

**Responses of Adventist HealthCare, Inc.  
To Exceptions of the Interested Parties and  
Participating Entity**

**Attachment List**

<b>Attachment No.</b>	<b>Description</b>
A	November 6, 2006 Memorandum from the HSCRC to Commissioner Phillips
B	HSCRC final market share calculation for CY 2014 and an excerpt from a September 29, 2015 HSCRC memorandum that contains preliminary CY 2015 first and second quarter market shift data
C	February 20, 2015 letter from Ziegler to the MHCC, with data concerning recent “BBB” and non-rated health care financings
D	AHC and WAH Community Programs
E	Chart entitled “Overview of Accomplishments”
F	Slides: Center for Health Equity & Wellness

# **Exhibit A**

State of Maryland  
Department of Health and Mental Hygiene



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Chairman

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Vice-Chairman

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Deputy Director  
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# Memorandum

Date: November 6, 2015

To: Frances B. Phillips  
Commissioner/Reviewer, MHCC

From: Gerard J. Schmith   
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Relocation of Washington Adventist Hospital (“WAH”) and Establishment of a  
Special Psychiatric Hospital on the Existing Takoma Park Campus  
Docket No. 13-15-2349

On August 31, 2015 you requested that we review and comment on the financial feasibility and underlying assumptions of the relocation of WAH from its existing location in Takoma Park to the White Oak area and establishment of a Special Psychiatric Hospital on the existing Takoma Park Campus. Adventist HealthCare Incorporated, (“AHI”), the owner and operator of WAH, submitted an amended CON on September 29, 2014 with additional supplemental information including a letter dated July 27, 2015 from James Lee, Executive Vice President and CFO of AHI.

This memorandum provides our general comments and addresses your specific questions regarding the project.

## ***General Comments on Financial Feasibility***

### **Data Reviewed**

We reviewed the revised financial portions submitted on October 21, 2015 as well as other pertinent supplemental information associated with the CON provided by WAH prior to that date. The information submitted included audited financial data for the fiscal years ending December 31, 2013 and 2014, actual and budgeted data for fiscal year ending 2015, and projected data for the fiscal years ending 2016 through 2020 (the second full year after the completion of the project.)

Along with these financial projections, we have also reviewed WAH’s audited financial statements for the year ended December 31, 2014 and the expected financing plan for this project.

**Revenue Projections**

We have reviewed the assumptions regarding the projections of operating revenue. The assumed annual HSCRC approved revenue increases listed in the CON assumptions provided by WAH that were the basis for the revenue increases shown in the table below are as follows:

Table 1 - Summary of Projected HSCRC Approved Revenue Increases  
Washington Adventist Hospital

	Years Ending June 30,					
	2015	2016	2017	2018	2019	2020
Update Factor	2.21%	2.17%	2.30%	2.30%	2.30%	2.30%
Age Adjusted Population Growth	0.00%	.56%	.56%	.56%	.56%	.56%
Population Infrastructure	0.00%	1.05%	0.00%	0.00%	0.00%	0.00%
Market Shift	0.0%	.23%	0.00%	0.00%	0.00%	-.05%
Other Reversals, One Time Adj, etc.	-.75%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	1.46%	4.01%	2.86%	2.86%	2.86%	2.81%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

In addition to the revenue increases shown above, WAH assumed that revenue would increase by \$15,391,282 (5.4%) on January 1, 2019 to reflect the HSCRC approved capital increase.

Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue.

WAH projected that charity write offs would equal 6.5% of gross patient revenue from 2015 through 2020, an increase of .5% from the 2014 actual 6.0%. WAH projected that bad debt expenses would equal 5.0% of gross patient revenue less Uncompensated Care Fund payments from 2015 to 2020, which represents a 1.7% decrease from the 2014 actual of 6.7%. WAH attributes these changes to the changes brought about by the Affordable Care Act.

WAH’s actual other deductions from revenue equaled 11.8% of gross patient revenue in 2014. WAH projected that its other deductions from revenue would decrease to 9.5% of gross patient revenue in 2015, decreasing to 9.4% from 2016 through 2018, and then decreasing to 9.3% in 2019 and 2020. WAH attributes this improvement to engaging a revenue cycle management firm to manage the revenue cycle operations and the reduction in HSCRC assessments due to the elimination of the Maryland Health Insurance Program (MHIP).

The HSCRC staff also reviewed WAH’s projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable. WAH did not project any non-operating revenue associated with this project.

## Expense Projections

Staff reviewed the assumptions regarding the projection of expenses. WAH stated that it applied the following variable expense change assumptions in the CON projected financial statements

Table 2 - Summary of Assumed Expense Increases  
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,					
	2015	2016	2017	2018	2019	2020
Salaries Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	2.0%	1.8%	-.2%	-.4%	1.8%	.8%
Supplies Excluding Overhead:						
Inflation	8.2%	2.0%	3.5%	3.5%	3.5%	3.5%
Volume	-.4%	1.8%	0.4%	-.1%	.7%	1.2%
Contract labor Excluding Overhead:						
Inflation	2.3%	2.2%	2.3%	2.2%	2.3%	2.2%
Change in FTE's	17.1%	-12.5%	-.2%	-.4%	1.8%	0.0%
Purchased Services Excluding Overhead:						
Inflation	-10.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Volume	2.6%	0.0%	0.0%	0.0%	-.2%	.7%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

For fixed expenses, WAH assumed a series of inflation factors for 2016 to 2020 ranging from 0% for professional fees to 2.5% for administrative and general expenses. For 2015 inflation, WAH assumed 0.0% for professional fees, 11.5% for building and maintenance expense, negative (1.9%) for the overhead allocation from AHI, a negative (.2%) for general and administrative costs, and a negative (7.7%) for insurance costs.

WAH assumed that it would reduce building and maintenance operating costs by 20%, or approximately \$1,800,000, after the move to the new White Oak facility. WAH has stated that it will contract with an unrelated party to provide utility services to the new White Oak facility through a Centralized Utility Plant (CUP).

WAH is projecting that its number of FTE's per Average Equivalent Occupied Beds (AEOB) will increase from an actual 4.1 in 2014 at the existing WAH facility to a projected 4.7 in 2020 at the new White Oak facility. The reason for the large increase in projected FTE's per AEOB is due to the fact that approximately 16% of WAH's patient days are related to the psychiatric patients who will remain at the existing WAH facility. The 2014 FTE's per AEOB for other neighboring Montgomery and Prince Georges County hospitals range from 5.0 at Montgomery General Hospital to 5.8 at Prince Georges General Hospital. Part of the reason for WAH's lower FTE's per AEOB is due to the fact that WAH does not report FTE's for all of the shared services that it purchases from AHI including patient billing and Information Technology Services.

Staff calculated the projected overall annual expense percentage variability with volume based on the percentage change in uninflated revenue compared to the annual change in total expenses including depreciation and interest depreciation and interest. The results of staff’s analyses were as follows:

Table 3 – Projected Expenses Percent Variability with Volume  
Washington Adventist Hospital Revised CON Projections

	Years Ending December 31,				
	2016	2017	2018	2019	2020
Including Depreciation and Interest	104.0%	14.2%	97.3%	-11.8%	97.2%

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

The average variable cost change averages approximately 90% over the 5 year period. However, since the overall volume change is very small during this period, any change to the variable cost percent would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable.

In the project budget for capital expenses, WAH made an assumption that it would incur \$2,700,000 in relocation costs for the move of the medical/surgical and obstetrics units and practically all outpatient services at the old facility to the new facility. The \$2,700,000 estimated relocation costs seem low. WAH may incur cost at the new facility before it opens related to training, staffing, inventories, food, and other items related to relocation. There may also be transportation costs of moving patients and staff from the old facility to the new facility. If WAH needs to maintain some of the medical/surgical and obstetrics units and practically all outpatient services at the old facility after the new facility is open, then costs may be higher than the \$2,700,000 WAH has projected.

**Financial Ratios**

WAH states on Page 128 of the CON that AHI will secure financing for the project pursuant to its amended and restated master trust indenture dated February 1, 2003. WAH provided the projected financial information and ratios for the obligated group of AHI. On a consolidated basis AHI projects that it will meet the ratio levels required under its bond documents.

Listed below are the AHI projected ratios and the required ratios per the bond covenants provided by WAH:

**Table 4 - Adventist HealthCare Obligated Group Key Financial Information and Ratios  
Washington Adventist Hospital Revised CON Projections**

	Years Ending December 31, (in millions)							
	2013	2014	2015	2016	2017	2018	2019	2020
Operating Income	\$8.7	\$22.5	\$34.4	\$32.7	\$28.4	\$29.1	\$17.4	\$16.0
Operating Margin	1.2%	3.1%	5.1%	4.8%	4.1%	4.1%	2.4%	2.1%
Excess of Revenue over Expenses	\$12.1	\$25.8	\$42.7	\$41.8	\$37.8	\$38.7	\$27.2	\$25.9
Excess Margin	1.7%	3.5%	6.3%	6.1%	5.5%	5.5%	3.7%	3.4%
Operating Cash Flow	\$54.2	\$71.1	\$74.7	\$74.5	\$70.9	\$72.5	\$87.4	\$87.9
Operating Cash Flow Margin	7.7%	9.7%	11.1%	10.9%	10.3%	10.3%	11.8%	11.6%
Debt Service Coverage-Projected	1.80x	2.13x	2.39x	2.08x	2.00x	2.04x	2.52x	2.79x
Debt Service Coverage --Required	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x	1.25x
Cash and Equivalents	\$225.9	\$245.1	\$213.5	\$226.4	\$230.3	\$196.3	\$212.7	\$229.2
Days Cash on Hand --Projected	124.6	132.4	127.8	133.8	133.2	111.1	114.8	120.6
Days Cash on Hand-Required	70	70	70	70	70	70	70	70
Long Term Debt	\$321.2	\$319.8	\$299.2	\$523.5	\$504.7	\$502.7	\$482.7	\$464.1
Net Assets	\$396.0	\$419.0	\$432.8	\$480.4	\$519.8	\$575.4	\$587.5	\$604.0
Debt to Capitalization-Projected	44.8%	43.3%	40.9%	42.1%	49.3%	46.6%	45.1%	43.4%
Total Liabilities to Unrestricted Net Assets-Projected	1.23x	1.15x	1.03x	1.38x	1.22x	1.11x	1.07	1.03
Total Liabilities to Unrestricted Net Assets-Required	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x	2.50x

Source: Data Provided by WAH on November 2, 2015

Based upon these projected ratios, Staff believes that AHI would be able to obtain financing for the project on terms that are consistent with those assumed in the plan of finance.

### **Projected Volumes**

Even though hospital global budgets are fixed and are not sensitive to volume, Staff is concerned about potential declines in volumes that may occur as care models are changed and as population health is improved. Even without these initiatives, there has been a steady decline in inpatient hospital utilization over decades, in spite of an aging population. The introduction of DRGs, technological advances in surgery, radiation therapy, and new medications have contributed to this change. While costs have not decreased, services have moved to outpatient settings. Nationally and in Maryland, payment and delivery models are changing. These models are likely to accelerate these trends toward lower inpatient utilization. Our advice is that attention should be directed to making sure that bed need projections account for these trends and changes while the State is evaluating the size of the facility. There is a risk that excess capacity could develop, and that this excess capacity could affect the feasibility of the WAH project. For example, several of the TPR hospitals saw intensive inpatient volume decreases resulting in excess capacity, including capacity in new facilities.

One measure of the potential for utilization to fall is Potentially Avoidable Utilization (PAU). This is a measurement of categories of unplanned hospital utilization that can be reduced through better care, better care coordination, and other interventions. Staff is measuring several categories of PAUs. Not all PAUs are avoidable, but Staff has not yet identified all categories of utilization that are avoidable. Staff is currently working with recognized national experts to add to the categories of avoidable utilization.

In HSCRC’s recent calculations of PAUs used to update statewide revenues as of July 1, 2015, WAH’s percentage of PAU’s was 16.47% versus a statewide average of 13.65%. This comparison of PAU’s has not yet been adjusted for socioeconomic status or other health disparities. In the most recent ROC calculations, WAH had 29.3% of its patients classified as disproportionate share (poor patients) compared to an average of 17.8% for the total hospitals in its comparison group. WAH’s significantly higher than average percentage of disproportionate share patients is likely contributing to its higher than average percentage of PAU’s.

On a combined basis, the hospitals in Prince Georges County had 18.50% of their patients classified as PAU’s, while Montgomery County hospitals had 14.43% of their patients classified as PAUs. Therefore, not only does WAH have a high proportion of PAU’s but the hospitals surrounding WAH also have high proportions of PAU’s. Staff believes the potential for volume declines in WAH’s service area related to future reductions in PAUs should be considered when evaluating bed need projections as potentially affecting feasibility. We understand that MHCC carries the responsibility for this effort and that it is difficult to predict the exact impact of change. Nevertheless, Staff believes conservatism is warranted. WAH is projecting the following discharges and observation patient volumes for CYs 2015 through 2020:

Table 5 – Projected Volumes  
Washington Adventist Hospital Revised CON Projections

	Year Ended December 31,						
	Actual		Projected				
	2014	2015	2016	2017	2018	2019	2020
Inpatient Discharges Excl. Psych.	9,892	9,131	9,558	9,567	9,576	9,672	9,768
Outpatient Observation Patients	1,185	2,299	1,881	1,881	1,881	1,900	1,919
Totals	11,077	11,430	11,439	11,448	11,457	11,572	11,687

Source: Updated financial information and projections submitted by WAH on October 21, 2015.

Included in WAH’s construction plans are 8 dedicated Short Stay Observation Beds in the lower tower and 12 Clinical Decision beds adjacent to the Emergency Department for a total of 20 additional beds to treat patients classified as observation patients. WAH is projecting 76,132 observation hours in 2020, the second year of operations at the new White Oak facility. Dividing these hours by 24 hours per day results in 3,172 days of observation care, or an average daily census of 8.7 patients. Many patients stay less than 24 hours, so we are not certain how this translates into bed need or occupancy.

Adding the 20 observation beds to the 152 proposed medical surgical (MSGA) beds results in a total of 172 beds to take care of patients requiring inpatient MSGA services at the new White Oak facility. Adding the projected 3,172 observation patient days to the projected 41,763 MSGA days projected

for 2020 results in a total of 44,935 patient days to be treated in the 172 total MSGA beds for an average occupancy rate of 71.6% in 2020. For the 152 proposed MSGA inpatient beds only, WAH is projecting an occupancy rate of 75.3% in 2020. The State Health Plan calls for a minimum occupancy level of 80% for hospitals with 100 to 299 medical surgical beds. The use of all private rooms may increase the level of occupancy that can occur. We understand that MHCC will evaluate occupancy in its review of bed need.

Staff is concerned about future inpatient volume levels in the service area. If WAH is unable to achieve the projected volumes, the Hospital would be less efficient and would have higher rates, which in turn could affect the overall feasibility of the project. In summary, Staff is suggesting that conservatism in bed need projection is warranted relative to project feasibility and efficiency, given the level of change in the delivery system that is underway nationally and in Maryland.

***Responses to Specific Questions:***

**1. Are the sources of funds assumed by the applicant appropriate? In your opinion, is the equity contribution and the proportion of other non-debt sources of project funding adequate?**

WAH intends to finance the total project costs of \$330,829,524 by incurring \$244,750,000 in debt, fund raising \$20,000,000, contributing cash of \$50,575,175, and earning \$4,504,349 in interest income during construction. All of the \$330,829,524 project cost is related to capital costs with no allowance made for working capital costs or transition costs.

In addition to the \$20,000,000 assumed fund raising and \$50,575,175 cash contribution, WAH is assuming that the \$11,000,000 previously expended for the purchase of the land for the project will also be a source of funds leaving the total equity contribution at \$81,575,175, or approximately 25% of the project costs.

Staff spoke with representatives of the Maryland Health and Higher Educational Facilities Authority (MHHEFA) who stated that AHI has a Baa2 debt rating. WAH has assumed an interest rate of 6% for the debt associated with this project, which seems to be high given current interest rates. If the actual interest rate is less than that assumed, the rate adjustment approved by the HSCRC would be modified to reflect the lower interest rate.

Additionally, while the estimated annual depreciation, amortization, and interest is \$24.6 million, the HSCRC only approved an additional \$15.4 million revenue increase. Therefore, AHI will be financing a significant portion of the borrowing.

Given AHI's debt situation, staff believes that WAH has provided a reasonable amount of equity contribution for the project to be financially feasible. Ideally staff would like to see higher equity contributions so that the interest rate might be lower on the debt issued for the project resulting in overall lower costs to the patients.

**2. As you know, one of the applicant's assumptions is that it will obtain a 7% increase in the hospital's global budget revenue to account for the increased capital costs resulting from this project. In your opinion, is this increase necessary for this project to be feasible and for the replaced and relocated WAH to be financially viable? If, in your opinion, this increase is not**

**necessary for project feasibility and the viability of WAH, please provide the basis for this opinion.**

The 7.0% rate increase assumed by WAH represents approximately 80% of the additional depreciation and interest related to the new project. As stated above, Staff has recommended a \$15.4 million (5.4%) increase to revenue instead of the 7.0% requested. WAH had used projected operating results for FY 2014 in its original CON submission. Its actual operating results for that year were much better than projected. These results were incorporated in its projections submitted on October 21, 2015. This improvement significantly offsets the impact of the lower approved revenue increase.

**3. Based on your analysis and the experience of HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement hospital to be competitively priced, when compared with general hospitals in its region of the state and when compared with similar (peer-group) hospitals throughout the state, if the project is implemented as proposed and the applicant’s utilization projections are realized?**

Competitive rates for proposed hospital – In order to evaluate the proposed rates of the relocated hospital, we developed a comparison of how WAH’s inpatient and outpatient hospital charges compared to its local competitors for the year ended June 30, 2014. Staff’s analyses compared average inpatient charges per case by APRDRG broken down between the 4 severity levels within each APRDRG. Staff’s analyses also compared average outpatient charges per case broken down by APG.

Listed below are the percentage variances between WAH’s average charges per inpatient case and outpatient case and its neighboring hospitals for the year ended June 30, 2014:

Table 6  
Comparison of Average Inpatient and Outpatient Charges per Case  
Washington Adventist Hospital and Neighboring Competitors  
Using Actual Charge Data  
Year Ended June 30, 2014

Hospital	Percent Variance from WAH Average Inpatient Charges per Case	Percent Variance from WAH’s Average Outpatient Charges per Case	Combined Percent Variance from WAH’s Average Charges per Case
Doctors Hospital	(8.4%)	(4.3%)	(7.5%)
Howard County	(13.6%)	(21.9%)	(17.9%)
Montgomery Medical Center	(13.1%)	(8.4%)	(12.3%)
Suburban Hospital	(18.4%)	(4.3%)	(14.4%)
Holy Cross Hospital	(14.1%)	(7.8%)	(12.8%)
Laurel Regional Medical Center	(12.0%)	6.6%	(5.7%)
Average Difference	(13.3%)	(6.1%)	(11.6%)

Source: HSCRC Market share data base. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As this table indicates, the charges at WAH’s competitors were on average 13.3% below WAH’s charges for inpatients and 6.1% below for outpatients based on actual charge data for the year ended June 30, 2014. Once WAH is granted an additional 5.4% rate increase for capital its competitors will have rates on average that may be more than 15% less than WAH’s new rates based on the comparisons of actual FY 2014 charges. However, these comparisons do not take into account the cost differences that may be attributable to taking care of populations with lower socioeconomic status. The ROC comparison discussed below includes an adjustment to estimate the impact on costs of these population differences.

Staff compared adjusted charges using information from the most recent ROC calculation, which utilized data from 2013 adjusted for revenue changes to 2014. The adjusted charge comparison from the ROC data is as follows:

Table 7  
Comparison of Average Combined Inpatient and Outpatient Charges per Case  
Washington Adventist Hospital and Neighboring Competitors  
Using Adjusted ROC Charges  
Year Ended June 30, 2014

<u>Hospital</u>	<u>Percent Variance from WAH’s Average Combined Adjusted Charges per Case</u>
Doctors Hospital	12.5%
Howard County	.5%
Montgomery Medical Center	10.4%
Suburban Hospital	9.9%
Holy Cross Hospital	(9.5%)
Laurel Regional Medical Center	(6.4%)
Average Difference	7.5%

Source: HSCRC ROC data. Percentages were determined by first comparing to statewide averages and then comparing to WAH variances from statewide average.

As noted above, the ROC analysis takes into account that WAH has a greater percentage of poor patients than the average of the hospitals in its peer group, which tends to cause higher costs and rates.

***Other requests:***

You also asked to receive comments on the financial feasibility of providing acute psychiatric hospital services in Takoma Park as a 40-bed special hospital. The project budget, five year pro forma schedule of revenues and expenses, and assumptions for this proposed special hospital

were submitted on December 12, 2014. Note that the project budget erroneously indicated that the source of funds for renovating space for behavioral health would be cash. The correct source of funds is debt, as specified in Exhibit 6 of the September 29, 2014 replacement application. This was confirmed by WAH in its response to my April 29, 2015 request for additional information.

*Financial Feasibility of 40 bed special psychiatric hospital on Takoma Park campus.*

Staff reviewed the pro forma income statement provided by WAH in the December 12, 2014 supplemental submission letter for the 40 bed psychiatric unit that will remain at WAH after the relocation of the other beds to White Oak. The 40 bed unit will be owned and operated by Adventist Behavioral Health (ABH), a psychiatric specialty hospital owned by AHI that is located in Rockville Maryland. The pro forma is only for the 40 bed psychiatric unit and does not include any information on the other services that will exist at WAH after the relocation such as the 24-hour urgent care clinic and the Women's Health Clinic.

On August 24, 2015, the Maryland Medicaid program reduced reimbursements to free-standing psychiatric facilities larger than 16 beds because CMS withdrew a waiver that had been approved for the State of Maryland, which had allowed Maryland Medicaid to reimburse these facilities for acute psychiatric services. Maryland's Department of Health and Mental Hygiene is currently seeking a new federal waiver that would significantly expand the scope of treatment options available to Medicaid enrollees with substance abuse and mental health disorders. WAH provided documentation showing that ABH has not been impacted by the reduction in Medicaid reimbursement, and that WAH, for a variety of reasons including the pending new waiver request, does not anticipate any reduction in projected Medicaid payments for the 40 bed psychiatric unit remaining in Takoma Park. Staff believes that the projected net revenues for the 40 bed psychiatric unit are reasonable, assuming that Medicaid does not reduce payments to free-standing psychiatric hospitals in the future.

Staff performed reasonableness tests of the direct costs for salaries and benefits and other expenses included in the December 12, 2014 pro forma for the 40 bed psychiatric unit. Staff compared the projected 2019 costs per patient day in the pro forma to the regulated costs per patient day that ABH incurred during the year ended December 31, 2014 based on ABH's HSCRC Annual Report provided to the HSCRC. Staff inflated the actual ABH expenses for the year ended 2014 by 2.3% per year to 2019 based on the inflation assumptions included in WAH's CON.

The results of staff's analysis are presented below:

Table 8 - Comparison of Projected Takoma Park Psychiatric Unit Costs to Adventist Behavioral Health Actual Costs on a per Equivalent Inpatient day Basis

Expense Category	Cost per Equivalent Inpatient Day		
	Takoma Park Psychiatric Unit Projected FY 2019	Adventist Behavioral Health YE 12/31/2014 Inflated to 2019	Percent Variance
Salaries and benefits	\$574	\$600	4.5%
Depreciation and interest	186	27	(85.5%)
Other	352	229	(65.1%)
<b>Total Costs</b>	<b>\$1,112</b>	<b>\$837</b>	<b>(24.7%)</b>
Equivalent inpatient days	10,578	32,467	

Sources: HSCRC Annual Report for the Year Ended December 31, 2014 and additional WAH CON information submitted December 12, 2014.

Although Staff would expect that there would be economies of scale causing lower salary and benefits per patient day at ABH than at the Takoma Park site, the overall expenses per day appear reasonable. Staff believes that ABH’s management team will be able to bring cost in line where appropriate.

The income statements in the CON include projected net income of \$5,465,000 in 2019 and \$6,897,000 in 2020 for the new White Oak facility. The pro forma for the 40 bed psychiatric unit included a \$210,000 projected profit in the first year of operations after the White Oak facility opens. The projected income statements provided by WAH in the July 27, 2015 letter from James Lee for both the White Oak facility and the services remaining at WAH show projected net income of only \$747,000 in 2019 and \$1,770,000 in 2020. The approximate annual \$5,000,000 difference between the two sets of projected financial statements represents the annual projected loss on the other services that will remain at Takoma Park.

Staff reviewed additional information provided by WAH regarding the projected financial operations of services remaining at Takoma Park. This financial information appears reasonable.

Finally, you asked that we comment on Laurel Regional Hospital’s and MedStar Montgomery Medical Center’s submission of an analysis of the impact of the relocation on their discharges and the impact of such a reduction in volume on their revenues and bottom line profit. While you did not necessarily agree with the hospitals’ assessments of the impact on volume and you did not ask for our opinion on their calculation of the expected loss in discharges, you did ask for our comments on the methodology used to convert such losses in volume to reductions in revenue and impact on the hospitals’ bottom line profit (the relevant analysis submitted by the interested parties on May 29, 2015 was attached).

*Laurel Regional Hospital and MedStar Montgomery Medical Center Comments*

The major issue with the analysis prepared on behalf of Laurel Regional Hospital (LRH) and MedStar Montgomery Medical Center (MMC) is that LRH and MMC are projecting a far greater number of discharges moving from their facilities than WAH has projected. WAH is projecting that 95 discharges will move to their new White Oak facility from LRH, while 91 discharges will move from MMC to the new White Oak facility. LRH is projecting that it will lose 582 discharges to the new WAH facility at White Oak. MMC is projecting that it will lose 284 discharges to the new WAH facility.

Assuming that all of LRH's and MMC's assumptions regarding revenue, collection percentages, and variability of expenses are accurate, but substituting WAH's projected changes in discharges, the estimated impact at LRH would then decrease from (\$1,123,000) annually to (\$183,000.) At MMC, the impact would be reduced from (\$952,000) annually to (\$305,000) if WAH's projected changes in discharges are accurate.

Another less important issue is the assumption of variability in expenses for supply and drug costs. Both LRH and MMC assume that supply and drug costs would vary at a 60% rate with changes in volumes. Normally supplies and drugs should vary at or near 100% with changes in volumes. Assuming a higher variability factor for supplies and drugs would also reduce the projected impact on LRH and MMC.

We also note that the submission by LRH may be irrelevant, given its recent announcement of facility reconfiguration and plans to eliminate much of the acute inpatient capacity of the hospital.

### **Summary**

Staff believes that the overall assumptions regarding the financial viability of the new facility at White Oak are reasonable and achievable depending on WAH attaining the volumes projected in the CON. The current environment of change in health care financing and delivery increase the probability that inpatient volumes will decline. WAH and the surrounding hospitals in the area presently have substantial volumes of f PAUs. Staff recommends conservatism in evaluating need. If WAH does not attain the projected volumes in the CON its overall rate and revenue structure may be viewed as inefficient and may affect the overall financial viability of the project.

# **Exhibit B**

Table 1: The Global Budget Market Shift Adjustments for Rate Year 2016 by Hospital

Hospital Name	Total Discharge/Visits July-Dec 2014	Total Discharge/Visits July-Dec 2015	Total Discharge/Visits Growth	ECMAD July-Dec 2014	ECMAD July-Dec 2015	ECMAD GROWTH	ECMAD Market Shift	Market Shift Adjustment
ANNE ARUNDEL	101,761	106,320	4,559	19,871	20,492	621	69	\$396,143
ATLANTIC GENERAL	42,762	44,132	1,370	2,927	3,054	127	(19)	-\$108,402
BALTIMORE WASHINGTON MEDIC	72,835	75,080	2,245	12,845	12,992	147	(117)	-\$799,826
BON SECOURS	20,431	20,184	(247)	2,681	2,475	(206)	(172)	-\$1,562,367
BOWIE HEALTH	16,340	17,544	1,204	540	583	43	14	\$97,155
CALVERT	32,783	32,992	209	4,249	4,232	(17)	(68)	-\$401,728
CARROLL COUNTY	42,128	41,377	(751)	7,259	7,028	(230)	(70)	-\$396,380
CHARLES REGIONAL	34,821	37,948	3,127	4,730	4,696	(35)	(43)	-\$37,376
CHESTERTOWN	18,295	18,532	237	1,466	1,457	(9)	(37)	-\$341,212
DOCTORS COMMUNITY	34,265	37,569	3,304	6,200	6,439	239	40	\$373,537
DORCHESTER	18,141	18,178	37	1,335	1,410	76	22	\$202,127
EASTON	28,377	29,608	1,231	5,155	5,090	(64)	(48)	-\$430,911
FRANKLIN SQUARE	90,274	89,939	(335)	15,037	15,506	469	245	\$1,420,348
FREDERICK MEMORIAL**	55,030	59,622	4,592	10,389	11,292	903	259	\$1,347,105
FT. WASHINGTON	20,464	20,299	(165)	1,463	1,396	(66)	(58)	-\$383,283
G.B.M.C.	80,801	81,477	676	14,014	13,689	(325)	(437)	-\$2,278,961
GARRETT COUNTY**	23,174	23,902	728	1,237	1,534	297	49	\$188,050
GERMANTOWN	16,232	16,446	214	618	622	3	(13)	-\$72,215
GOOD SAMARITAN	68,320	60,163	(8,157)	9,286	8,663	(623)	(518)	-\$3,085,321
HARBOR	42,157	41,499	(658)	6,102	6,038	(64)	(129)	-\$905,499
HARFORD	34,419	35,001	582	3,195	3,166	(29)	(18)	-\$125,166
HOLY CROSS	69,503	71,215	1,712	16,144	16,958	814	272	\$1,039,213
HOLY CROSS GERMANTOWN	-	6,654	6,654	-	782	782	379	\$0
HOPKINS BAYVIEW MED CTR	189,358	195,830	6,472	15,099	15,781	683	250	\$1,795,780
HOWARD COUNTY	61,847	63,850	2,003	10,395	10,752	357	38	\$395,457
JOHNS HOPKINS	299,913	320,772	20,859	36,137	38,180	2,043	921	\$7,714,776
LAUREL REGIONAL	20,109	19,637	(472)	3,308	3,096	(212)	(267)	-\$1,937,225
MCCREADY	10,000	10,417	417	423	436	13	2	-\$40,155
MERCY	135,022	133,919	(1,103)	15,632	15,513	(120)	(74)	-\$601,739
MERITUS	44,621	44,362	(259)	9,195	8,987	(208)	(124)	-\$709,616
MONTGOMERY GENERAL	25,466	26,431	965	5,112	5,261	149	(64)	-\$461,212
NORTHWEST	49,807	48,786	(1,021)	6,604	6,463	(141)	(225)	-\$1,385,014
PENINSULA REGIONAL	70,441	71,246	805	11,029	11,218	189	(3)	-\$55,102
PRINCE GEORGE	27,789	28,002	213	6,217	6,902	685	186	\$1,396,315
QUEEN ANNES	6,800	7,625	825	243	280	38	4	\$18,298
REHAB & ORTHO	20,859	20,962	103	3,468	3,374	(95)	(99)	-\$704,634
SHADY GROVE	55,371	55,979	608	13,074	12,857	(218)	(458)	-\$2,846,113
SINAI	104,282	104,965	683	18,647	18,497	(151)	(274)	-\$1,977,215
SOUTHERN MARYLAND	35,468	33,991	(1,477)	7,090	6,848	(242)	(255)	-\$1,493,265
ST. AGNES	75,264	80,905	5,641	12,031	12,413	382	104	\$656,125
ST. MARY	49,059	50,469	1,410	5,463	5,920	457	173	\$972,173
SUBURBAN	29,315	29,700	385	9,544	9,840	295	76	\$333,569
UM ST. JOSEPH*	54,895	56,203	1,308	12,027	13,304	1,277	758	\$4,161,524
UMMC MIDTOWN	42,015	56,741	14,726	4,111	4,702	591	305	\$3,249,062
UNION HOSPITAL OF CECIL COUN'	46,095	42,029	(4,066)	4,324	3,990	(334)	(140)	-\$1,041,023
UNION MEMORIAL	73,678	72,498	(1,180)	12,396	13,061	665	280	\$1,735,895
UNIVERSITY OF MARYLAND	137,529	136,820	(709)	28,506	28,361	(145)	(280)	-\$1,822,357
UPPER CHESAPEAKE HEALTH	67,086	68,901	1,815	9,608	9,193	(415)	(232)	-\$1,029,914
WASHINGTON ADVENTIST	33,359	33,668	309	7,110	7,020	(90)	(256)	-\$1,464,523
WESTERN MARYLAND HEALTH SYS	40,177	41,841	1,664	6,655	6,619	(36)	45	\$248,759
Grand Total	2,768,938	2,842,230	73,292	420,192	428,462	8,270	0	-\$756,341

HSCRC Casemix Data- Updated 7/7/2015

Notes:

Shifts within systems for service movements between system hospitals have not been reflected in these figures.

\*Market shift adjustment for St. Joseph Medical Center was implemented concurrently during FY2015.

\*\* Market shift adjustments will be revised due to data accuracy issues.

Accessed at: <http://www.hscrc.state.md.us/hsp-gbr-tpr-update.cfm> on 12/4/2015.

Table 1: CY2015 Q1 Q2 Preliminary Market Shift Calculations

Hospital Name/ServiceLine/Zipcode	Total	Total	Total	ECMAD CY14Q1Q2	ECMAD CY15Q1Q2	ECMAD GROWTH	Market Shift	Market Adjustment
	Discharge/Visits CY14Q1Q2	Discharge/Visits CY15Q1Q2	Discharge/Visit Growth					
HOLY CROSS GERMANTOWN	-	14,727	14,727	-	2,107	2,107	1,394	
SOUTHERN MARYLAND	33,398	34,679	1,281	6,574	7,085	511	401	\$2,739,841
JOHNS HOPKINS	313,126	322,751	9,625	37,141	37,429	288	395	\$2,829,546
ANNE ARUNDEL	102,499	103,844	1,345	19,497	19,980	484	392	\$2,108,999
UMMC MIDTOWN	47,374	52,808	5,434	4,331	4,629	298	309	\$3,445,227
MERCY	137,040	130,571	(6,469)	15,185	15,489	304	299	\$1,359,541
ST. MARY	49,509	51,167	1,658	5,579	5,833	254	154	\$795,354
HOPKINS BAYVIEW MED CTR	191,604	192,400	796	15,231	15,337	106	124	\$1,394,275
HOWARD COUNTY	61,278	61,176	(102)	10,301	10,529	227	115	\$595,841
UM ST. JOSEPH	56,993	53,519	(3,474)	12,625	12,637	12	91	\$569,994
PRINCE GEORGE	26,930	26,165	(765)	6,261	6,591	330	82	\$230,376
CARROLL COUNTY	40,547	40,201	(346)	6,873	7,077	205	74	\$475,000
WASHINGTON ADVENTIST	32,181	31,854	(327)	7,007	7,060	54	71	\$613,299
UPPER CHESAPEAKE HEALTH	66,739	69,263	2,524	9,248	9,271	24	68	\$482,988
UNIVERSITY OF MARYLAND	135,795	131,434	(4,361)	26,799	26,796	(3)	39	\$272,197
GARRETT COUNTY	23,423	23,924	501	1,490	1,566	76	36	\$163,562
FRANKLIN SQUARE	89,880	89,810	(70)	15,290	15,349	59	34	\$114,869
PENINSULA REGIONAL	69,596	70,101	505	10,847	10,735	(112)	25	-\$893
BALTIMORE WASHINGTON MEDICAL CENTER	73,743	72,761	(982)	12,941	12,737	(204)	21	\$73,957
BOWIE HEALTH	17,200	16,910	(290)	567	616	50	15	\$108,053
BON SECOURS	19,487	20,376	889	2,455	2,420	(36)	14	-\$503,726
ATLANTIC GENERAL	41,788	40,531	(1,257)	2,836	2,879	43	14	\$58,350
MERITUS	43,944	42,777	(1,167)	8,961	8,921	(40)	6	\$32,968
MCCREADY	10,093	9,972	(121)	414	431	17	6	\$64,347
EASTON	29,035	29,299	264	4,986	4,973	(13)	1	\$17,686
WESTERN MARYLAND HEALTH SYSTEM	41,968	41,400	(568)	6,600	6,482	(118)	(0)	\$32,567
QUEEN ANNES	7,394	7,510	116	277	281	4	(0)	-\$1,603
CHESTERTOWN	17,437	18,362	925	1,468	1,421	(47)	(12)	-\$145,599
REHAB & ORTHO	20,204	20,606	402	3,363	3,310	(53)	(15)	-\$6,481
UNION HOSPITAL OF CECIL COUNT	43,000	40,346	(2,654)	3,978	3,851	(126)	(24)	-\$213,302
FT. WASHINGTON	20,583	19,781	(802)	1,492	1,408	(84)	(24)	-\$12,438
HARFORD	33,935	32,984	(951)	3,275	3,108	(167)	(30)	-\$238,457
DORCHESTER	18,009	18,210	201	1,429	1,376	(53)	(41)	-\$352,073
ST. AGNES	77,003	77,531	528	12,197	12,121	(75)	(61)	-\$342,454
LAUREL REGIONAL	19,447	18,998	(449)	3,169	3,162	(8)	(86)	-\$723,927
SUBURBAN	29,214	28,372	(842)	9,581	9,513	(67)	(98)	-\$741,521
GERMANTOWN	17,115	14,268	(2,847)	656	549	(107)	(107)	-\$570,133
CALVERT	32,670	32,956	286	4,186	4,100	(86)	(131)	-\$820,007
FREDERICK MEMORIAL	56,850	55,180	(1,670)	10,402	10,198	(204)	(144)	-\$1,166,124
UNION MEMORIAL	74,219	67,896	(6,323)	12,579	12,217	(363)	(158)	-\$901,362
DOCTORS COMMUNITY	35,117	37,506	2,389	6,387	6,288	(99)	(172)	-\$1,251,701
NORTHWEST	48,381	46,141	(2,240)	6,512	6,228	(284)	(184)	-\$1,170,036
CHARLES REGIONAL	35,999	37,000	1,001	4,767	4,489	(278)	(199)	-\$967,498
HOLY CROSS	68,904	66,562	(2,342)	15,914	15,791	(123)	(241)	-\$1,260,771
MONTGOMERY GENERAL	25,817	24,967	(850)	5,242	4,995	(247)	(288)	-\$1,656,436
HARBOR	41,697	39,322	(2,375)	5,932	5,403	(529)	(298)	-\$2,540,452
G.B.M.C.	81,186	78,133	(3,053)	13,596	12,979	(618)	(319)	-\$1,979,731
GOOD SAMARITAN	65,387	58,775	(6,612)	8,831	8,143	(688)	(327)	-\$2,190,771
SHADY GROVE	55,627	52,330	(3,297)	12,853	11,988	(866)	(571)	-\$3,328,487
SINAI	105,894	100,141	(5,753)	18,363	17,397	(966)	(646)	-\$5,033,989
Grand Total	2,786,259	2,768,297	(17,962)	416,488	415,279	(1,209)	(0)	-\$9,541,136

# **Exhibit C**



# Ziegler

CAPITAL :: INVESTMENTS :: ADVICE

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February 20, 2015

Mr. Ben Steffan  
Executive Director  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Mr. Steffan,

As one of the leading investment banks in the nation for tax-exempt healthcare financing, Ziegler is intimately familiar with all aspects of the bond markets as they relate to hospitals and health systems. The financing assumptions included in the modified CON application, submitted on September 29, 2014, were based on best available capital markets information at the time, with relatively conservative assumptions on credit and interest rate environment. Ziegler's credit opinion of Adventist HealthCare ("AHC") is based on how external credit parties, including rating agencies, credit lenders and investors, would view AHC's credit profile, reflective of the proposed Washington Adventist Hospital project and financing. As represented in Exhibits 1-3, attached to this letter, various "BBB" and lower rated hospital and health system financings are being completed at historically low borrowing costs. During 2014, the average BBB and non-rated healthcare borrowers' borrowing cost were approximately 4.57% vs. 6.0% assumed in the CON application. In addition, the interest rate environment for tax-exempt financing continues to be favorable with the 30-Year MMD, a benchmark for long-term tax-exempt borrowing cost, hovering around the near historical lows, as shown in Exhibit 4. The 30-Year MMD is currently at 2.88% (vs. 2.95% when the CON application was submitted). Financing assumptions made in the CON application were conservative assumptions based on current market environment, and it is Ziegler's view that the project is financeable and important to the future of AHC.

Sincerely,

Donald A. Carlson, Jr.  
Vice Chairman



## EXHIBIT 1: RECENT “BBB” AND NON-RATED HEALTHCARE FINANCINGS

- A large number of BBB and non-rated healthcare deals are being completed at historically low borrowing costs
- Borrowing costs, represented by the Yield, decreased by more than 0.25%-0.50% from the beginning of 2014 to the end of 2014
- In 2014, BBB and non-rated healthcare borrowers achieved long-term borrowing cost at or around 4.57% Yield compared to a 6.0% Yield assumed in the modified CON application for the Washington Adventist Hospital project financing

Sale Date	Borrower	State	Moody's	S&P	Fitch	Par Amount (Millions)	Final Term	Years	Coupon	Yield
12/16/14	Washington Regional Med Ctr	AR	Baa1	NR	NR	\$ 107.75	2/1/2038	23.1	4.00%	4.21%
12/10/14	Loma Linda University Medical Center	CA	NR	BBB	BBB-	\$ 547.58	12/1/2054	40.0	5.50%	4.96%
11/18/14	Erlanger Health System	TN	Baa2	NR	BBB	\$ 149.92	10/1/2044	29.9	5.00%	4.29%
10/21/14	Western Maryland Health System	MD	NR	BBB	NR	\$ 236.17	7/1/2035	20.7	4.00%	4.02%
10/16/14	Cooper Health System	NJ	Baa2	BBB	NR	\$ 139.73	2/15/2035	20.3	5.00%	3.53%
10/02/14	Karnes Co Hospital Dt	TX	NR	NR	BBB	\$ 43.82	2/1/2044	29.3	5.00%	4.65%
09/24/14	Major Hospital	IN	Baa2	NR	BBB+	\$ 53.51	10/1/2044	30.0	5.00%	4.40%
09/10/14	Madonna Rehabilitation Hospital	NE	NR	BBB+	NR	\$ 80.17	5/15/2044	29.7	5.00%	4.11%
08/20/14	Mt. Sinai Medical Center	FL	Baa1	NR	BBB	\$ 170.90	11/15/2044	30.2	5.00%	4.20%
06/17/14	St. Alexius Medical Center	ND	NR	BBB+	BBB+	\$ 46.48	7/1/2035	21.0	5.00%	4.35%
06/04/14	Wise Regional Health System	TX	NR	BB+	BB+	\$ 93.73	9/1/2044	30.2	5.25%	5.30%
05/20/14	Centegra Health System	IL	NR	BBB	BBB	\$ 134.72	9/1/2042	28.3	5.00%	4.74%
05/14/14	St. Francis Hospital - NY	NY	Baa1	BBB+	BBB+	\$ 77.73	7/1/2034	20.1	5.00%	4.07%
04/23/14	Denver Health	CO	NR	BBB	BBB+	\$ 67.87	12/1/2045	31.6	5.25%	4.75%
02/26/14	Leesburg Regional Medical Center	FL	Baa1	BBB+	NR	\$ 50.00	7/1/2044	30.3	5.25%	5.42%
01/28/14	Lawrence General Hospital	MA	NR	BBB-	BBB	\$ 43.49	7/1/2044	30.4	5.50%	5.62%
01/22/14	Henry Mayo Newhall Mem Hospital	CA	NR	BBB-	NR	\$ 70.00	10/1/2043	29.7	5.25%	5.30%
01/16/14	Milford Regional Medical Center	MA	Baa3	NR	NR	\$ 45.66	7/15/2043	29.5	5.75%	5.80%
<b>Weighted Average</b>									<b>5.03%</b>	<b>4.57%</b>

Source: Bloomberg - List includes “BBB” and non-rated health care financings with more than \$40 million in borrowing amount and borrowing term longer than 20 years

## EXHIBIT 2: LOMA LINDA UNIVERSITY MEDICAL CENTER 2014 FINANCING CASE STUDY

- Loma Linda University Medical Center (aka Loma Linda University Health System, “Loma Linda”) is a California, non-profit health system composed of 3 hospitals with net patient revenue of approximately \$1.4B
- Loma Linda issued \$547M tax-exempt revenue bonds on Dec. 23, 2014 to fund new projects and refund existing debt
- Loma Linda is rated BBB with a negative outlook from Standard and Poor’s Financial Services and BBB- with a negative outlook from Fitch Ratings
- Adventist HealthCare, Inc. (AHC) has stronger key financial ratios as depicted below. In addition, Loma Linda is experiencing declining performance, unlike AHC who had strong operating performance for FY 2014
- Loma Linda financing was completed with weighted average coupon of 5.41% to yield 4.76%
- Despite the negative outlook by rating agencies, more than 70 investors placed order for the bonds and interest level exceeded the borrowing amount by more than 6x

	AHC OG FY 2014	Loma Linda FY 2013
Net Patient Revenue (in 000s)	\$ 699,289	\$ 1,396,247
Days Cash on Hand	133	102
Long-Term Debt-to-Cap	41.1%	55.0%
Cash-to-Long Term Debt	83.8%	52.3%
Max Ann. DS Coverage	2.17x	2.15x

### Final Pricing Summary

Maturity	Par (000s)	Coupon	Yield
12/1/2029	\$ 43,580	5.25%	4.18%
12/1/2034	56,280	5.25%	4.44%
12/1/2044	166,575	5.25%	4.70%
12/1/2054	281,140	5.50%	4.96%
	<b>\$ 547,575</b>	<b>5.41%</b>	<b>4.76%</b>

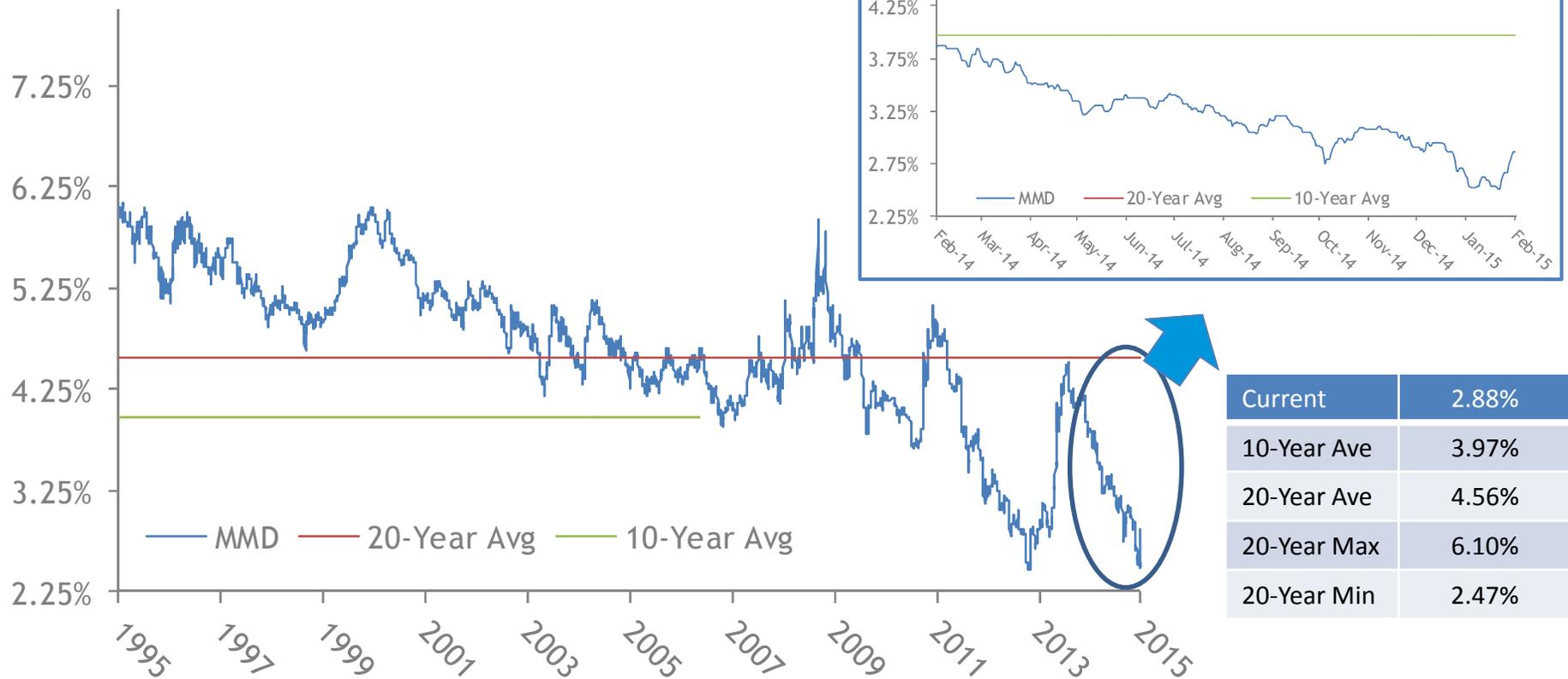




## EXHIBIT 4: TAX-EXEMPT FIXED RATE INTEREST RATE

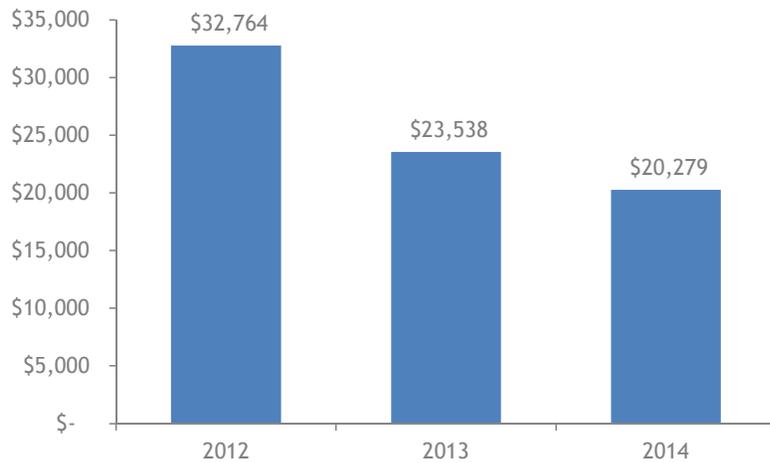
- The 30-YR MMD (tax-exempt long-term borrowing cost benchmark) is currently at 2.88% vs 2.95% when CON application was submitted
- Interest rate environment continues to be favorable for borrowers, hovering near the all-time low of 2.47% which occurred on 11/29/2012
- The average 30-YR MMD for CY 2014 was 3.36% and the YTD 2015 is at 2.68%

30yr MMD 1995 to Present

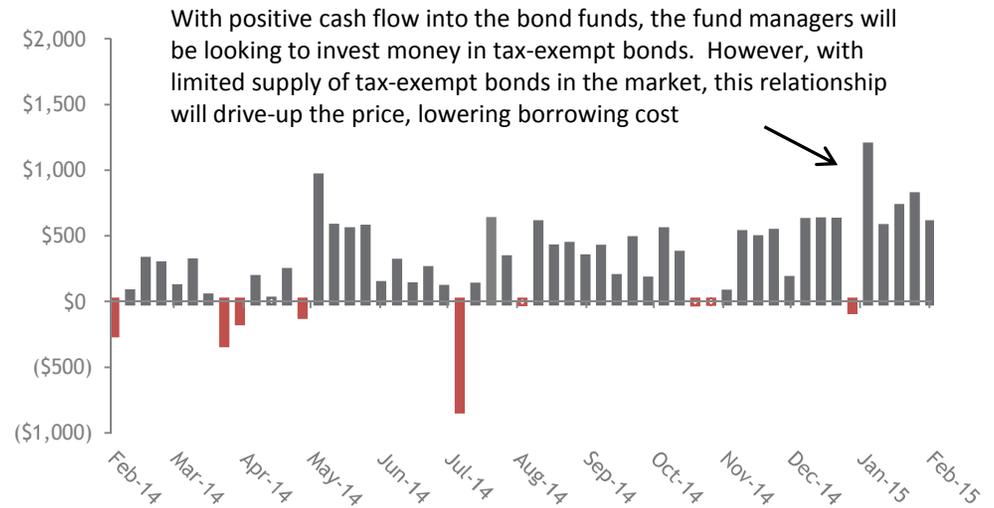


## EXHIBIT 5: SUPPLY AND DEMAND IMBALANCE IN TAX-EXEMPT PAPERS WILL CONTINUE TO PRESSURE BORROWING COST

**Hospital and Health System New Money Financing (in Millions)**



**Municipal Bond Fund Cash Flow (in Millions)**



- Amount of hospitals and health systems tax-exempt debt issuance volume decreased by more than 38% between 2012 and 2014 as hospitals and health systems utilized direct bank lending programs to fund capital projects
- Meanwhile, cash continues to follow into the municipal bond funds increasing demand for tax-exempt bonds. This imbalance between demand and supply puts downward pressure on interest rates

# **Exhibit D**

## **AHC AND WAH COMMUNITY PROGRAMS**

In addition to the services that will remain on the Takoma Park campus once WAH relocates to White Oak -- and consistent with its long-standing commitment to providing health and wellness programs for the community -- AHC will continue to offer a number of community programs. Among the types of programs currently offered are the following.

### **Center for Health Equity and Wellness**

AHC has a Center for Health Equity and Wellness (the "Center"), specifically focused on the delivery of needed, culturally competent services to communities that are often subject to health disparities. In 2007, the Adventist HealthCare Center on Health Disparities was created to raise community awareness, develop solutions to eliminate local disparities in health care and improve access to quality health care, especially for minorities, women, and people who have language barriers or other communications needs. In 2012, the Center on Health Disparities and the Adventist HealthCare Health and Wellness Department joined together to form the Center, to address disease prevention and management and to promote health equity in the communities served by AHC. The Center collaborates with hospitals and other community stakeholders to promote community outreach and improve cancer, cardiovascular disease, diabetes, maternal/child health, and other health outcomes especially among minority and vulnerable populations. In the community, it raises awareness of health issues and disparities, screens for various conditions, and offers educational and support programs to residents in Montgomery County. Also, the Center coordinates language services to eliminate barriers among minority, limited English proficient, and vulnerable populations. In addition, the Center provides cultural competence training to clinical and non-clinical healthcare professionals and coordinates language access services (i.e., interpretation) to eliminate barriers to effective communication between healthcare providers and limited English-proficient patients.

Exhibit 120 is a print-out of a presentation given by the Center concerning its population health strategies, including: (a) collection of data and research; (b) fostering of cultural competence in the delivery of health care, (c) providing multi-lingual support, (d) conducting cancer screenings, (e) supporting smoking cessation, (f) providing breast cancer screening to low income populations, (g) providing cardiac screening, (h) providing comprehensive diabetes education and support, and (i) providing support for childbearing families.

### **Cardiac and Vascular Outreach Services Program**

The Center also offers a Cardiac and Vascular Outreach Services Program (Cardiac Program) to promote and support positive cardiovascular health in the community. The Cardiac Program, fully implemented since 1996, grew out of AHC's concern to provide increased health care access to underserved populations, including racial/ethnic minorities and older adults. The Cardiac Program emphasizes the prevention of heart disease through healthy lifestyle habits, including (but not limited to) proper nutrition, fitness and exercise, cessation of smoking and stress reduction. The program creates awareness of health issues facing the targeted population; educates them about risk factor identification, reduction and management; assesses needs in the area of cardiac and vascular health; provides education, tools and support to assist with behavior

change; and identifies diseases early through screenings. At-risk patients identified through screenings are linked with health care providers who are sensitive to their cultural, linguistic, and physical needs.

A registered nurse and health educator with 20+ years of experience runs the Cardiac Program, and collaborations with various community agencies and groups (senior centers, low-income housing, etc.) have increased both the outreach and the effectiveness of the program to those at risk for heart disease. Partnerships include, but are not limited to: the African American Health Program, Senior Centers, Complete Health Improvement Plan, Plus 15, The Eden Experience, American Heart Association, Sister to Sister, and Women and Heart. Selected components of the Cardiac Program are described below.

### **Heart Health Screening Program**

This screening program is offered to assist people in being proactive regarding heart health and to work with their physician in tracking their “numbers”. At the event, individuals choose from a menu of cardiac related screening tests and also speak one-on-one with a clinician regarding personal risk factors. Results from the screenings are sent both to the participant and their personal physician. Approximately 20-30 screenings are offered annually, at eight (8) Montgomery County locations. Screening tests offered include: Lipid Profile, Vertical Auto Profile, Homocysteine, HsCRP, Fasting Blood Sugar, A1c, Body Fat Analysis, BMI, Blood Pressure and PSA for men to be done in conjunction with physician examination.

### **Blood Pressure Screening and Counseling**

In addition to the Heart Health Screening described above, AHC separately offers free monthly blood pressure screenings and counseling session at 10 Montgomery County sites.

### **Community Classes/Lectures on Cardiac and Vascular Topics**

AHC offers several classes in the community on topics relating to cardiovascular health (by request). These classes include, but are not limited to: Heart Attack Recognition, Don't Wait, Call 9-1-1; Women and Heart Disease (HD); Cholesterol and HD; Nutrition and HD; Stroke; and Spirituality and Health.

### **Cardiovascular Support and Activity Groups**

Groups meet at least monthly to promote both disease prevention and disease management. Groups include: Heart to Heart, Stroke Club, Implantable Defibrillator, Diabetes Support Group, Walking Club, Congestive Heart Failure, and DVT (Deep Vein Thrombosis).

### **Complete Health Improvement Program**

The Complete Health Improvement Program (CHIP) is a 32-hour lifestyle enrichment program designed to reduce disease risk factors (primarily cardiovascular and diabetes risk factors, which contribute to many other conditions as well) through the adoption of better health habits and

appropriate lifestyle modifications. The goal is to lower blood lipids, blood pressure, blood sugar levels, and reduce excess weight, which are all risk factors for more serious conditions. This is done by improving dietary choices (primarily through adopting a plant based diet), enhancing daily exercise, increasing support systems and decreasing stress, thus aiding in preventing and reversing disease. At the end of the formal class, there is an on-going support group, called Club CHIP to help the participants' sustain their efforts in continuing the healthy lifestyle habits learned. This evidence-based program is endorsed by the Physicians Committee for Responsible Medicine, the Center for Science in the Public Interest and the International Nutrition Research Foundation. Further, results from CHIP programs have been published extensively in peer-reviewed journals, including *Advances in Preventive Medicine*, the *American Journal of Cardiology*, the *British Medical Journal*, and *Preventing Chronic Disease*.

In the pilot CHIP program conducted at WAH between August 1 and September 12, 2013 results showed an average drop in total cholesterol from 174 mg/dL to 142 mg/dL, and average weight loss of 8 lbs, and an average drop in body fat from 43.0% to 41.9%.

### **Other Programs and Special Events**

In addition to the many programs listed above, the Center also offers many special events, such as a Heart Health Education and Health Fair in collaboration with the African American Health Program at WAH, and Vascular Screenings (Carotid Artery Screening, Ankle Brachial Index, and Abdominal Aortic Aneurysm). An Advisory Board has been established to help guide efforts to reduce and eliminate health disparities, to identify community needs, and to help assess and direct AHC's responses to those needs. The Advisory Board is comprised of both internal and external (community) leaders which include clinicians, researchers, administrators and other hospital staff, community-based organizations, local and state health departments, the University of Maryland, the National Institutes of Health (specifically, the National Institute of Minority Health and Health Disparities), and other public health stakeholder organizations. All of the Community Health Needs Assessment and Implementation Strategy reports were reviewed and approved by the AHC Board of Trustees, as well as the board of each entity, both of which consist of leaders from community-based organizations, local safety net clinics, physicians, and health care leaders. These reports are all available to the public through the AHC website.

The Center maintains a close partnership with the Montgomery County Department of Health and Human Services to provide training and education to employees as well as deliver The Center's annual fall conferences. Since 2008, The Center has served as a consulting partner with the LifeBridge Health System in Baltimore to implement a health equity strategy. During the six year relationship, The Center has assisted LifeBridge Health System in assessing culturally competent practices and creating a Health Equity Task Force and Community Advisory Panel at Sinai Hospital of Baltimore and is currently undertaking similar tasks with two other hospitals within the LifeBridge Health System (e.g., Northwest Hospital and Levindale Hebrew Geriatric Center). The Center is also at the heart of implementing and evaluating several successful evidence-based wellness programs for AHC, including the Tobacco Cessation Program, and the American Association of Diabetes Educators Endorsed Diabetes Education Program. In addition to the activities described, The Center is responsible for hosting and implementing numerous community health and screening fairs reaching more than 20,000 individuals annually, health

education classes enrolling more than 15,000 people per year, and an annual conference on health disparities that engages 250 community leaders from health, education, policy, and urban development sectors.

### **Focus on Continental African Communities**

A particular highlight of the Center's activities with this community is Project BEAT IT! (Becoming Empowered Africans Through Improved Treatment of Diabetes, Hepatitis B, and HIV/AIDS). Originally funded by the federal Office of Minority Health Resource Center in 2012, Project BEAT IT! seeks to improve the health of African immigrants and refugees through health education to the patient community and cultural competence training for their healthcare providers in chronic and infectious disease management. During the 20-month pilot program, The Center established an advisory panel of 26 members, 23 of whom are African-born, to assist in reviewing health education content and engage the African community to participate in Project BEAT IT! The Center also hosted community focus groups with African-born individuals and healthcare providers to review health education materials. Separate curricula for chronic (e.g., type 2 diabetes) and infectious (e.g., HIV/AIDS and hepatitis B) diseases were developed using the Culturally Competent Model of Care created by Campinha-Bacote (2002) to teach prevention and treatment strategies from a culturally appropriate perspective. The Center employed two African immigrant experts in chronic and infectious disease management to facilitate two hour course instruction to African consumers and healthcare providers. For providers, the instruction focused on general cultural information (e.g., common diets, traditions, and religious practices) and reviewing case studies. Classes for African consumers involved debunking disease myths using a deck of cards, role playing, reviewing treatment and prevention strategies, and enjoying a nutritious catered meal featuring common African dishes. Over the course of the six month implementation period (2012-13), The Center hosted 15 courses, including two webinars, and trained over 800 healthcare providers in effective communication strategies for the African patient and 40 African immigrants and refugees through Project BEAT IT! In addition, the Center formed many community partnerships with African immigrant serving entities, including: the Dennis Avenue Health Clinic; Immanuel's Church; Maryland Department of Health and Mental Hygiene; Montgomery College—Takoma Park Campus; and the African American Health Program.

### **Other WAH Population Health Initiatives**

WAH has initiated a number of innovative programs designed to provide socioeconomic support to patients discharged from the Hospital and to prevent unnecessary hospital admissions. These programs are offered irrespective of geographic location and are consistent with the goals of the new Global Budget Revenue model implemented in Maryland.

#### **ED U-Turn Program**

This program is focused on decreasing unnecessary admissions/readmission at WAH by assessing patients for discharge needs (both medical and social) at the point of entry into the hospital. Staff partners with WAH's 911 skilled nursing facilities to allow for increased

communication regarding the plan of care for the patient. This will expedite treatment and allow for appropriate and timely admissions. Through the ED U-Turn Program WAH also provides intensive case management and multidisciplinary care planning for many patients.

### **QIO Partnership**

WAH has partnered with the Virginia Health Quality Center and other community partners to provide consulting services geared towards improving care transitions across the healthcare continuum by applying the latest quality improvement tools and techniques.

### **High Risk Discharge program**

Patients who are identified as high risk through the use of WAH's screening tool, as well as any diabetic patient, can be a part of this program, which involves a high risk discharge checklist that is reviewed with the patient at time of discharge.

### **Senior Peer Hea Wholesome Wave**

WAH is initiating a program beginning in March 2015 to provide a "prescription" for healthy foods for its underinsured/uninsured diabetic patients. We have commitments from 22 vendors at local farmers markets to accept these and provide their goods at a reduced cost. This is a partnership with Long Branch Health Enterprise.

### **Remote Patient Monitoring Program**

This program places remote tele-scales and blood pressure cuffs in the patient's home to evaluate for increasing signs/symptoms of congestive heart failure. Early interventions are taken for patients who are at risk for readmission. The program will launch in March 2015 and expand to diabetic and COPD patients in mid-2015.

# **Exhibit E**

## Overview of Accomplishments:

Accomplishments	Strategy	Outcome
1. Implemented best practices that promote Patient- and Family-Centered Care within Adventist HealthCare and the state hospital association.	Maryland Hospital Association (MHA) partnership in Race, Ethnicity, Age, Language & Gender (REALG) Demographic Data Collection	Trained 80 individuals from 30 hospital systems
	AHC Health Equity Report	7 reports
	Cultural Competence in End of Life Conference	Held Nov. 2014 with over 200 participants
2. Through the Center for Health Equity and Wellness, we have been recognized as a state and national leader in the utilization of culturally competent approaches to care and provision of linguistic services guided by the CLAS Standards (Culturally and Linguistically Appropriate Service Standards develop by Federal DHHS).	Recognition	Health Equity Award from National Dialogue on Diversity, Inc. Health Care Heroes Award from Daily Record Newspaper
	Annual National Conferences	Addressed ~1400 community members
	Qualified Bilingual Staff Program	Trained a total of 676 people
	Cultural Competence Training for Providers and Staff	Trained ~9,660 people
	MultiCare Health System	
	LifeBridge Health	Conducted Cultural Competence Organizational Assessment; developed a Health Equity Task Force of hospital employees; and developed a Community Advisory Board
	Maryland Health Quality and Cost Council	Chair the Cultural Competence Committee for MHQCC; Influenced the development of Health Enterprise Zones in Maryland
3. Successfully partnered with local government, state, safety net clinics and others to address needs of vulnerable populations in line with state goals to reduce health disparities in our communities	Low-Income Breast Cancer Program	Screened ~6,800 women in the past 4 years
	Primary Care Coalition Clinics Partnerships	Partner with 8 out of the 12 safety net clinics in Montgomery County
4. The Center spearheaded Adventist HealthCare entities' alignment of community benefit resources with the community health needs assessed by our local county government	Focus areas for 2014, 2015, 2016: Behavioral Health, Immunizations, Diabetes Management, Cancer Screening, Concussion Care	
5. Advanced Prevention and Wellness strategies that improved access and health outcomes for our most vulnerable populations	Community Influenza Vaccination Program	Provided ~ 6,400 vaccines at 182 flu shot clinics in past 4 years  2011 – 1,800 vaccines at 50 clinics; 2012 – 1,700 vaccines at 65 clinics; 2013 – 1,400 vaccines at 32 clinics; 2014 – 1,500 vaccines at 35 clinics
	Tobacco Cessation Counseling	Offered to ~1,400 patients (at WAH) per year (or about 5,600 patients in past 4 years)
	Outreach events/activities (e.g. community health screenings, health fairs)	~400 events/activities per year or 1,600 in past 4 years
	<u>Health Education Classes:</u>	~400 total classes per year or 1,600 classes in past 4 years
	o Maternal/Child/Family Health Classes/Support Groups (breastfeeding classes & support groups, childbirth classes, baby care basics classes, fatherhood support group, motherhood support group, grandparent classes, & sibling classes)	o ~ 210 classes & support groups/year
	o Diabetes (self-management & pre-diabetes classes)	o ~50 classes/year
	o Youth Health (babysitting and home alone classes)	o ~ 40 classes/year
	o CPR/First Aid (Infant and Adult)	o ~ 85 classes/year
o Cardiac classes (i.e., CHIP) & lectures	o ~30/year	
6. Partner with academic institutions to provide meaningful Public Health Internships to over 25 undergraduate and graduate students yearly to develop the next generation of diverse health professionals	University of Maryland School of Public Health, School of Pharmacy, Johns Hopkins, Towson University, and more	Trained ~ 100 health professionals in past 4 years

# **Exhibit F**

[www.AdventistHealthCare.com](http://www.AdventistHealthCare.com)

# Center for Health Equity & Wellness

Population Health  
Care Coordination Meeting  
January 23, 2015



# Center for Health Equity & Wellness

Identifying patient and community needs...

Health Equity Report  
Community Health Needs Assessment (CHNA)  
Community Partnerships  
Health Outreach & Program Evaluation Data  
Organizational Assessments

...addressing identified needs...

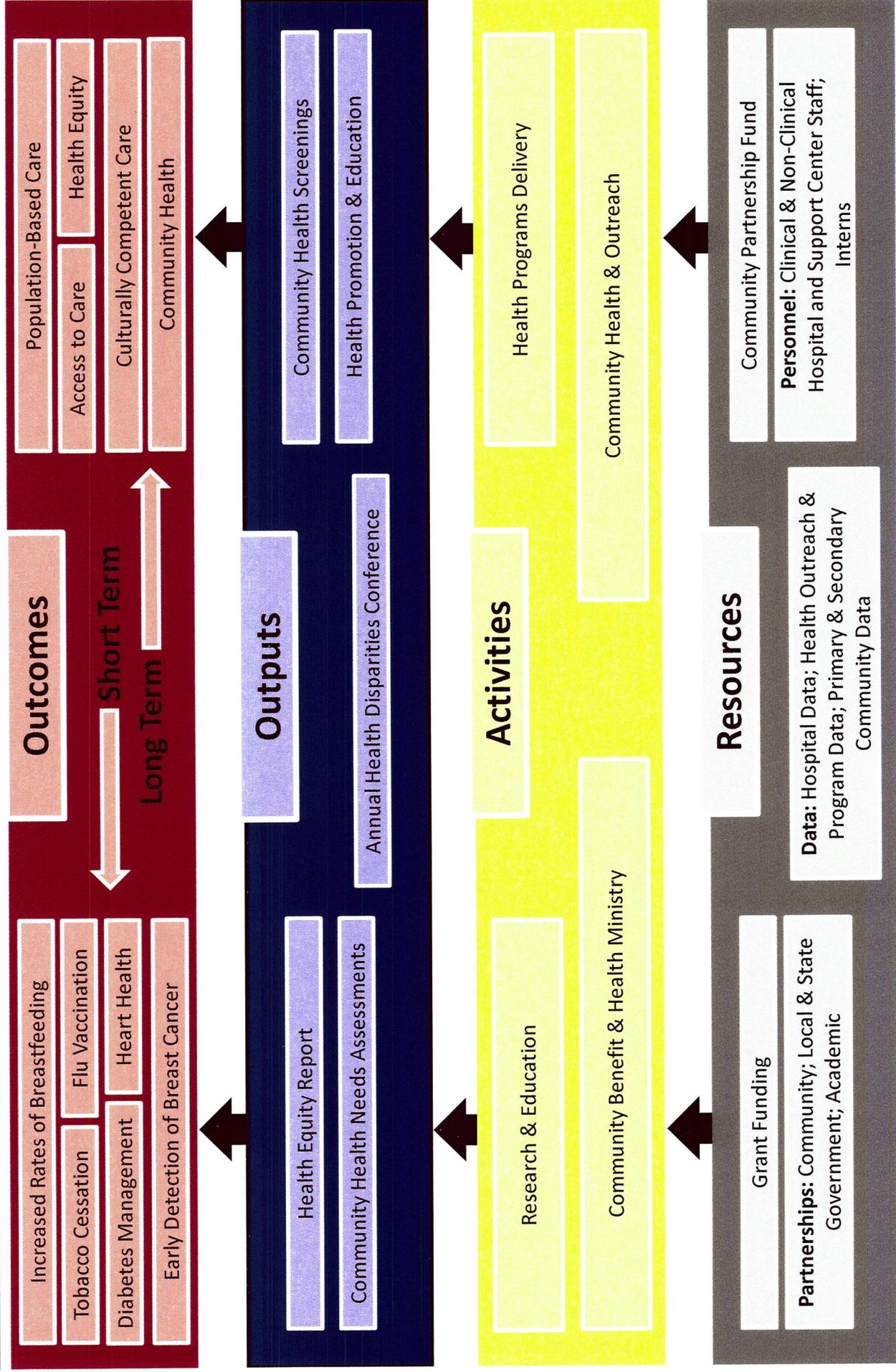
Health Programs Delivery  
Community Health Outreach  
Linguistic Services  
Cultural Competence Training  
Community Partnership Fund  
Implementation Strategy Initiatives

...working toward population health.

Health Equity  
Access to Care  
Culturally Competent Care  
Social Determinants of Health



# Logic Model

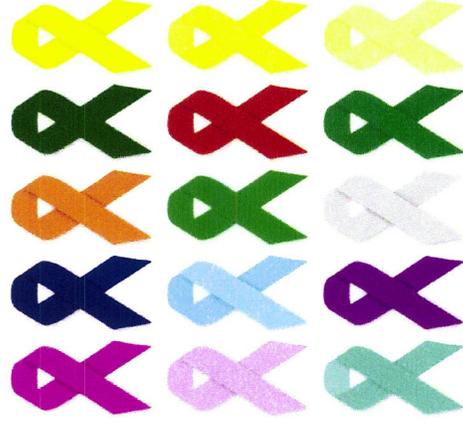


# Population Demographics

- **Data Collection and Reporting**
  - Accuracy and ability to report process of care and outcomes stratified by R, E, A, L, G and SES
  - MHA / HSCRC Partnership
- **Cultural Competence Capacity Building**
  - Web-based training / Classroom
  - Cultural Competence Organizational Assessments
- **Linguistic Access Support**
  - Qualified Bilingual Staff Program
  - CyraCom, VRI, Sign Language

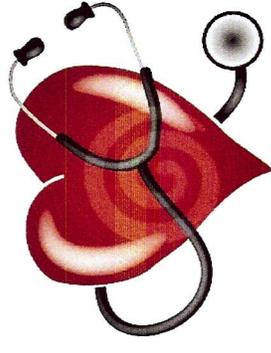
# Cancer Prevention

- **Cancer Screening Days**
  - WAH & SGMC
  - Colorectal, throat, skin, breast, prostate
- **Smoking Cessation Programs**
  - WAH: # of patients counseled/Success Rate/Follow-up
  - SGMC: Starting January 2015
- **Low-Income Breast Cancer Program**
  - WAH & SGMC



# Cardiac & Diabetes Outreach

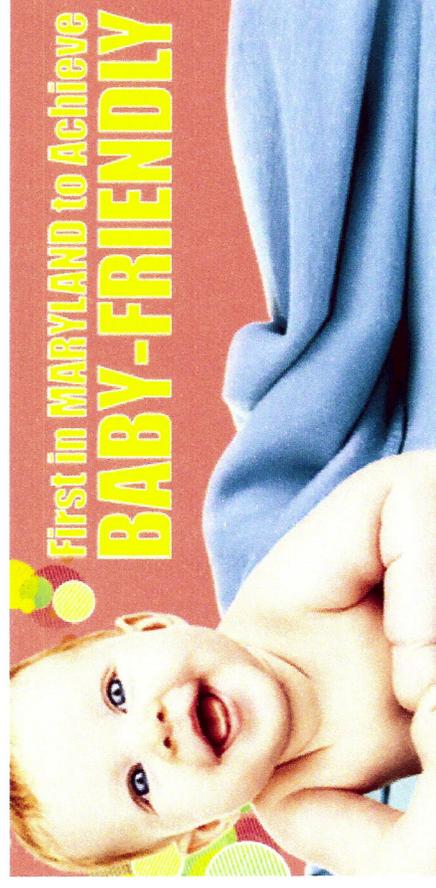
- **Cardiac Outreach**
  - Love Your Sweetheart: Multiple local events scheduled in February including 2 large events at WAH & SGMC
  - Support Groups
  - Low cost heart health screenings: WAH & SGMC
- **Diabetes Outreach**
  - Pre-Diabetes Class: WAH & SGMC
  - Comprehensive Diabetes Education Classes
  - Mobile Med: Education during joint medical appointments
  - Complete Health Improvement Plan (CHIP)



# Baby Friendly Support

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- Childbirth & Baby Care
- Breastfeeding Class
- Maternity Tours
- Lactation Services
- The BEST breastfeeding support group
- Discovering Motherhood support group
- Gestational Diabetes
- Fatherhood 101



# Addressing Social Determinants

- **Community Partnership Fund**
  - Grants for improving the health of the community
- **Community Clinics Partnerships**
  - Mercy Health Clinic
  - Community Clinic Inc.
- **Hard to reach populations**
  - Low Income Housing Outreach
  - Health Ministry

