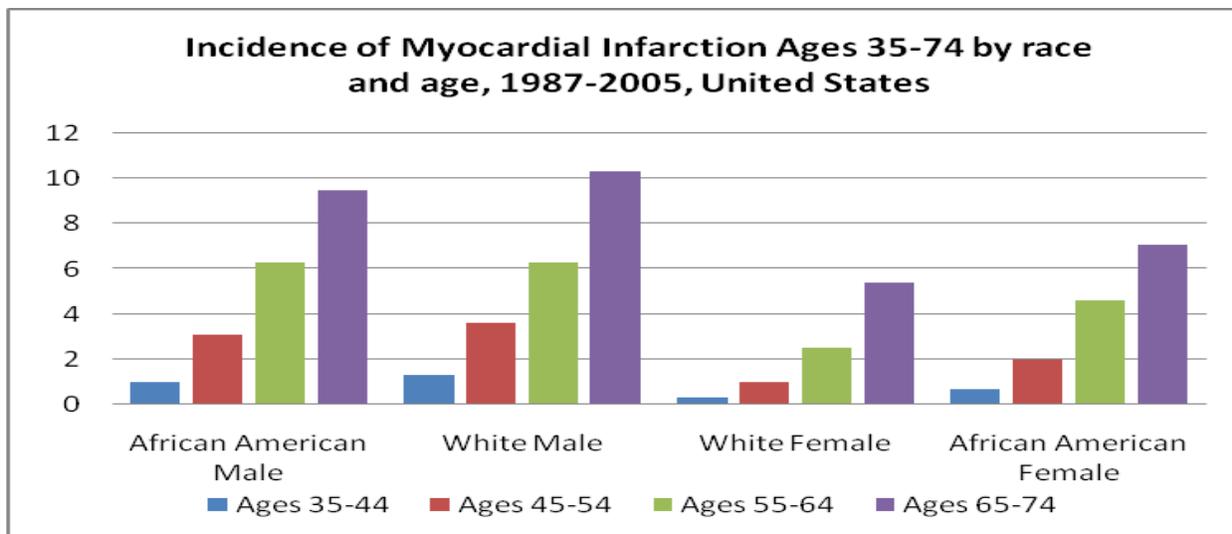
Heart disease is the leading cause of death in the state of Maryland and the second leading cause of death in Charles County. According to the 2005 Maryland Vital Statistics Report, the age-adjusted average death rate for diseases of the heart in Charles County from 2003-2005 was 224.2 per 100,000, which is slightly higher than the Maryland state average rate of 218 per 100,000.²

For Maryland African Americans, the mortality rate from diseases of the heart is much higher than the mortality rate for any other racial group in Maryland. In 2005, the African American age-adjusted death rate for diseases of the heart was 253.3 per 100,000 compared to 200.9 per 100,000 for Caucasians. When comparing by gender, African American males have the greatest death rates from heart disease. The 2005 age-adjusted death rate for black males was 301.6 per 100,000, while the 2005 age-adjusted death rate for white males was 244.1 per 100,000. African American females are also at an increased risk of death from heart disease. The 2005 age-adjusted death rate for diseases of the heart for black females was 216.2 per 100,000, which was significantly higher than the 2005 age-adjusted death rate for white females at 166.3.²

Historically the death rates for African Americans have been higher for heart disease than Caucasians. The heart disease death rates have been slowly decreasing over the past decade for both races, but there is still a racial disparity in the heart disease death rates between blacks and whites. The difference in the death rates for blacks and whites is actually increasing over the years. This is true regardless of gender. The biggest difference in rates can be seen when comparing the male populations.

Using data from the 2005 Maryland Health Services Cost Review Commission, Ambulatory and Hospital Discharge Data and the 2005 Maryland Vital Statistics Report, relative risks for hospitalization and mortality from heart disease were calculated between Maryland African American males/White males and Maryland African American females/White females. African American males were 1.18 times more likely to be hospitalized for heart disease than white males, and 1.24 times more likely to die from heart disease than white males. African American females were 1.51 times more likely to be hospitalized for heart disease than white females, and 1.30 times more likely to die from heart disease than white females.¹

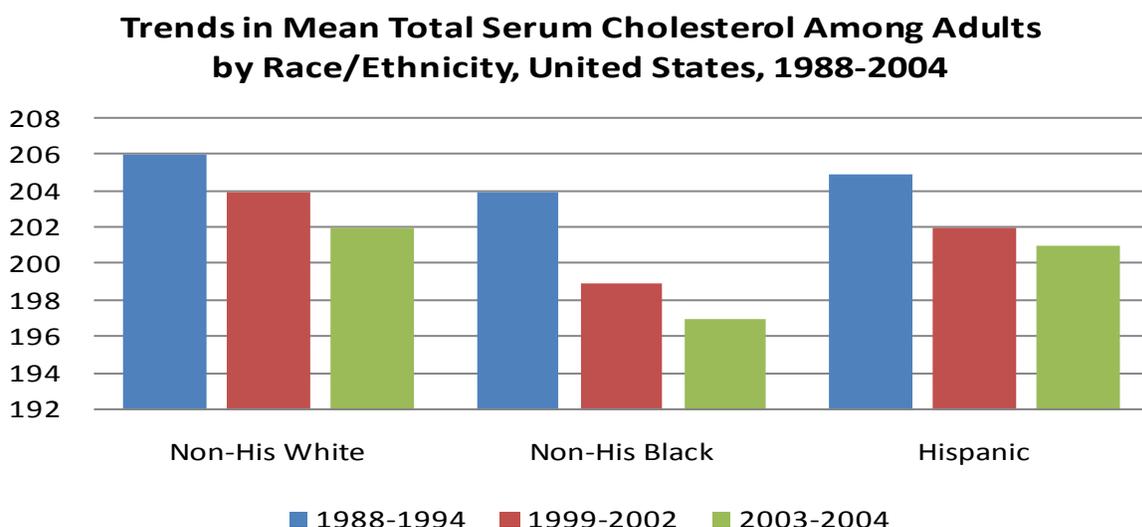
Higher mortality rates for heart disease in African Americans are in part related to the fact that the disease occurs more frequently in African Americans. The following figure shows that incidence (the rate of new cases) of heart attack (myocardial infarction) is higher in African Americans than in Whites in the United States.



Source: American Heart Association, Heart Disease and Stroke Statistics 2007 Updated.

Analogous Maryland data on incidence of heart disease are not available. Prevalence data for heart attack in the BRFSS shows that prevalence is similar between African Americans and Whites. However, prevalence data can be misleading regarding disparity in disease occurrence. If a disease has higher incidence in a minority group and also has poorer survival in that group, prevalence may be similar. That is despite higher rates of new disease, and lower rates of survival in the minority group. Therefore, similar disease prevalence for a condition where minorities have higher mortality is not reassuring.

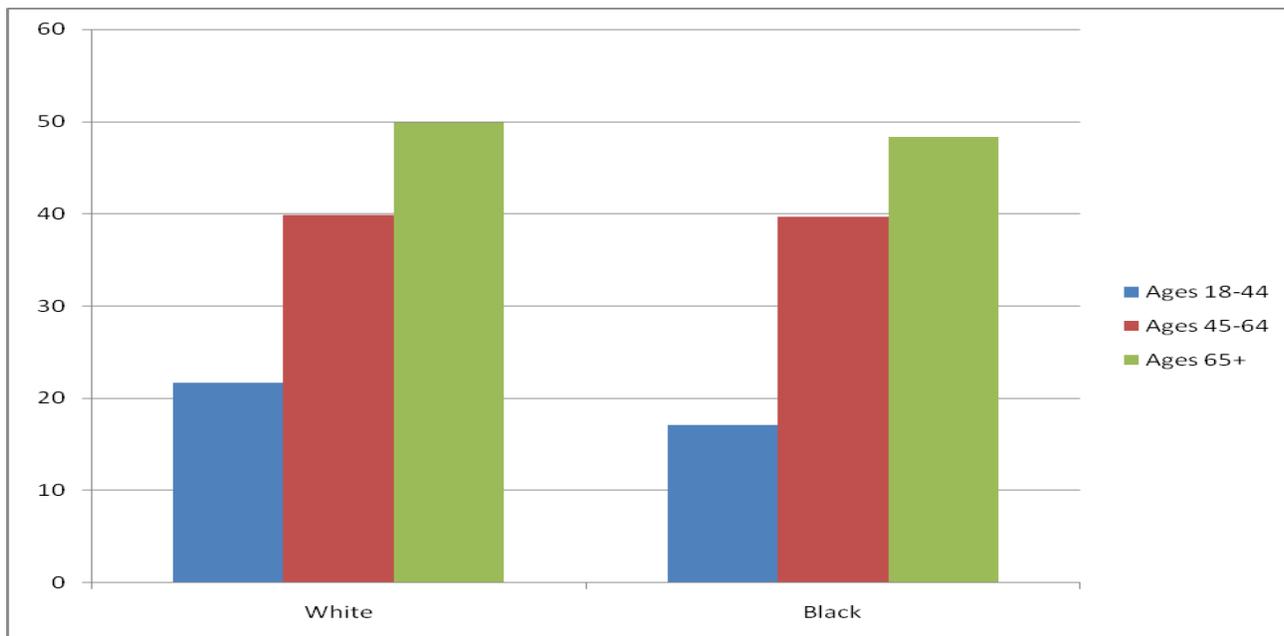
Higher occurrence of heart disease reflects differences in risk factors for heart disease. African Americans have higher rates of hypertension (high blood pressure) and diabetes than whites. Survey data in the U.S. does not show a difference in cholesterol levels.



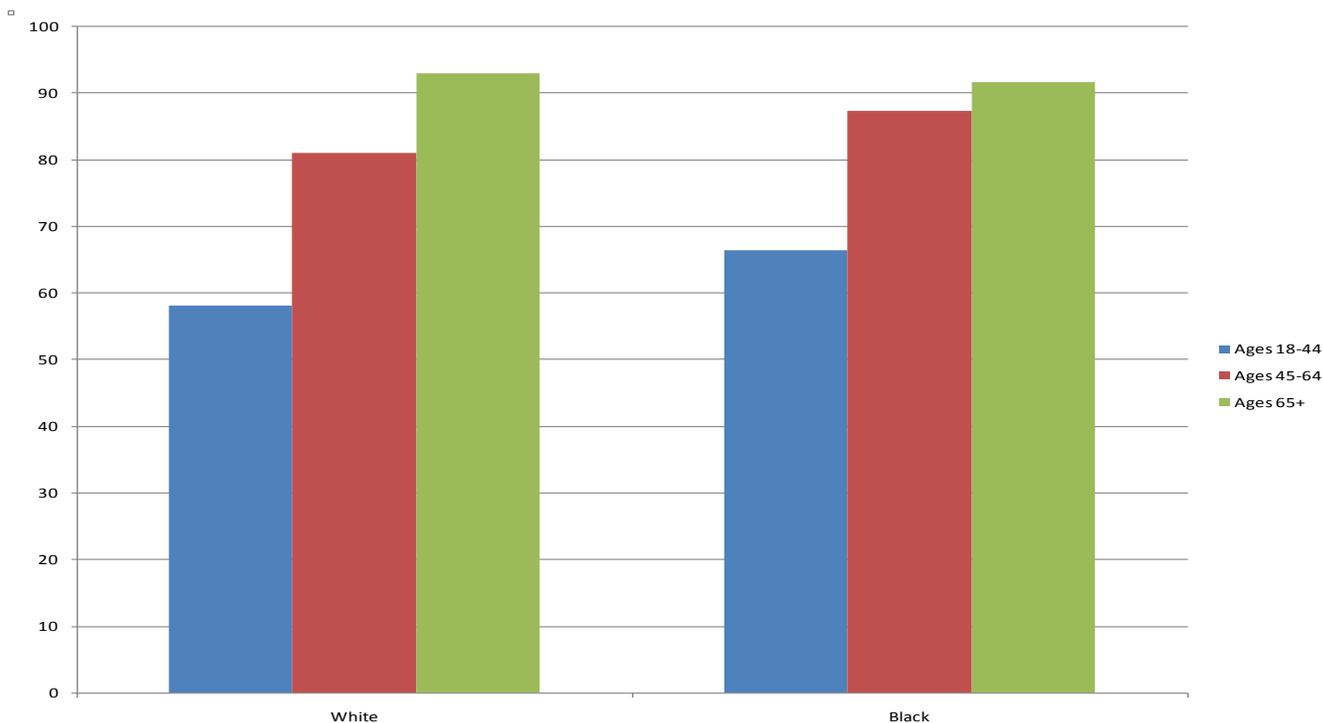
Source: American Heart Association, Heart Disease and Stroke Statistics 2007 Updated.

BRFSS survey data in Maryland does not show a difference in the number of adults reporting a diagnosis of high cholesterol between African Americans and Whites. Rates of cholesterol testing are also similar for the two groups.⁵

Prevalence of High Cholesterol by Race, Maryland BRFSS, 2001 and 2003 pooled



Percent with Cholesterol Test in Last 2 Years, Maryland BRFSS, 2001 and 2003 pooled

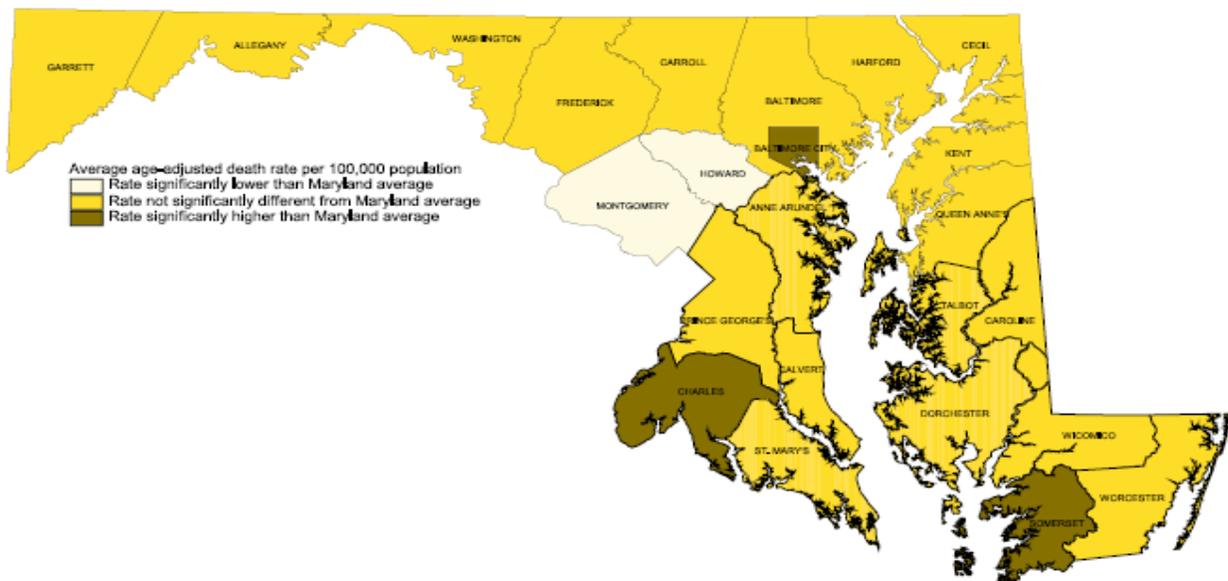


Cancer:

Cancer is the second leading cause of death in both the U.S. and in Maryland. The age-adjusted cancer death rates have been declining for both Whites and African Americans in Maryland, although African Americans have experienced a steeper decline in rates than Whites. Progress has been made in reducing the cancer disparity. In 1996, African Americans had 28 percent higher cancer mortality rates than Whites, while in 2005 the age-adjusted cancer mortality rate for African Americans in Maryland was 12 percent higher than for Whites. The difference between African American and White cancer mortality rates in 2000 was 44 deaths per 100,000, while in 2005 the difference was 22 deaths per 100,000. This represents a 50% reduction of the cancer mortality disparity in Maryland from 2000 to 2005.¹

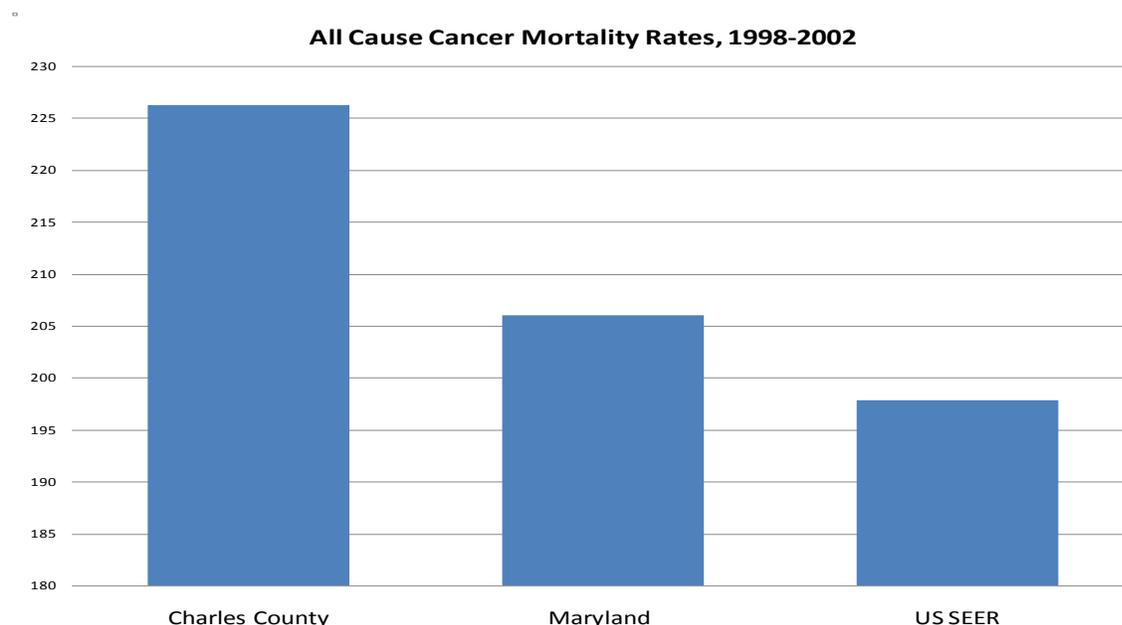
The same patterns of decline in cancer mortality rates have been seen in Charles County. In 2004, cancer was the leading cause of death in Charles County. The age-adjusted death rate for overall cancer from 2003-2005 in Charles County was 222.4 per 100,000.² This rate exceeds the state overall cancer death rate of 190 per 100,000. For 1998-2002, lung and bronchus cancer incidence in Charles County is 66.9 per 100,000 and mortality is 59.9 per 100,000. On a county level, both the incidence and mortality rates for overall cancer and lung/bronchus cancer have decreased since the previous cancer report data. The county incidence rate for lung/bronchus cancer has dropped below the State incidence (68.0); however, the county mortality rate has remained slightly higher than the state mortality (58.1) rate for lung/bronchus cancer.⁶

Comparison of County Age-adjusted Death Rates* for Malignant Neoplasms with the Maryland State Average, 2003-2005.



When comparing cancer mortality among racial groups, there was a reversed disparity for cancer mortality between the periods of 1999-2003. The White cancer mortality rate (approximately

230 per 100,000) is slightly higher than the African American cancer mortality rate (approximately 225 per 100,000), though the difference is not statistically significant.⁴ The White cancer mortality rate exceeds the state average rate and is one of the highest among all of the Maryland jurisdictions. The African American cancer mortality rate is the sixth lowest among the Maryland jurisdictions and is well below the Maryland and national rates.



Source: 2005 Maryland Vital Statistics Report

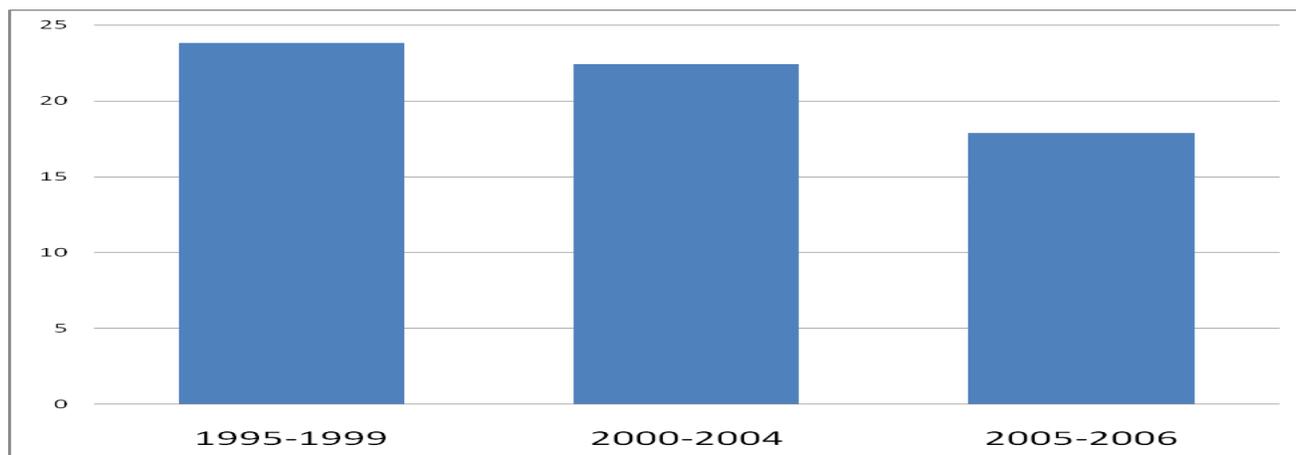
Cigarette smoking is a well-known risk factor for many types of cancer. Among the Maryland jurisdictions, Charles County had the 6th lowest rate of tobacco use by minority youth in 2000 and dropped to the 4th lowest rate in the state in 2002. Charles County ranked 13th in 2000 and 15th in 2002 for highest rates of tobacco use by minority adults. In 2000, the state rates for tobacco use among minority youth and minority adults was less than the county rates; however, the county rates fell below the state rates by 2002.⁷

Prevalence of Any Tobacco Use by Minority Under-age Youth and Minority Adults, Statewide and Charles County, 2000 vs. 2002

| Year | Youth | Adults |
|----------------|-------|--------|
| State – 2000 | 18.8% | 20.6% |
| State – 2002 | 16.8% | 19.1% |
| Charles – 2000 | 21.8% | 21.8% |
| Charles – 2002 | 16.6% | 18.5% |

Source: 2002 CRF Tobacco Use in Maryland

Prevalence of Current Smoking, Charles County, Maryland BRFSS, 1995-2006



Site-Specific:

A table is presented below with the site-specific incidence and mortality rates for Charles County and the state of Maryland for 2004 and the United States for 2001. Charles County is number one in the state for new cases of prostate cancer. Charles County has consistently held the highest prostate cancer incidence rate in Maryland for the last decade. The county has higher death rates for lung, prostate, colorectal, and oral cancers than the United States.

| Site | 2004 Charles County Incidence Rate* | 2004 Maryland Incidence Rate* | 2001 US Incidence Rate* | 2004 Charles County Mortality Rate* | 2004 Maryland Mortality Rate* | 2001 US Mortality Rate* |
|------------------|-------------------------------------|-------------------------------|-------------------------|-------------------------------------|-------------------------------|-------------------------|
| Lung/Bronchus | 469 | 475.3 | 468.8 | 239.6 | 209.9 | 195.6 |
| Colorectal | 54.5 | 55.7 | 51.8 | 27.7 | 23.1 | 20 |
| Female Breast | 121.4 | 132.8 | 134.8 | 32.5 | 28.5 | 25.9 |
| Prostate | 221.1 | 178.6 | 176.8 | 49.6 | 34.3 | 29.1 |
| Oral | 8.4 | 10.7 | 10.4 | ** | 3.1 | 2.7 |
| Melanoma of Skin | 12.8 | 16.9 | 18.7 | ** | 2.5 | 2.7 |
| Cervical | 8.9 | 8.3 | 7.9 | ** | 2.8 | 2.7 |

Source: 2006 CRF Cancer Reports.

*Rates per 100,000 population.

** Rates based on cells with 25 or fewer cases are not presented.

Prostate:

Incidence:

In the United States, the African American population is at an increased risk of developing prostate cancer. Nineteen percent of, or 1 in 5, all African American men will develop prostate cancer in their lifetime.

In Maryland, health disparities among the African American population have also been observed. In 1999, the prostate cancer incidence rate among white Maryland men was 157.4 per 100,000; for African American men in Maryland, the prostate cancer incidence rate was 226.8.⁶

However, for the Southern Maryland region these differences in prostate cancer incidence rates among races have not been noticed. In 1998, the incidence rates among the white and African American populations in Southern Maryland were similar. In 1999, the prostate cancer incidence rate among the African American population was less than the rate among the white population for the Southern Maryland region.

Table 1: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1998

| 1998 | <u>White Males</u> | <u>Black Males</u> |
|--------------------------|--------------------|--------------------|
| <i>Southern Maryland</i> | 166.3 | 167.9 |
| <i>Maryland</i> | 121.1 | 187.2 |

Source: 2006 CRF Cancer Report

Table 2: Prostate Cancer Incidence Rates per 100,000, Southern Maryland and Maryland, 1999

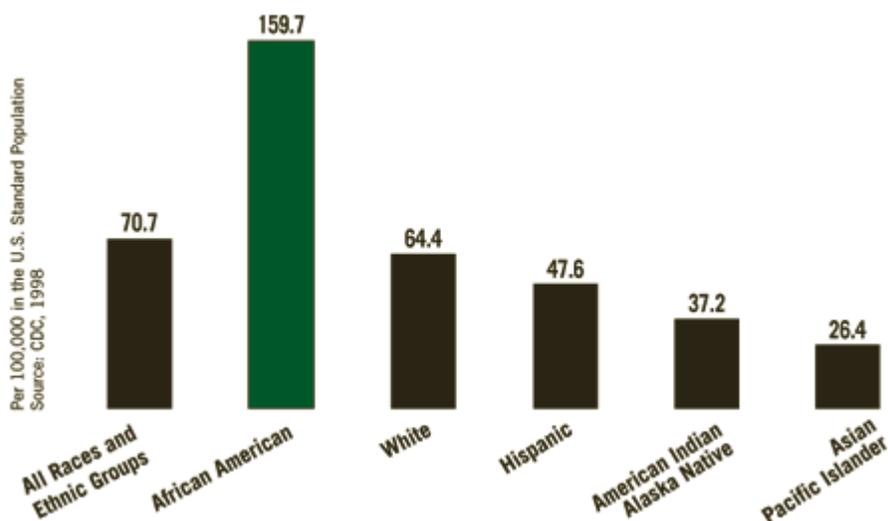
| 1999 | <u>White Males</u> | <u>Black Males</u> |
|--------------------------|--------------------|--------------------|
| <i>Southern Maryland</i> | 171.3 | 159.6 |
| <i>Maryland</i> | 157.4 | 226.8 |

Source: 2006 CRF Cancer Report

Mortality:

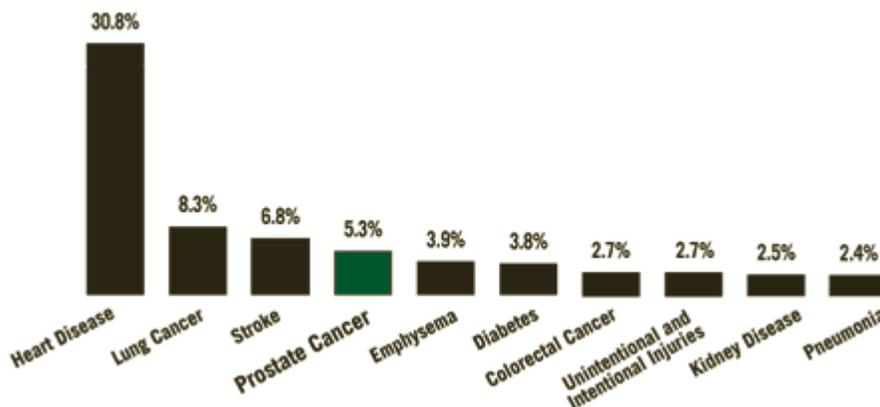
African American men are more likely to be diagnosed with prostate cancer at an advanced stage and more likely to die from the disease than white men. The death rate for prostate cancer among African American men over the age of 45 years is 159.7 per 100,000. This is statistically higher than the death rate for all races of 70.7 per 100,000.⁸

Prostate Cancer Death Rates by Race/Ethnicity in Men Aged 45 and Above



African American men have a 5% chance of dying from prostate cancer; it is the fourth leading cause of death in African American men over the age of 45 years.

Top Ten Causes of Death among African American Men over Age 45

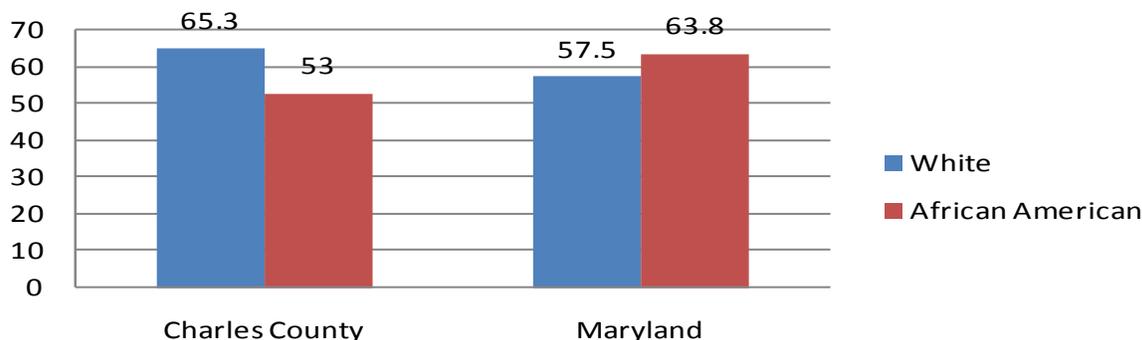


Prostate cancer mortality rates in Charles County are higher than the national mortality rates. However, they appear to be following the same trends as the state mortality rates.

Lung/Bronchus:

Lung cancer is the most fatal form of cancer, and the Charles County lung/bronchus mortality rate is the highest among all county-level cancer site death rates. Unlike the minority disparity seen on the state level, Charles County has experienced a reverse disparity with the White lung cancer death rate higher than the African American rate.

Lung/Bronchus Cancer Mortality Rates by Race, Charles County vs MD, 1999-2003

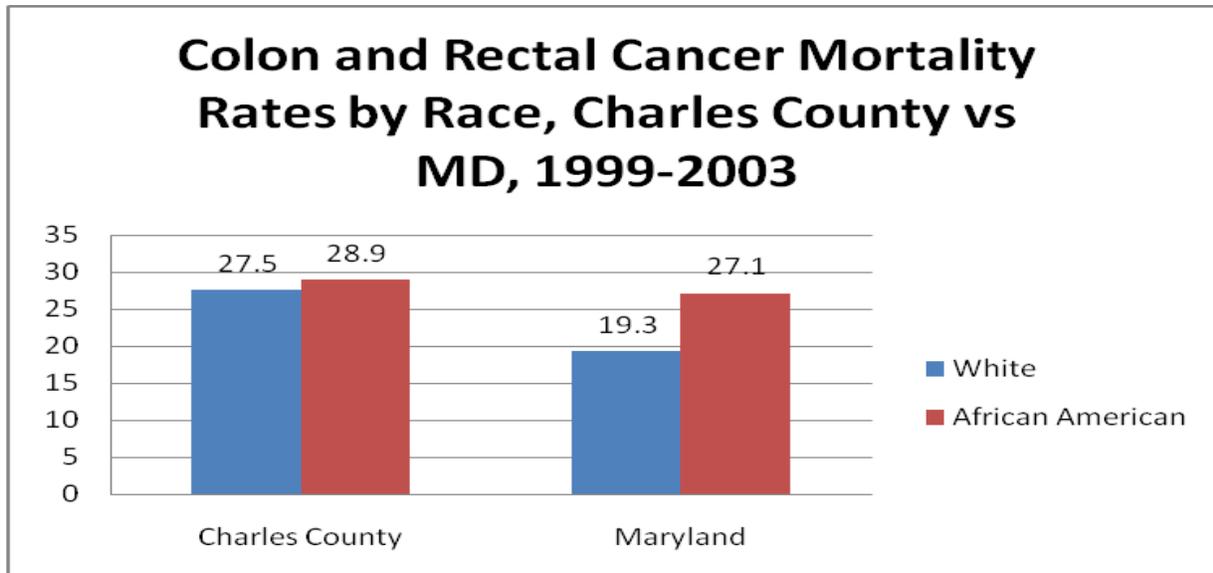


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

*Rates per 100,000 population.

Colon and Rectal Cancer:

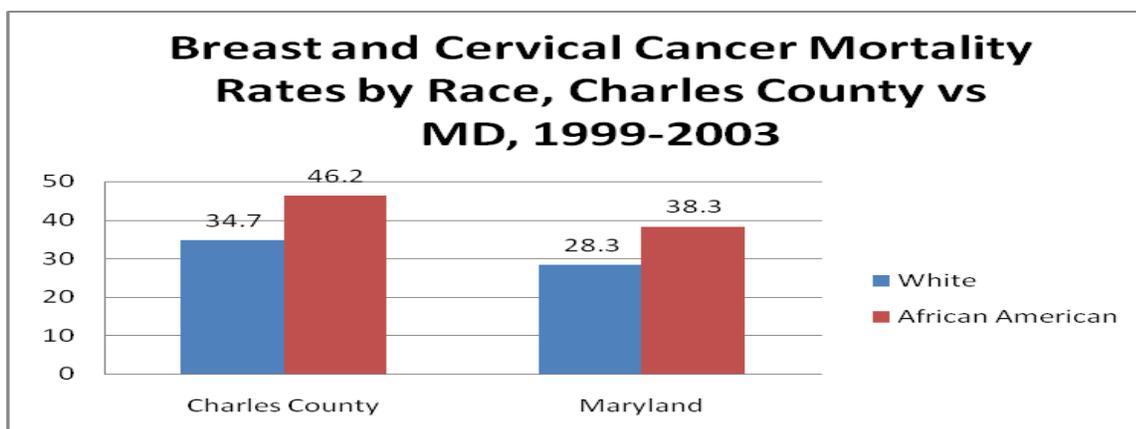
In Maryland, there is a small disparity in terms of Colon and Rectal Cancer deaths, with African Americans experiencing high rates of mortality. However, on a county level, Charles County has not seen the same patterns. The rates for both the White and African American populations are similar. Charles County has the smallest difference in mortality between the White and African Americans than any other jurisdiction in the state.



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities
*Rates per 100,000 population

Breast and Cervical Cancer:

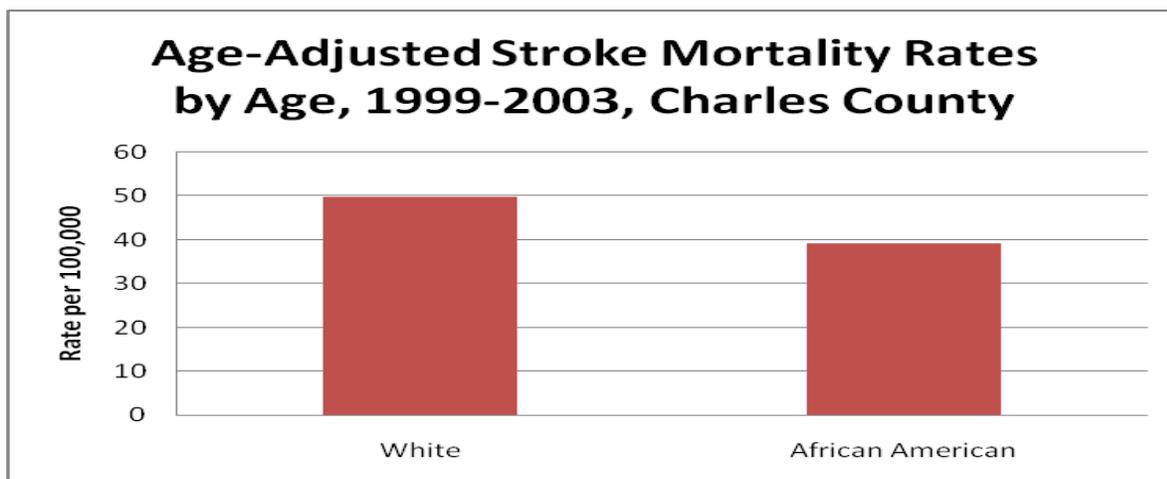
Disparities are visible between the African American and White populations on a county and state level for breast and cervical cancer mortality. The Charles County African American breast and cervical cancer mortality rate is significantly higher than the rate for the Charles County White population. The excess difference in the disparity is higher on a county level (11.5) than on a state level (10).



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities
 *Rates per 100,000 population.

Stroke:

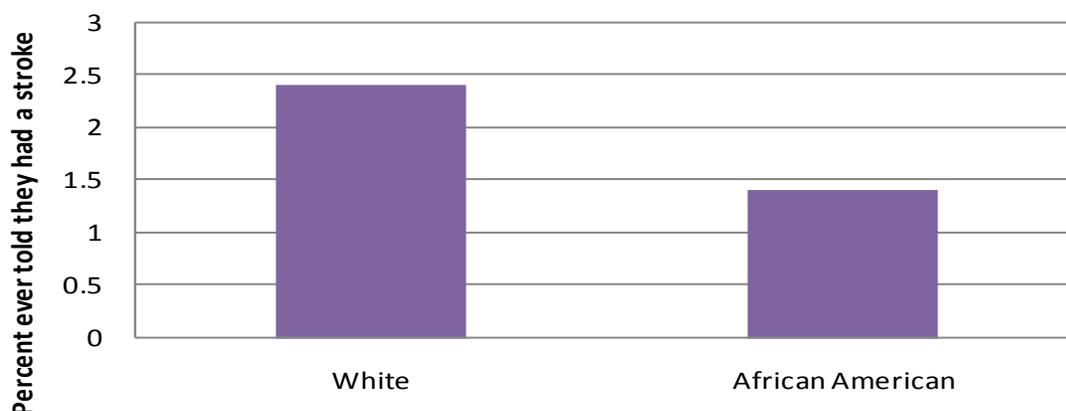
Stroke incidence and mortality are often seen at an increased rate among the African American population. This disparity has been observed on the state and national level. However, the same patterns of disparity are not observed on the county level. From 1999-2003, the Charles County White mortality rate was 27% higher than the African American stroke mortality rate and 13% lower than the Maryland statewide White stroke mortality rate. Additionally, Charles County had the lowest African American stroke mortality rate among all of the Maryland jurisdictions.¹



Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Using 2003-2006 pooled data from the Maryland Behavioral Risk Factor Surveillance System, a county prevalence of stroke can be estimated. Respondents are asked if they have ever been told by a doctor that they had a stroke. Again, a reversed disparity can be seen. Approximately 2.4% of White respondents from Charles County answered “Yes” that they had been told by a doctor that they had a stroke. Only 1.4% of the African American respondents from Charles County answered “Yes” to the same question.⁵

Prevalence of Stroke by Race, Charles County, MD, BRFSS 2003-2006



High blood pressure is a risk factor for stroke. The estimated prevalence for high blood pressure can be approximated by using the Maryland Behavioral Risk Factor Surveillance System (BRFSS) data. One of the questions asks participants if they have ever been told by a doctor that they have high blood pressure. The responses for each racial group are presented in the table below. Several years of data have been included to increase the sample size and to demonstrate any trends in the prevalence of high blood pressure.

According to the self-reported data from the BRFSS, Whites have the highest levels of high blood pressure in the county. The percentage of African Americans reporting that they have high blood pressure is lower than the percentage of individuals reporting high blood pressure in the White population.⁵ This is true for all years of data presented. However, it should be noted that the percentage of respondents reporting hypertension increased from 2001-2004 to 2005 regardless of race. The estimated prevalence could not be determined for other racial groups due to small sample sizes.

| Charles County BRFSS: Have you ever been told that you have High Blood Pressure? 2001-2004 and 2005 | (%) | (%) |
|--|------------------|-------------|
| Percentage that responded "Yes" | <u>2001-2004</u> | <u>2005</u> |
| Charles County African Americans | 31.3 | 34.9 |
| Charles County Caucasians | 33.6 | 44.7 |

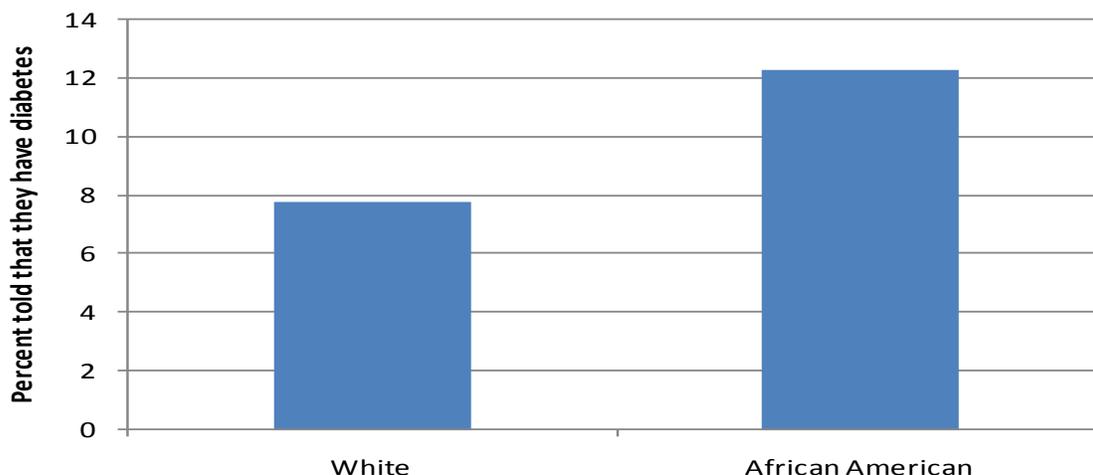
Diabetes:

Incidence:

An estimated prevalence of diagnosed diabetes can be determined on a county level using 2005-2006 Maryland BRFSS data. The data from the question, "Have you ever been told by a doctor

that you have diabetes?” was combined into a two-year period in order to increase the sample size and therefore increase the reliability of the statistics. Disparities can be seen between the African American and White population. The African American population has a significantly higher percentage of people with diabetes than the White population.

Maryland BRFSS: Diabetes Module: Have you ever been told by a doctor that you have diabetes? 2005-2006



The Center for Preventive Health Services at the Maryland Department of Health and Mental Hygiene combined five years of BRFSS data for diabetes and then weighted the responses to reflect the total Maryland and Charles County populations. The table below presents the five-year average prevalence of diagnosed diabetes for Charles County and Maryland defined by gender, race, and age from 2000-2004.

The average prevalence of diabetes in Charles County is lower than the state prevalence (4.2 vs. 6.9). The diabetic prevalence among males is significantly lower for Charles County (2.7% of the total Charles County population) than the state average prevalence of 7.3% of the total MD population. However, for females, the average prevalence is similar between Charles County and the state of Maryland (5.7% vs. 6.5%). Females in Charles County are nearly three times more likely to have been diagnosed with diabetes than Charles County males.⁹

When comparing the average diabetic prevalence by race, the percentage of diabetics within the total black population is higher than the percentage of diabetics in the total white population. The prevalence of diabetes for all races in Charles County is lower than the prevalence among all races for the state of Maryland. However, the number of African Americans in Charles County has increased in recent years. From 1998-2002, 854 African Americans were diagnosed with diabetes in Charles County; from 2000-2004, the number of African Americans with diagnosed diabetes increased to 1103 persons.⁹

When comparing the prevalence of diabetes among age groups, the highest diabetic prevalence falls within the elderly population over the age of 65 years. This is true for Charles County and for the state of Maryland, though the Charles County diabetic prevalence for this age group is below the state prevalence. The prevalence of diagnosed diabetes within the 65+ age group has increased over the past few years. The 1998-2002 five-year diagnosed diabetes prevalence for

Charles County was 12.1%, with 990 people affected. The 2000-2004 five-year prevalence has increased to 12.3%, with 1083 people affected. The prevalence estimates of diabetes within the other age groups (18-44 and 45-64) for Charles County are below the state of Maryland.⁹

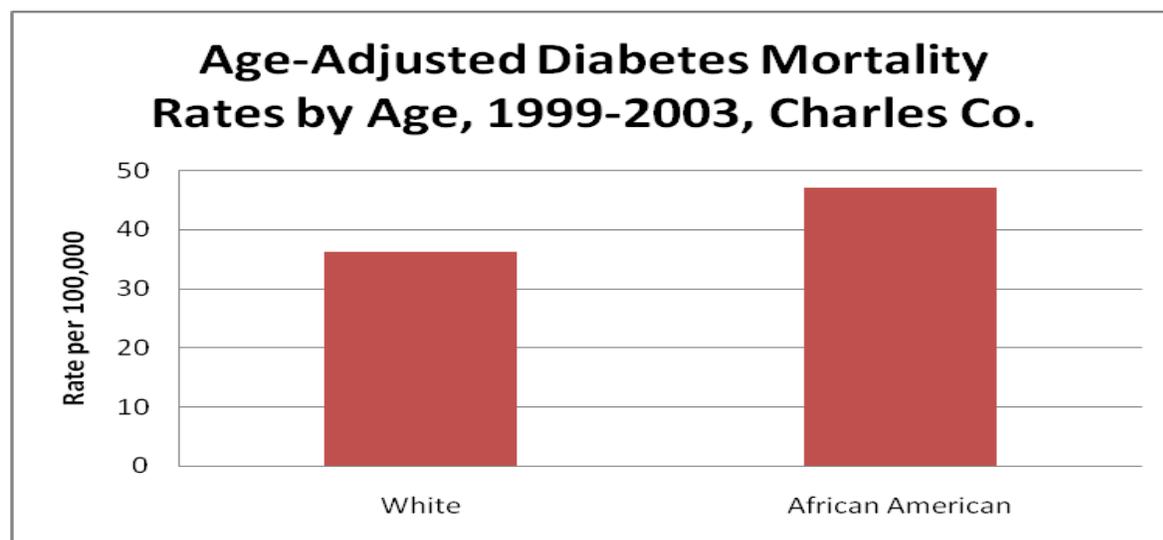
2000-2004 Five-Year Average Prevalence of Diagnosed Diabetes in Charles County and Maryland

| Region | Total | Gender | | Race | | Age | | |
|----------------|------------------|------------------|------------------|------------------|-----------------|-----------------|------------------|------------------|
| | | Male | Female | White | Black | 18-44 yrs | 45-64 yrs | 65+ yrs |
| Charles County | 3716 (4.2%) | 1222 (2.7%) | 2493 (5.7%) | 2612 (4.6%) | 1103 (5.4%) | 817 (1.6%) | 1767 (6.5%) | 1083 (12.3%) |
| Maryland | 278713 (6.9%) | 140246 (7.3%) | 138467 (6.5%) | 151775 (6.1%) | 96598 (9.7%) | 53040 (2.5%) | 125652 (9.6%) | 96225 (16.4%) |

Source: Diabetes in Maryland. Maryland DHMH: Family Health Administration.

Mortality:

Disparities seen in Charles County for diabetes incidence are also evident in the county levels of mortality due to diabetes. The greatest mortality ratio disparity for African Americans compared to Whites in Charles County is with diabetes, where African Americans have a 30% higher death rate than Whites.¹

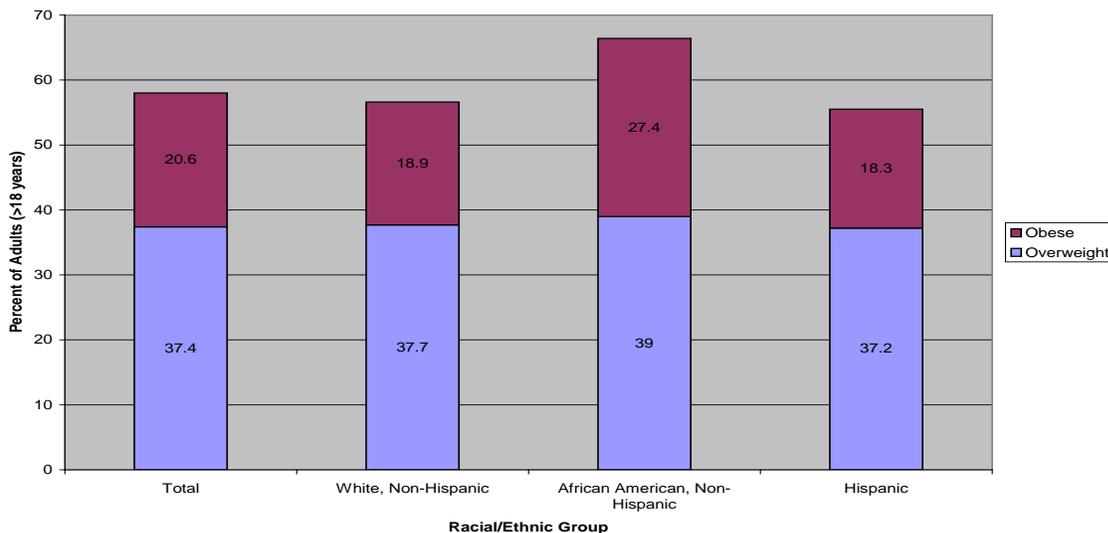


Source: 2007 Maryland Chartbook of Minority Health and Health Disparities

Obesity:

Obesity is a known risk factor for many chronic diseases and conditions. When comparing among racial and ethnic groups, the prevalence of overweight and obesity was higher for African American Marylanders than for White or Hispanic Marylanders. African Americans experienced higher rates of obesity than Caucasians or Hispanics.

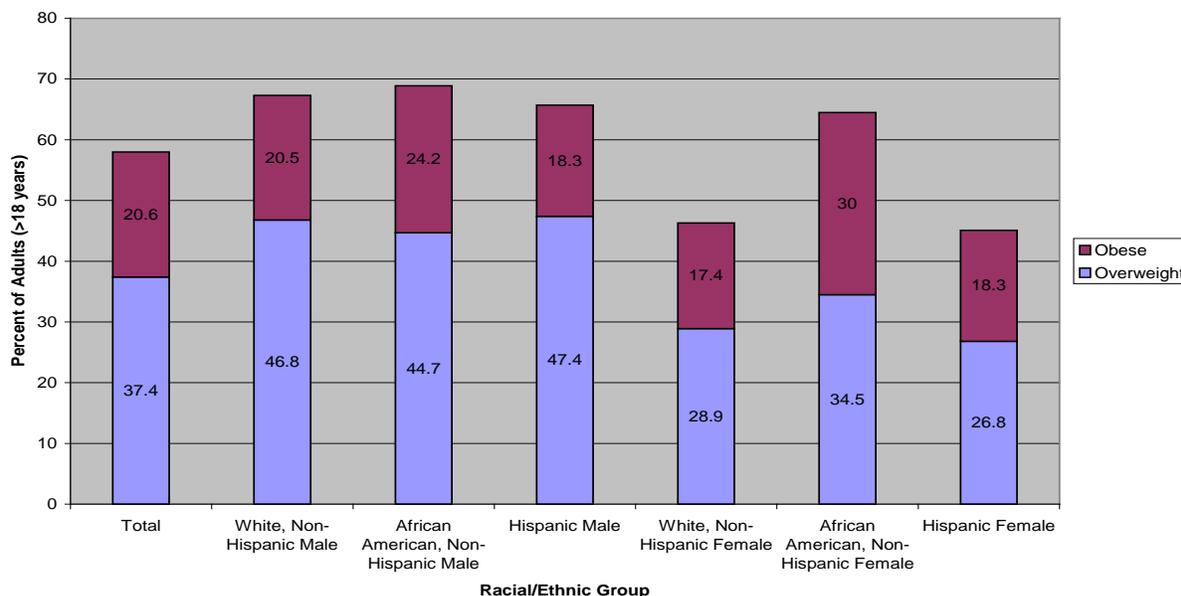
Figure 1: Prevalence of Overweight and Obesity by Race/Ethnicity in Maryland, 2001-2003



Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

The prevalence of overweight and obesity in Maryland was higher among African American women compared to White or Hispanic women. Among males, the prevalence of overweight was comparable across racial groups; however, obesity prevalence rates were higher among African American males in Maryland than White or Hispanic males. African American women were more likely to be obese than African American men. However, white men were more likely to be obese than white women. For the Hispanic population, the obesity prevalence was the same for both men and women in Maryland.

Figure 2: Prevalence of Overweight and Obesity by Race/Ethnicity and Gender in Maryland, 2001-2003

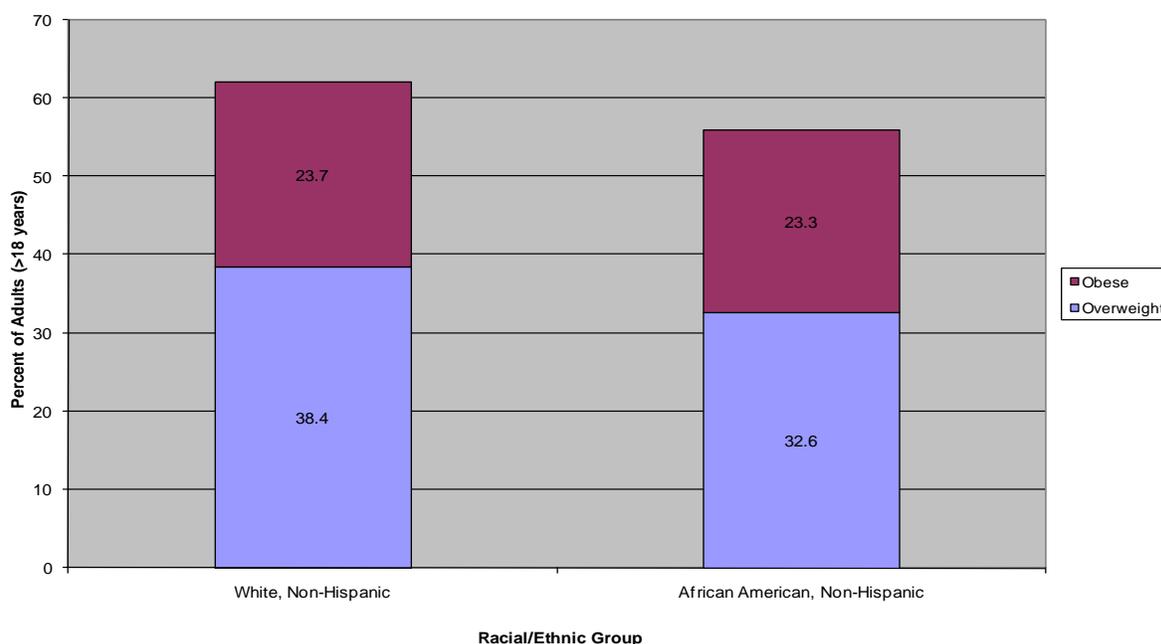


Source: Burden of Overweight and Obesity in Maryland 2005, Maryland DHMH

Obesity prevalence rates have increased in Charles County over the last decade. Several years of data were aggregated together to increase the sample size to a more statistically stable level. Data are compared by 3 year time periods. The prevalence of obesity among Charles county adults was 15-19% during 1995-1997. By 2001-2003, the prevalence of obese adults had increased to 20-24% of the Charles county population.¹⁰

When comparing overweight and obesity rates in Charles County by race, the disparities seen on the state level are not observed. The obesity rates for the White and African American population are similar. A reversed disparity is seen when comparing rates of overweight individuals. There is a slightly higher rate in the county's White population than the African American population.⁵

Prevalence of Overweight and Obesity by Race/Ethnicity, Charles County, 2001-2004



Source: Maryland Behavioral Risk Factor Surveillance System

HIV/AIDS:

Maryland has the 19th highest total population among the 50 states and the District of Columbia. However, in 2004, Maryland was 9th in the US for the cumulative number of AIDS cases at 27,550 cases through 2004 and 4th for its cumulative AIDS incidence rate of 26.1 cases per 100,000.¹¹

For Charles County, the 2004 HIV incidence rate was 5.8 per 100,000, and the 2004 AIDS incidence rate was 6.6 per 100,000. The Charles County 2004 HIV prevalence rate was 91.3 per 100,000, and the 2004 AIDS prevalence rate was 72.2 per 100,000.¹¹

| | 2004 HIV Incidence Rate | 2004 AIDS Incidence Rate | 2004 HIV Prevalence Rate | 2004 AIDS Prevalence Rate |
|----------------|-------------------------|--------------------------|--------------------------|---------------------------|
| Maryland | 40.5 | 24.4 | 308.5 | 241.3 |
| Charles County | 5.8 | 6.6 | 91.3 | 72.2 |

Source: Maryland 2005 HIV/AIDS Annual Report

However, Charles County makes up 58% of the total HIV/AIDS cases in the Southern Maryland region. Among the increases in the incidence rates of HIV, the biggest increases have been seen in the African American population. African Americans currently make up 66% of the total HIV/AIDS cases in Southern Maryland. African Americans make up approximately 63% of the prevalent HIV cases in Charles County and 52.2% of the prevalent AIDS cases in the county.¹¹

Distribution of Gender and Race/Ethnicity among Prevalent HIV Cases on December 31, 2004

Gender:

Race:

| Male | <u>Female</u> | <u>Missing</u> | <u>White</u> | <u>African American</u> | <u>Hispanic</u> | <u>Other</u> | <u>Missing</u> |
|-------------|---------------|----------------|--------------|-------------------------|-----------------|--------------|----------------|
| 63 | 46 | 1 | 20 | 69 | 2 | 0 | 19 |

Source: Maryland 2005 HIV/AIDS Annual Report

Distribution of Gender and Race/Ethnicity among Prevalent AIDS Cases on December 31, 2004

Gender:

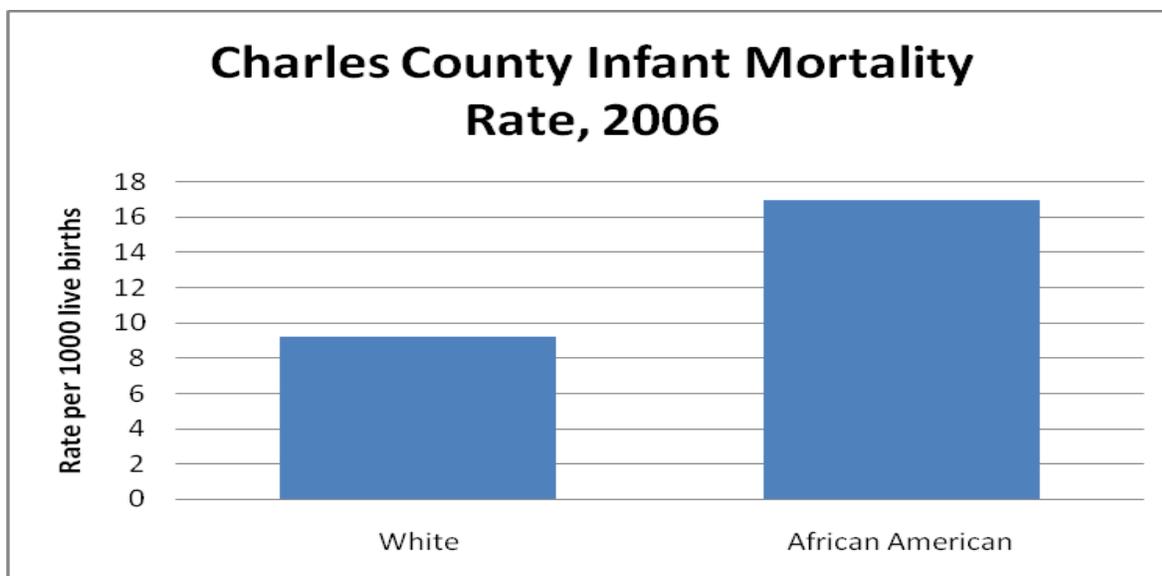
Race:

| <u>Male</u> | <u>Female</u> | <u>Missing</u> | <u>White</u> | <u>African American</u> | <u>Hispanic</u> | <u>Other</u> | <u>Missing</u> |
|-------------|---------------|----------------|--------------|-------------------------|-----------------|--------------|----------------|
| 58 | 29 | 0 | 26 | 59 | 1 | 1 | 0 |

Source: Maryland 2005 HIV/AIDS Annual Report

Infant Mortality:

On a state and national level, infant mortality disproportionately affects the African American population. The same is true for Charles County. According to the 2006 Maryland Vital Statistics Report, infant mortality rates per 1000 live births are almost double for Charles County African Americans than for Charles County Whites.¹²



Source: 2006 Maryland Vital Statistics Report, DHMH

One of the hypothesized reasons for the increase in infant mortality among minorities is a lack of prenatal care. According to the 2006 Maryland Vital Statistics Report, Charles County minorities were more likely to report receiving late or no prenatal care than non-Hispanic Whites. The greatest percentage of late or no prenatal care was seen in the Asian/ Pacific Islander population.¹²

| 2006 BRFSS: Late of No Prenatal Care | <u>Percent</u> |
|---|----------------|
| <i>White, Non-Hispanic</i> | 3.4 |
| <i>African American</i> | 6.6 |
| <i>Asian/ Pacific Islander</i> | 9.4 |
| <i>Hispanic</i> | 6.7 |

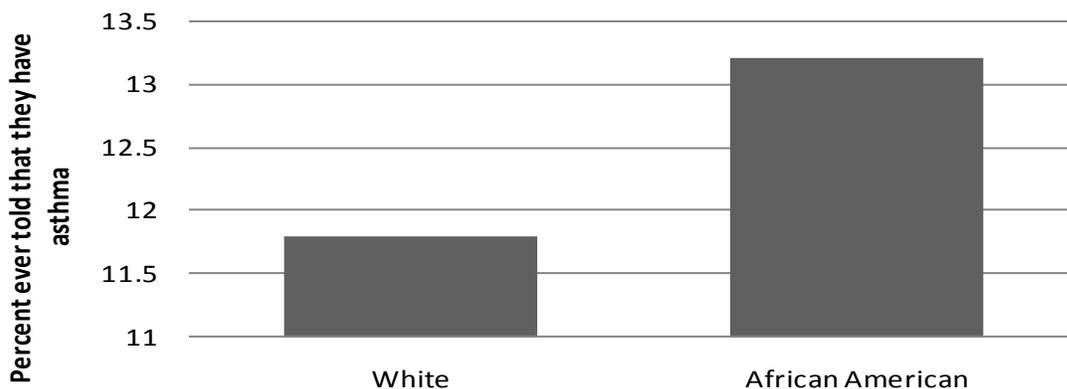
Source: 2006 Maryland Vital Statistics Report, DHMH

Asthma:

The prevalence of asthma in Maryland, from the Maryland BRFSS, is 1.2 times higher for African Americans than for Whites. Based on that, it might be expected that African American adults would experience 1.2 times as many asthma emergency department visits, asthma hospitalizations, and asthma deaths. However, African Americans experience 3.7 times as many asthma emergency visits, 2.6 times as many asthma hospitalizations, and 2.8 times as many asthma deaths. The disparity in these asthma consequences indicates that African Americans experience less treatment success in managing their asthma. Treatment success for asthma depends on access to care, quality of provider treatment planning, and the ability of patients to carry out their treatment plan at home (understanding of plan, affordability of medications and devices). It also depends on the ability to remove asthma triggers from the patient's environment. Individual differences in asthma severity and in patient responsiveness to or side effects from medications also influence treatment success. Elimination of the disparities in asthma outcomes will only occur when the disparities in asthma treatment success are eliminated.¹

Estimates on a county level from the Maryland BRFSS data find that African Americans report slightly higher rates of diagnosed asthma than the White population.

Charles County Asthma Prevalence, 2001-2004, MD BRFSS

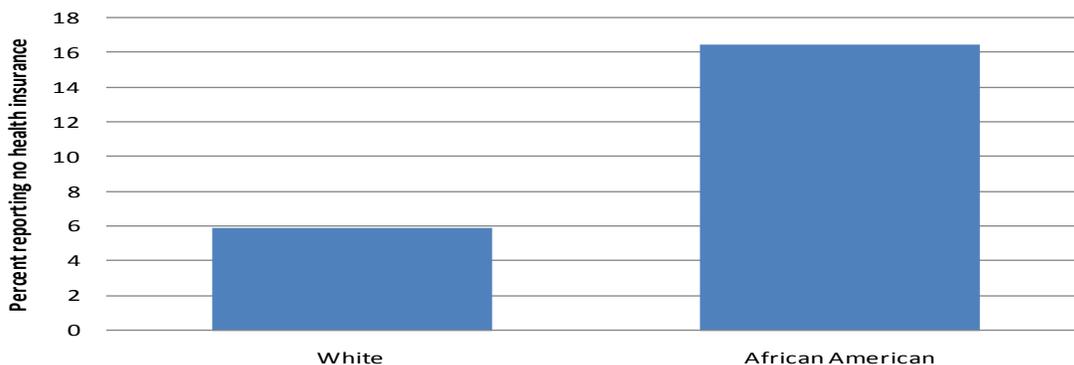


Source: 2001-2004 Maryland Behavioral Risk Factor Surveillance System

Health Insurance:

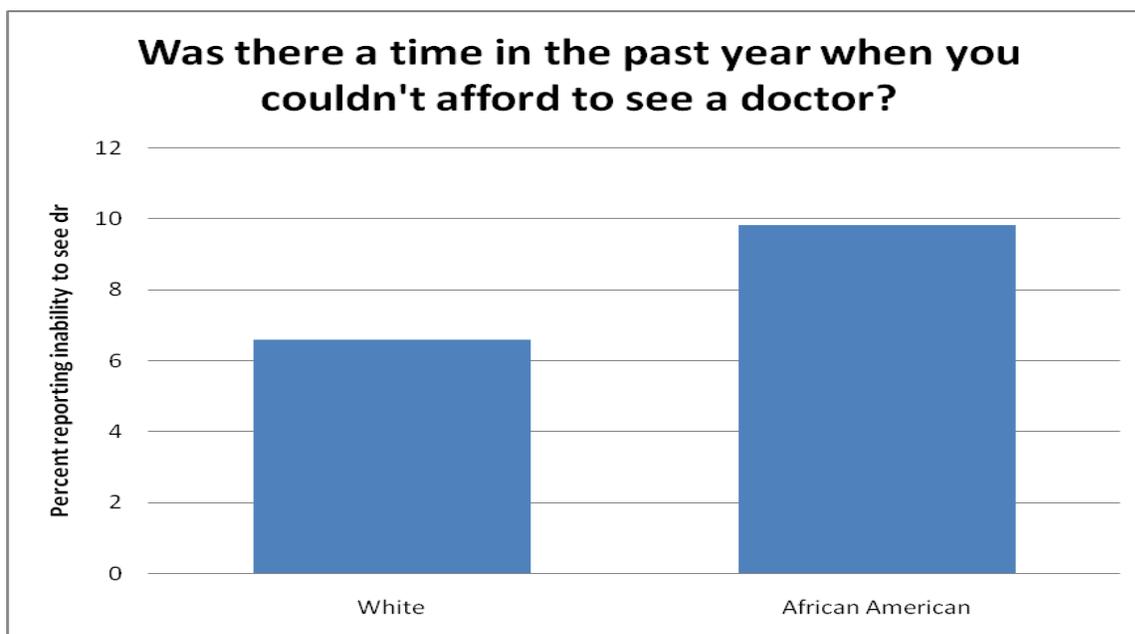
Disparities are often seen among racial groups in terms of health insurance rates. Using the 2005-2006 Maryland BRFSS data, a greater percentage of Charles County African Americans reported a lack of health insurance compared to the county's White population. The difference is more than double.⁵

Percent Reporting Lack of Health Insurance, Charles County, MD, BRFSS, 2005-2006



Source: 2005-2006 Maryland Behavioral Risk Factor Surveillance System

Using the Maryland BRFSS data from 2005-2006 for the question “Was there a time in the past year when you could not afford to see a doctor?” another disparity is observed. Slightly more African Americans reported an inability to see a doctor due to money than Whites in the county.⁵



Source: Maryland Behavioral Risk Factor Surveillance System, 2005-2006

Information on health status was asked in the 2006 Maryland BRFSS. When stratified by race, African Americans are more likely to report having “Excellent” health; however, they are also more likely to report having “Fair” or “Poor” health.⁵

“How is your health in general?”, Charles County, MD, BRFSS, 2006

| <u>Health Status</u> | <u>Excellent</u> | <u>Very Good</u> | <u>Good</u> | <u>Fair</u> | <u>Poor</u> |
|-------------------------|------------------|------------------|-------------|-------------|-------------|
| <i>White</i> | 20.2% | 41.3% | 26.1% | 8.3% | 4.1% |
| <i>African American</i> | 22.5% | 37.1% | 24.2% | 9.7% | 6.5% |

2008 Survey Results

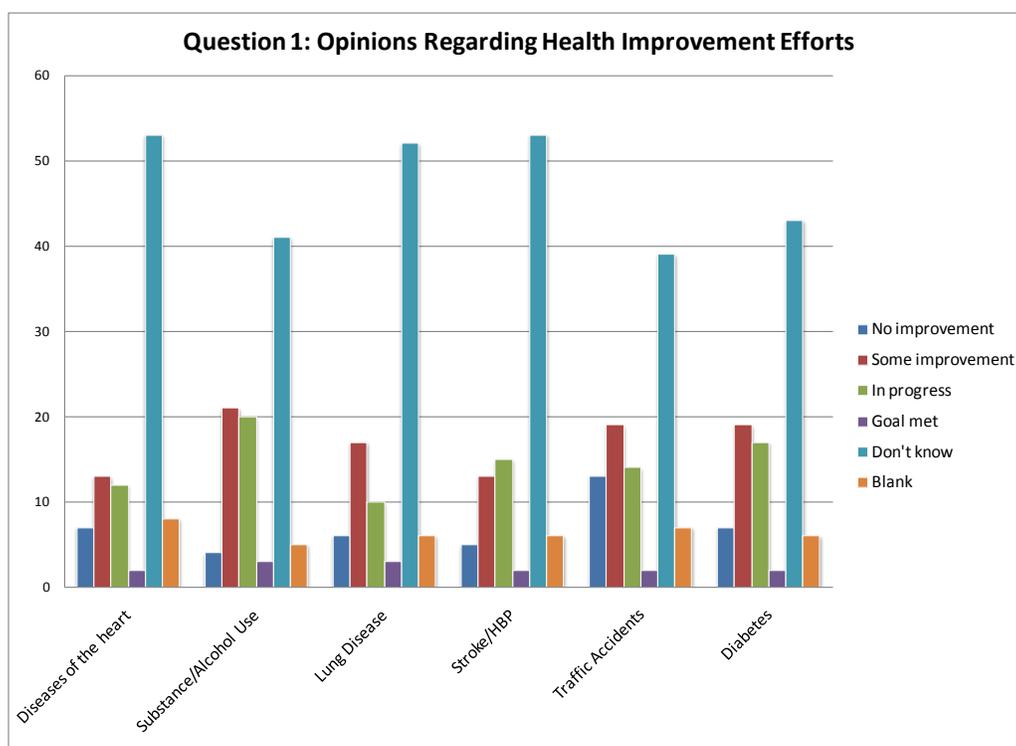
Cumulative Survey Results

As part of the latest community need profile for Charles County, a questionnaire was developed to ask health department professionals, community stakeholders, and health services clients their opinions on the status of health and health services within Charles County.

In order to identify the health achievements, obstacles, and significant problems within the county, 94 surveys were completed. These individuals represent the community's opinion on the status of health and improvements that need to be made. The results of those questionnaires are presented below.

Results

As seen from the chart below, the most common response to each question was "Don't Know." Traffic Accidents received the largest number of "no improvement" ratings. Substance and Alcohol Use received the largest number of "Some improvement" and "In Progress" responses. Each area received a small portion of "Goal Met" ratings. On the other hand, Heart Disease and Stroke/High Blood Pressure had the largest number of "Don't know" responses.



Question 1: Has there been improvement in preventive health education efforts in the following areas in Charles County?

Heart disease is the second leading cause of death in Charles County. The most common response was that they did not know if any improvement had been made in preventive health education efforts for heart disease. This answer was given by 56% of the cumulative group. Among those who did comment on the status of heart disease efforts, most felt that "some

improvement” had been made or that improvements were “in progress.” This was true cumulatively as well as for each group individually.

| <i>Diseases of the Heart</i> | Number | Percentage |
|------------------------------|--------|------------|
| No Improvement | 7 | 7% |
| Some Improvement | 13 | 14% |
| In Progress | 12 | 13% |
| Goal Met | 2 | 2% |
| Don't Know | 53 | 56% |
| Blank | 8 | 8% |

Preventive health education efforts for substance and alcohol use have been long standing priorities at the health department. Just under half of the clients were not able to give a rating to this question and answered “don’t know.” Among those who expressed an opinion of the status of substance and alcohol use improvement efforts, most of the clients felt that “some improvement” had been made or that substance and alcohol use prevention efforts are “in progress”. This was true cumulatively as well as for each group individually.

| <i>Substance and Alcohol Use</i> | Number | Percentage |
|----------------------------------|--------|------------|
| No Improvement | 4 | 4% |
| Some Improvement | 21 | 22% |
| In Progress | 20 | 21% |
| Goal Met | 3 | 3% |
| Don't Know | 41 | 44% |
| Blank | 5 | 6% |

Lung disease caused by smoking is the third leading cause of death in Charles County. Slightly over half of the respondents (55%) reported that they did not know if any efforts had been made to improve chronic lower respiratory disease within the county. Among those who did rate the improvement status of lung disease, many perceived that “some improvement” has been made. The results cumulatively, for clients, and for health department employees found that “some improvement” had been made. Results for the community stakeholders fared more favorably as they felt that improvements were currently “in progress.”

| <i>Lung Disease Caused by Smoking</i> | Number | Percentage |
|---------------------------------------|--------|------------|
| No Improvement | 6 | 6.5% |
| Some Improvement | 17 | 18% |
| In Progress | 10 | 11% |
| Goal Met | 3 | 3% |
| Don't Know | 52 | 55% |
| Blank | 6 | 6.5% |

Cerebrovascular disease, commonly known as stroke and high blood pressure, is the fifth leading cause of death in Charles County. Even among groups surveyed, little is known of the health education efforts within the county for stroke and high blood pressure. More than half of the

group answered that they “Don’t know” about if there has been improvements in this field. Among those who rated the health education efforts, the most common response was that improvements are “in progress.” This was true cumulatively, for clients, and for stakeholders. The most common answer for health department employees was that “some improvement” has been made.

| <i>Stroke/High Blood Pressure</i> | Number | Percentage |
|--|--------|------------|
| No Improvement | 5 | 5% |
| Some Improvement | 13 | 14% |
| In Progress | 15 | 16% |
| Goal Met | 2 | 2% |
| Don’t Know | 53 | 57% |
| Blank | 6 | 6% |

Injuries, death, and hospitalizations due to traffic accidents continue to increase in Charles County. Among those rating this area, the responses were evenly distributed between “no improvements”, “some improvement”, and “in progress.” This is true cumulatively and for clients. The most common response among stakeholders as well as health department employees is that “some improvements” have been made.

| <i>Traffic Accidents</i> | Number | Percentage |
|---------------------------------|--------|------------|
| No Improvement | 13 | 14% |
| Some Improvement | 19 | 20% |
| In Progress | 14 | 15% |
| Goal Met | 2 | 2% |
| Don’t Know | 39 | 42% |
| Blank | 7 | 7% |

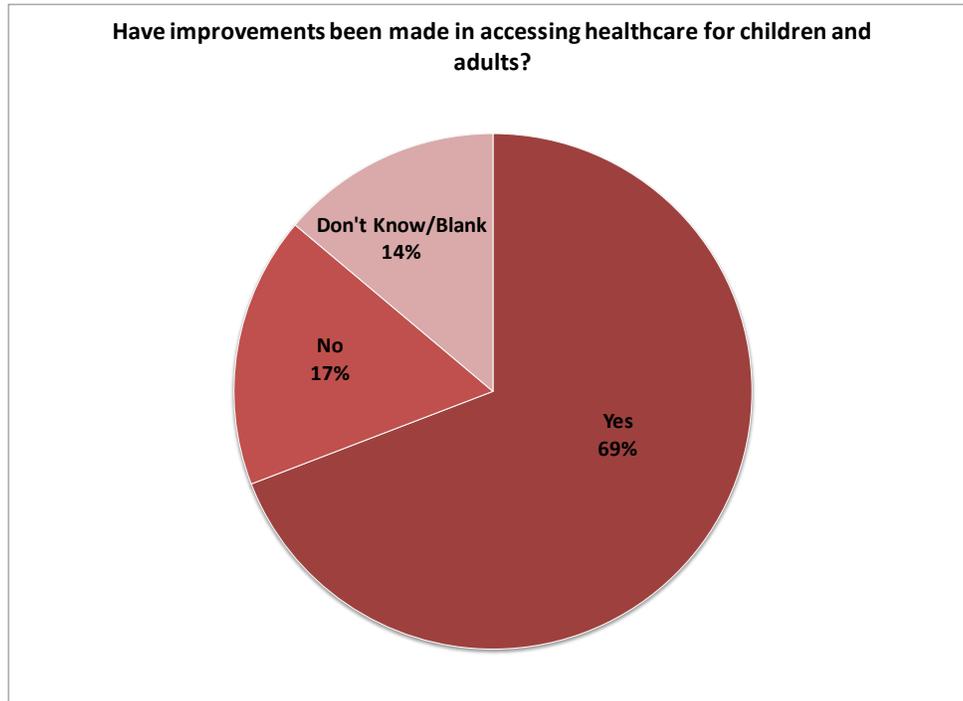
Diabetes mellitus is one of the top ten leading causes of death in Charles County as well as a significant contributor to morbidity. Slightly over half of the respondents were knowledgeable about diabetes health education efforts and rated the improvement seen within the county. Among those who rated the improvements, respondents felt that “some improvement” had been made or that improvements were currently “in progress.” This is true cumulatively and for all groups individually.

| <i>Diabetes</i> | Number | Percentage |
|-------------------------|--------|------------|
| No Improvement | 7 | 7% |
| Some Improvement | 19 | 20% |
| In Progress | 17 | 18% |
| Goal Met | 2 | 2% |
| Don’t Know | 43 | 46% |
| Blank | 6 | 7% |

Question 2: Has there been improvement in accessing healthcare for children and adults?

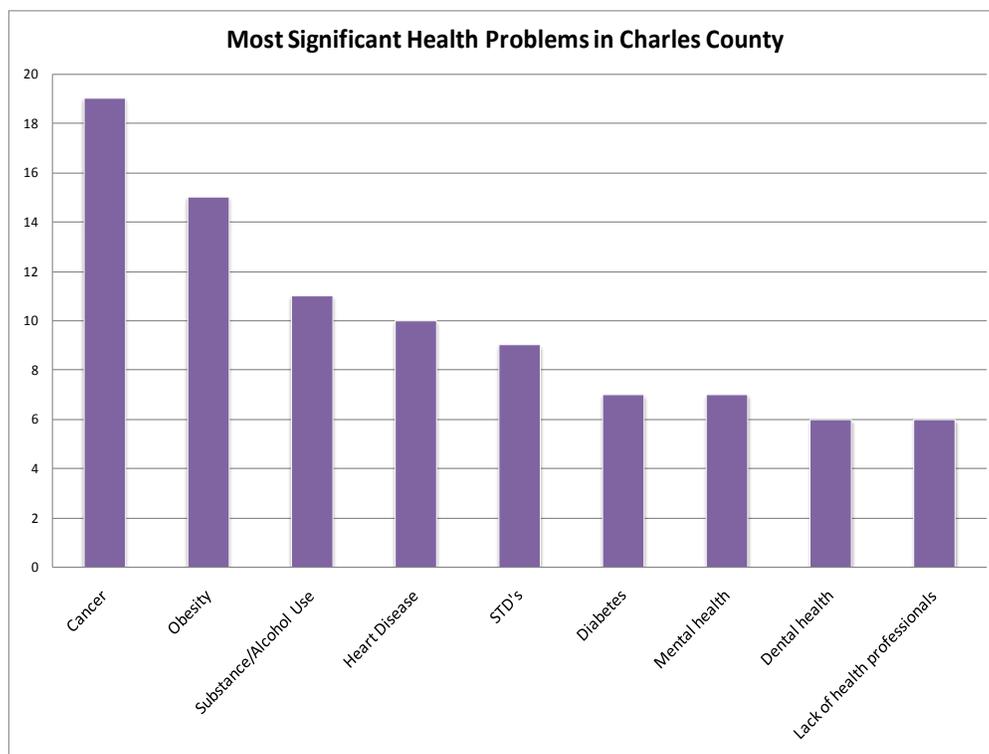
Two thirds of the respondents felt that improvements have been made to increase access to healthcare for adults and children (69%). The same trends in response were seen for all groups individually and for the group cumulatively. The most commonly listed improvement was

medical assistance programs. Another commonly listed improvement was more accessibility to health care and dental services.



Question 4/9: What do you think are significant health problems in Charles County today?

The commonly listed health problem listed by the cumulative group was cancer (20%). It was closely followed by obesity and substance abuse. Cancer was the most common answer for the group cumulatively, for the stakeholders, and for health department employees. Sexually transmitted diseases were the most common answer for clients, followed by Cancer.



Conclusions:

The minority population is increasing rapidly in Charles County. But with increases in the minority populations, increases in minority health disparities have not been observed. For many chronic and communicable diseases, rates appear to be similar for both the White and African American population. The biggest health disparities have been seen for heart disease, breast and cervical cancer, and diabetes. For some conditions, reverse disparities have occurred, such as lung cancer and all cause cancer mortality and stroke mortality.

It should be noted that comparisons on a county level could only be done with the White and African American populations. Because they are the two largest racial groups within the county, data with large sample sizes are available for comparative purposes. Data for other races and Hispanic ethnicity often have small sample sizes which yield unreliable results.

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| Subject: Financial Assistance Program | <u>Effective Date:</u> May 1, 2007 |
| | <u>Revision Date:</u> November, 3 2009 |
| | Approved by _____ |

RESPONSIBILITY: Customer Service Representative

Procedure:

Eligibility – patient eligibility will be based on 200% of the federal poverty guidelines and all of the following information listed below.

All emergent and urgent inpatient and outpatient accounts are eligible for financial assistance. An application must be filled out by the patient or guarantor.

- This application includes: (see attachment A – Financial Aid Application)
- Income from all sources, listing gross income from the last two pay stubs, If only 1 paycheck stub due to new employment then they must supply there wage history statement.
- Liquid assets from saving accounts, checking accounts, CD's, stocks, bonds, money markets, real estate, etc. (1 person \$7500, 2 persons \$15,000)
- Assets including home, cars, boats and other vehicles
- Monthly expenses and number of dependents
- Copy of most recent federal income tax forms (See attachment B – Financial Aid Checklist)

All third party resources and programs including public assistance, Medicaid, must be exhausted before financial assistance can be granted.

Deductible and co-insurance amounts are eligible for financial aid benefits if financial circumstances warrant.

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Program Administration – the financial aid program will be administered according to the following guidelines.

- The application along with the required documents will be reviewed and verified by patient accounts personnel
- After reviewing income and required documents, patient accounts personnel will forward documentation to the Supervisor of Patient Accounts to determine if the patient/guarantor will qualify for financial aid based on the income and assets guidelines worksheets (See Attachment C)
- If the patient/guarantor qualifies for 100% charity he/she will be notified and the account written off per procedure
- If the patient/guarantor qualifies for a reduction in liability he/she will be notified and a payment arrangement made for the non write off amount.

Falsification of application or refusal to cooperate will result in the denial of financial aid benefits.

Civista Medical Center reserves the right to change benefit, determination if financial circumstances have changed.

Patient/guarantor must re-apply every 6 months

MISSION

CIVISTA HEALTH provides excellent care to each patient in a safe, caring and family-centered environment. Civista fosters a healthier community by providing service, education and access to care in concert with other community organizations.

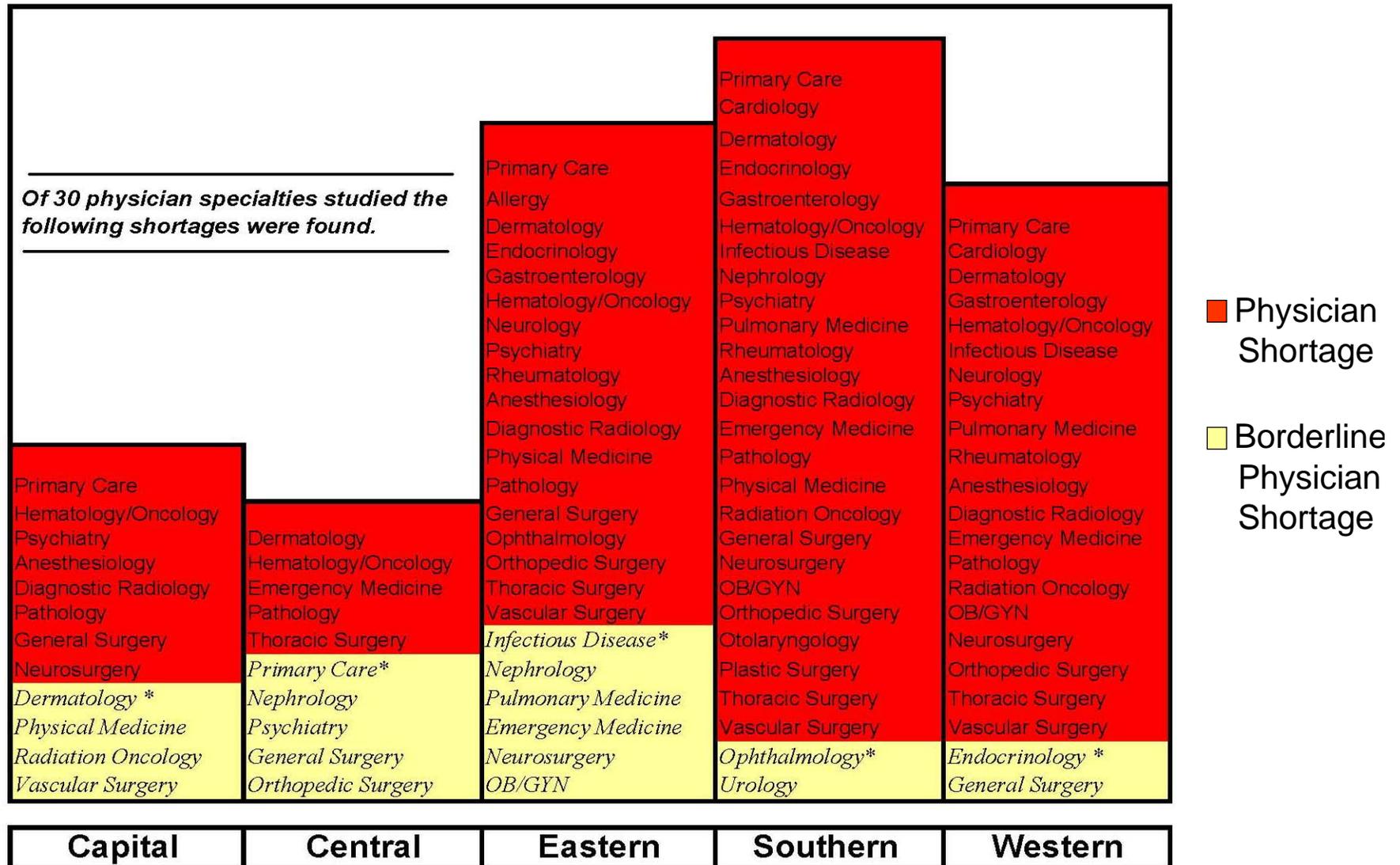
VISION

CIVISTA will be the preeminent healthcare provider for our community through:

- enhanced facilities, technology, and equipment;
- an excellent record of quality care and patient safety;
- highly responsive emergency services delivery;
- skilled workforce and excellent physician partners; and
- financial health to assure funds for re-investment.



Maryland Physician Shortages by Region 2007



*Specialties listed in italics represent specialties where there are borderline supplies of physicians.

12/15/2009

Civista Health, Inc

Selected Categories - Detail

For period from 7/1/2008 through 6/30/2009

| <u>Category / Title / Department</u> | <u>Monetary Inputs</u> | | | <u>Outputs</u> |
|---|------------------------|----------------|----------------|----------------|
| | <u>Expenses</u> | <u>Offsets</u> | <u>Benefit</u> | <u>Persons</u> |
| Community Building Activities (F) | | | | |
| Workforce Development (F8) | | | | |
| Charles County Commissioners | | | | |
| Administration/Corporate Services (9600) | 81 | 0 | 81 | 1 |
| CSM Advisory Board | | | | |
| Information Technology (9360) | 2,030 | 0 | 2,030 | 1 |
| Healthcare Roundtable | | | | |
| Marketing & Planning (9660) | 60 | 0 | 60 | 1 |
| Maryland Hospital Association - Nurse Retention | | | | |
| Administration/Corporate Services (9600) | 492 | 0 | 492 | Unknown |
| Physician Recruitment Search costs | | | | |
| Medical Staff Development (9680) | 362,235 | 0 | 362,235 | Unknown |
| Physician Shortage Task Force | | | | |
| Administration/Corporate Services (9600) | 1,558 | 0 | 1,558 | Unknown |
| University of Maryland Outreach Program | | | | |
| Administration/Corporate Services (9600) | 85 | 0 | 85 | Unknown |
| *** Workforce Development | 366,541 | 0 | 366,541 | 3 |
| **** Community Building Activities | 366,541 | 0 | 366,541 | 3 |
| Number of Activities 7 | | | | |
| Grand Totals | 366,541 | 0 | 366,541 | 3 |