Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Carroll Hospital Center	◉	○	
Your hospital's ID is: 210033	◉	○	
Your hospital is part of the hospital system called LifeBridge Health	◉	○	
The primary Narrative contact at your hospital is Sharon McClernan	◉	○	
The primary Narrative contact email address at your hospital is smcclernan@lifebridgehealth.org	◉	○	
The primary Financial contact at your hospital is UNKNOWN	○	◉	Julie Sessa
The primary Financial email at your hospital is sbrewer@CarrollHospitalCenter.org	○	◉	jsessa@lifebridgehealth.org

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [x] Percent with public health insurance
- [x] Percent with Medicaid
- [x] Mean travel time to work
- [ ] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [x] Life expectancy
- [x] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Health Disparities Carroll County has several health disparities in a variety of areas, including Access to Health Services, Cancer, Diabetes, Exercise, Nutrition & Weight, Family Planning, Heart Disease & Stroke, Maternal, Fetal & Infant Health, Mental Health & Mental Disorders, Older Adults & Aging, Other Chronic Diseases, Respiratory Diseases, Substance Abuse, Housing Affordability & Supply, and Wellness & Lifestyle. For a complete and updated list with data sources, visit our Disparities Dashboard powered by Healthy Communities Institute at: http://www.healthycarroll.org/assessments-data/our-community-dashboard/?hcn=DisparitiesDashboard Our Community Dashboard: http://www.healthycarroll.org/assessments-data/ourcommunity-dashboard/ Also obtain data from: -The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps (https://www.countyhealthrankings.org/) - Maryland Department of Health's Vital Statistics and Reports (https://health.maryland.gov/vsa/Pages/reports.aspx) - The University of Wisconsin School of Medicine and Public Health's Neighborhood Atlas/Area Deprivation Index Map (https://www.neighborhoodatlas.medicine.wisc.edu/)

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

- [ ] Allegany County
- [ ] Anne Arundel County
- [ ] Baltimore City
- [ ] Baltimore County
- [ ] Calvert County
- [ ] Caroline County
- [x] Carroll County
- [ ] Cecil County
- [ ] Charles County
- [ ] Dorchester County
- [ ] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Prince George's County
- [ ] Queen Anne's County
- [ ] Somerset County
- [ ] St. Mary's County
- [ ] Talbot County
- [ ] Washington County
- [ ] Wicomico County
- [ ] Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

- [x] 21048
- [x] 21074
- [x] 21102
- [x] 21104
- [x] 21136
- [x] 21155
- [x] 21157
- [x] 21158
- [x] 21757
- [x] 21771
- [x] 21776
- [x] 21784
- [x] 21787
- [x] 21791
- [x] 21797

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [x]

Based on ZIP codes in your Financial Assistance Policy. Please describe.

Carroll Hospital primarily defines its community benefit service area as Carroll County. The hospital further defines primary service areas in our Financial Assistance Policy. These communities and zip codes include:
Primary
Finksburg (21048)
Keymar (21757)
Hampstead (21074)
Manchester (21102)
Mount Airy (21771)
New Windsor (21776)
Sykesville (21784)
Taneytown (21787)
Union Bridge (21791)
Upperco (21155)
Westminster (21157 & 21158)
Woodbine (21797)

- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [ ] Based on patterns of utilization. Please describe.
- [ ] Other. Please describe.

Q35. Provide a link to your hospital's mission statement.

https://www.lifebridgehealth.org/Carroll/MissionVision.aspx

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

6/30/2021

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://healthycarroll.org/wp-content/uploads/2021/04/2021-executive-summary-community-health-needs-assessment-for-carroll-county-updated-1.pdf

Q42. Please upload your hospital's most recently completed CHNA.

Carroll 2021-executive-summary-community-health-needs-assessment.pdf
627.2KB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Physician(s)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☐	☑	☑	☐	☐	☐	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐	
Community Benefit staff (system level)	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☑	☑	☐	☐	☐	☑	☐	☐	
Nurse(s)	☐	☐	☑	☑	☐	☐	☐	☑	☑	☑	
Social Workers	☐	☐	☑	☑	☐	☐	☐	☑	☐	☐	
Hospital Advisory Board	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: LifeBridge Health Hospitals (Sinai, Northwest, Levindale, Grace)	☐	☐	☑	☑	☐	☐	☐	☑	☑	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Department -- Please list the Local Health Departments here: Carroll County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: LHIC - Carroll County/Partnership for a Healthier Carroll County	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Carroll County Commissioners	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Carroll County Public Schools; Gerstell Academy	☑	☑	☑	☑	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: McDaniel College; Carroll Community College	☑	☑	☑	☑	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Behavioral Health Advisory Board	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: Community Services Council, includes community nonprofits	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: Carroll Lutheran Village, Brinton Woods, Right at Home	☑	☑	☑	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: PFLAG - Carroll County; NAACP - Carroll County	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here: Department of Citizen Services	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here: Access Carroll, Public Safety (EMS, fire, police)	☑	☑	☑	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

6/30/2021

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://healthycarroll.org/cb-hip/

Q222. Please upload your hospital's CHNA implementation strategy.

Carroll communitybenefit_web-002.pdf
3MB

application/pdf

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

☑ Health Conditions - Addiction	☐ Health Behaviors - Drug and Alcohol Use	☐ Populations - Women
☐ Health Conditions - Arthritis	☐ Health Behaviors - Emergency Preparedness	☐ Populations - Workforce
☐ Health Conditions - Blood Disorders	☐ Health Behaviors - Family Planning	☐ Settings and Systems - Community
☑ Health Conditions - Cancer	☑ Health Behaviors - Health Communication	☐ Settings and Systems - Environmental Health
☐ Health Conditions - Chronic Kidney Disease	☐ Health Behaviors - Injury Prevention	☐ Settings and Systems - Global Health
☐ Health Conditions - Chronic Pain	☑ Health Behaviors - Nutrition and Healthy Eating	☐ Settings and Systems - Health Care
☐ Health Conditions - Dementias	☑ Health Behaviors - Physical Activity	☑ Settings and Systems - Health Insurance
☑ Health Conditions - Diabetes	☑ Health Behaviors - Preventive Care	☐ Settings and Systems - Health IT
☐ Health Conditions - Foodborne Illness	☐ Health Behaviors - Safe Food Handling	☐ Settings and Systems - Health Policy
☐ Health Conditions - Health Care-Associated Infections	☐ Health Behaviors - Sleep	☐ Settings and Systems - Hospital and Emergency Services
☑ Health Conditions - Heart Disease and Stroke	☐ Health Behaviors - Tobacco Use	☐ Settings and Systems - Housing and Homes
☐ Health Conditions - Infectious Disease	☑ Health Behaviors - Vaccination	☐ Settings and Systems - Public Health Infrastructure
☑ Health Conditions - Mental Health and Mental Disorders	☐ Health Behaviors - Violence Prevention	☐ Settings and Systems - Schools
☐ Health Conditions - Oral Conditions	☐ Populations - Adolescents	☑ Settings and Systems - Transportation
☐ Health Conditions - Osteoporosis	☐ Populations - Children	☐ Settings and Systems - Workplace
☐ Health Conditions - Overweight and Obesity	☐ Populations - Infants	☐ Social Determinants of Health - Economic Stability
☐ Health Conditions - Pregnancy and Childbirth	☐ Populations – LGBT	☐ Social Determinants of Health - Education Access and Quality
☐ Health Conditions - Respiratory Disease	☐ Populations - Men	☑ Social Determinants of Health - Health Care Access and Quality
☐ Health Conditions - Sensory or Communication Disorders	☐ Populations - Older Adults	☐ Social Determinants of Health - Neighborhood and Built Environment
☐ Health Conditions - Sexually Transmitted Infections	☐ Populations - Parents or Caregivers	☐ Social Determinants of Health - Social and Community Context
☐ Health Behaviors - Child and Adolescent Development	☐ Populations - People with Disabilities	☐ Other (specify)

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	SBIRT Program	Peer recovery coaches connect SUD patients with treatment and community resources.	Approximately 200 patients a month	# of interventions, # of referrals to treatment; rate of bup. induction while in the ED
Initiative B	Buprenorphine induction program	Initiate buprenorphine induction in the ED		
Initiative C	Alcohol and drug use screening during primary care visits	Routinely screen patients at primary care visits for alcohol and drug use.		
Initiative D	GBRICS - Greater Baltimore Regional Integrated Crisis System	Provide alternative to ED for individuals in crisis; includes call line.		
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

	Health Conditions - Cancer Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Breast and Cervical Cancer Screening Program	Partnership with the Health Department to focus on screening and diagnostics for low income residents of Carroll County		# of individuals seen
Initiative B	Embrace Wellness - Cancer Survivorship	Program for cancer survivors who have completed active treatment within the last 5 years. The goal of the program is to support continued healing and help participants thrive in survivorship and reduce the risk of reccurence. Components of the 12-week program include nutrition, self-care and physical activity. This program is offered annually at this time and funded by the Embrace Fund.	12 participants annually	Metrics such as BMI, blood sugar, cholesterol, self reported goal success & symptom improvement
Initiative C	Gather & Connect - Cancer Support Group	Monthly support group that provides an opportunity for people with cancer and their caregivers to share strategies on living and dealing with cancer. Offers opportunity to meet others facing similar situations and experts who can provide the support and resources needed.		
Initiative D	Breast Cancer Support Group	Monthly support group that provides education, support and special understanding for women who are newly diagnosed with breast cancer, currently receiving treatment or in recovery.		
Initiative E	Center for Breast Health	Provide high-quality, full-spectrum breast health services.	Approx 2,600 patient visits per year	Number of patients seen, number of surgeries
Initiative F	Mammothon	Provide a focus on screening and early detection		Number of people getting mammograms
Initiative G	Safer in the Shade & Fun in the Sun	Reduce sun exposure	Several sites per year	Number of individuals
Initiative H	Complementary/Supporting Health Services: acupuncture, reflexology, massage	Complementary health services are offered at the Tevis Center for Wellness by contracted Licensed Practitioners. These services help care for mind, body and spirit. They are used to help relieve disease symptoms, boost energy, reduce stress, manage pain and foster recovery.	FY20 - 3843 total complementary health treatments provided	
Initiative I				
Initiative J				
All Other Initiatives				

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

This question was not displayed to the respondent.

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

	Health Conditions - Diabetes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Diabetes wellness and management education	Focus on Diabetes prevention, wellness, and self-management throughout LBH service areas; partnership with Diabetes Resource Centers and Local ADA chapter. Includes "Diabetes Wednesdays" educational calls, a weekly series with telephonic classes with a Diabetes Educator on various subjects pertinent to managing diabetes.		
Initiative B	Diabetes Patient Guide (new) developed and distributed	Ensure individuals with diabetes have knowledge to best manage diabetes and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative C	Endocrinologist-led Webinar education series for Primary Care Providers: Diabetes best practice management	Endocrinologists educate LBH primary and specialty care providers on best practice for diabetes pt management.	20-40 primary care providers attending each of the 6 Endocrinologist-led webinars	Primary care provider attendance
Initiative D	Diabetes Balance Program	12 week education and support program led by Registered Dietitians designed to help people with diabetes achieve clinical indicators and establish behaviors that are known to reduce complications from Type 2 diabetes. This program is designed to promote a reduction in age-adjusted diabetes mortality and promote healthy BMI, both 2024 goals as stated in the Maryland Diabetes Action Plan.	10 participants	Metrics such as weight, BMI, blood sugar, self reported goal success and behavior change
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

	Health Conditions - Heart Disease and Stroke Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Telemonitoring Program	Remote patient monitoring program to improve the quality of care, patient outcomes, and reduce hospital utilization for patients with chronic diseases by improving patient-provider communication, improving coordination of care, and improving time of follow up with PCP.		ED and hospital utilization pre and post implementation of telemonitoring program.
Initiative B	Cardiologist-led Webinar education series for Primary Care Providers: Heart Failure best practice management	Cardiologists educate LBH primary and specialty care providers on best practice for cardiac patient management.	30-45 primary care providers attending each of the 6 Cardiologist-led webinars	Primary care provider attendance
Initiative C	Heart Failure Patient Guide (new) developed and distributed	Ensure individuals with heart failure have knowledge to best manage heart failure and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative D	Stroke Support Group	Monthly support group for stroke survivors, families and caregivers. Offers opportunity to meet others facing similar situations and experts who can provide the support and resources needed.		
Initiative E	Complementary/Supporting Health Services: Acupuncture; Reflexology; Massage	Complementary health services are offered at the Tevis Center for Wellness by contracted Licensed Practitioners. These services help care for mind, body and spirit. They are used to help relieve disease symptoms, boost energy, reduce stress, manage pain and foster recovery.	FY20 - 3843 total complementary health treatments provided	
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

This question was not displayed to the respondent.

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

	Health Conditions - Mental Health and Mental Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources	More than 10,000 patients worked with per year.	Successful linkage to resources and compliance with engagement with resource.
Initiative B	Integrated Behavioral Health Services with Primary Care Providers	As part of MDPCP program, working to identify a network of providers who will work with LBH Clinically Integrated Network for behavioral health services.		
Initiative C	Screening for Depression in Primary Care	Identify depression during primary care appointments and provide follow-up if needed.		% of primary care patients screened with PHQ-2/9 annually.
Initiative D	GBRICS - Greater Baltimore Regional Integrated Crisis System	Improve access to appropriate support for individuals in behavioral health crisis.		
Initiative E	Anti-stigma campaign	Lead community team of subject matter experts to reduce noncompliancy and resistance to treatment		
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

This question was not displayed to the respondent.

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

This question was not displayed to the respondent.

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

This question was not displayed to the respondent.

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

This question was not displayed to the respondent.

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

Health Behaviors - Health Communication Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Health Education Team	Prioritizing health education needs in the community and providing Health, Wellness, and Prevention education events, classes and risk assessments; connecting participants to resources to maintain health, and with medical providers and/or other programs.		Attendance, Behavior change, knowledge gained (self-report), also healthcare system engagement
Initiative B	PPE and IP/IC Education/Training	Facility/staff PPE training, IP/IC site assessments, and centralized training for MDH/MHA.	Over 1,000 trained.	Increased rate of transmission-based precautions and reduced staff/patient positivity. HSCRC LTC metrics and ad-hoc assessments with county/city Departments of Health.
Initiative C	Live Life Healthy	Cover various health topics in an innovative way to include elements of game shows, quizzes, and health talks	123 participants since Oct 2020.	Attendance, lifestyle change, engagement with health care system
Initiative D	Mental Health Mondays	Partnership with Mental Health practitioners in the area as well as LBH staff to offer classes on various mental health topics, created at the request of community members and faith leaders in our service areas.	166 participants since Oct 2020.	Attendance, lifestyle change, engagement with health care system
Initiative E	TeleLearning - Faith Edition	Education on various topics geared towards faith leaders in our communities to aid in forming congregational plans, wellness ministries, and health-related activities in faith-based organizations.		Attendance, lifestyle change, engagement with health care system
Initiative F	Work Out Wednesdays	TeleLearning program focused on physical activity with instructions for various types of exercises		Attendance, lifestyle change, engagement with health care system
Initiative G	Community Pastoral Outreach	Community Pastoral Outreach provides nurturing and supportive leadership with members of the faith community within LifeBridge Health's catchment area and beyond. Specifically, Community Pastoral Outreach is the resident faith liaison for the hospital system; assists congregations (all faiths) with developing health and wellness ministries; provide community pastoral care with participants of established programs of Community Initiatives (spiritual advisement, prayer, encouragement); help faith communities develop workshops, seminars, classes in relation to faith and health along with specific health concerns; explore opportunities for partnership with faith communities and LifeBridge Health; engage in faith relations (local governments, nonprofits, colleges & Universities, etc) througout LBH service areas.		Attendance, lifestyle change, engagement with health care system
Initiative H	Vinyasa Yoga	Yoga practice helps improve strength, flexibility and balance, and it promotes relaxation, calm and focus. These 4 week virtual sessions are offered monthly currently.	50-100 participants/ year	
Initiative I	Tevis Center for Wellness	Offers: Classes, workshops and health screenings, complementary health services, such as massage, acupuncture, yoga and facials, weekly healthy recipes and weight management programs, support groups to help people cope with a variety of health challenges, a resource library with internet access and books on hundreds of health and wellness topics, a retail boutique where you can shop for health and wellness products.	FY2020: 10,075	Number of participants, patient surveys/feedback
Initiative J				
All Other Initiatives				

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

Health Behaviors - Nutrition and Healthy Eating Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Leadership Team for Advancing Health & Wellness	Offers programs such as Carroll's Cooking, Community Gardens, Healthy Living Series		Number of participants per event.
Initiative B	Healthy Bites with Bridgette	A weekly virtual cooking class taught by a registered dietitian. Participants cook along with the instructor as she demonstrates cooking techniques and provides nutritional information.	8-10 participants per week.	Number of participants per event. Self-reported behavior change.

Initiative C	Lose to Win program	An annual 12-week wellness program to help individuals lose weight while adopting healthy lifestyles. The program includes weekly educational classes, a 12-week membership to the YMCA, pre and post program bloodwork, and ongoing support from a registered dietitian.	12-15 participants per year.	
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

	Health Behaviors - Physical Activity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Leadership Team for Advancing Health & Wellness	Park development, Walk Carroll, Fitness Fridays, Tryvent		
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

	Health Behaviors - Preventive Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Health Screening Events	Provide screenings and risk assessments at mutiple locations throughout the LBH service areas, reaching all outreach markets, working with local businesses and organizations based on prioritized needs. Collaborating with LBH call center to provide follow-up, also providing real time nurse consultations.	FY2020: 1,445 participants screened.	
Initiative B	Post-Acute COVID Testing	Community-based clinical touches covering COVID testing. vaccinations, chronic disease prevention and identification, and various use cases for LBH Mobile Health.		
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

This question was not displayed to the respondent.

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

	Health Behaviors - Vaccination Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Vaccination	Community-based clinical touches covering COVID vaccinations, testing.		
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

This question was not displayed to the respondent.

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

This question was not displayed to the respondent.

Q217. Please describe the initiative(s) addressing Populations - Infants.

This question was not displayed to the respondent.

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

This question was not displayed to the respondent.

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

This question was not displayed to the respondent.

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

This question was not displayed to the respondent.

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

This question was not displayed to the respondent.

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

	Settings and Systems - Health Insurance Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Access Carroll	Assists residents obtain health insurance.		
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

This question was not displayed to the respondent.

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

This question was not displayed to the respondent.

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services to address social needs for high-risk community members, including coordination of transportation to medical appointments and social services.		Successful linkage to resources and compliance with engagement with resource.
Initiative B				
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Access Carroll	Assists residents in all aspects of accessing health care resources.		
Initiative B	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources; coordination of transportation to medical appointments and Social Services.		
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

This question was not displayed to the respondent.

Q243. Please describe the initiative(s) addressing other priorities.

This question was not displayed to the respondent.

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:

Health Conditions - Addiction, Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Vaccination, Settings and Systems - Health Insurance, Settings and Systems - Transportation, Social Determinants of Health - Health Care Access and Quality
Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

This question was not displayed to the respondent.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

This question was not displayed to the respondent.

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

This question was not displayed to the respondent.

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [x] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (•) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

The community benefit narrative is reviewed regularly by the health system's Community Benefit Committee that makes recommendation for approval of the Community Benefit Report by the LifeBridge Health Community Mission Committee of the LifeBridge Health Board. The Partnership for a Healthier Carroll County Board also reviews the community benefit assessment and plan.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (•) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

The Community Health Needs Assessment results are prioritized by community leaders and system leadership. A Community Benefit plan is created from this prioritization process. The community benefit plan is used to identify needs and priorities for the organizational strategy.

Q70. If available, please provide a link to your hospital's strategic plan.

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [x] Maternal and Child Health - Reduce severe maternal morbidity rate
- [x] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (●) Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

LBH Financial Assistance Policy English 012821.pdf
277.4KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

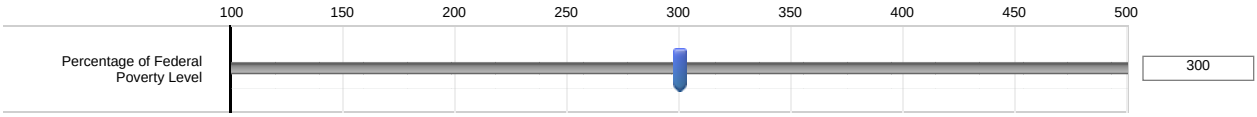
https://www.lifebridgehealth.org/Main/LifeBridgeHealthFinancialAssistance.aspx

Q147. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe: [ ]

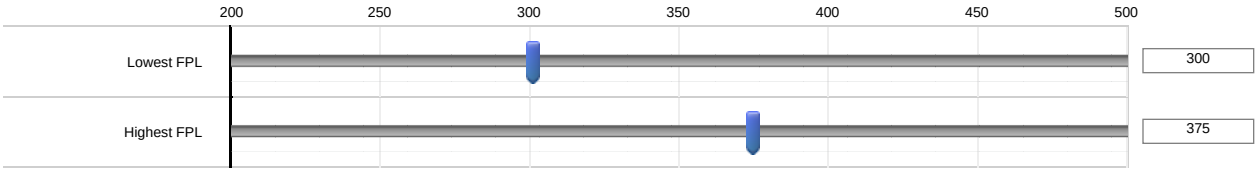
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



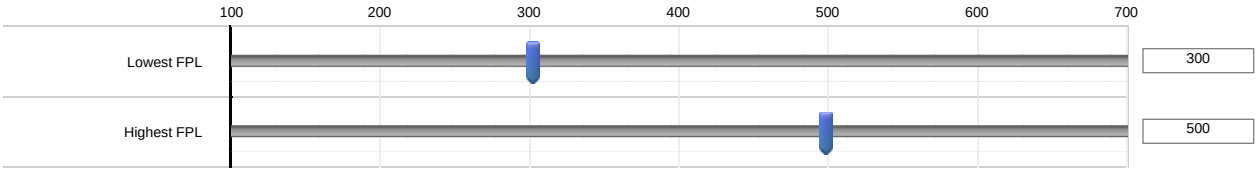
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

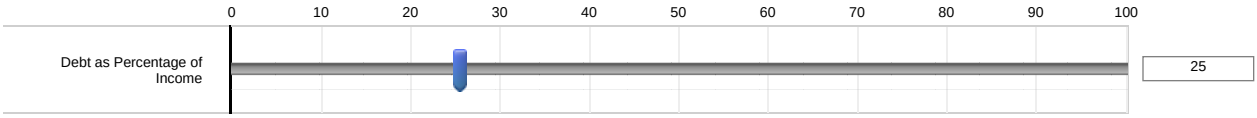


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [x] Other (Describe) FUTA

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (38.658294677734, -77.248100280762)

Source: GeoIP Estimation

Community Health Needs Assessment

Carroll County, Maryland

Executive Summary

2021

CHNA Research Components

Primary Data:

An online Community Health Needs Survey was conducted with Carroll County residents between July 1 and September 30, 2020. The survey was designed to assess their health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Key Informant Survey sessions were conducted with community leaders and partners. Key informants represented a variety of sectors, including public health and medical services, non-profit and social organizations, children and youth agencies, and the business community.

Ten sessions of Targeted Populations Research were conducted through focus groups including African American, Behavioral Health Consumers, Hispanic/Latino, LGBTQ, Low Income, Transitional Aged Youth, and Older Adults community members.

Secondary Data:

The CHNA also includes extensive secondary data which expands the information available for the final prioritization and planning steps.

The following information was collected in the assessment:

Demographics

- Age
- Education
- Employment status
- Gender
- Income
- Marital status
- Number of children
- Race
- Veteran's health
- Zip Code

Quality of Life

- Cognitive impairment
- Healthy days
- Healthy status

Health Access

- Health insurance
- Medication compliance
- Oral health
- Primary Care Physician
- Urgent care
- Visual health
- Tobacco use

Health Behaviors

- Breast/Cervical screening
- Child health
- Colon cancer screening
- Exercise
- Fruits and vegetables
- Immunizations
- Prostate cancer screening
- Second-hand smoke
- Sugar sweetened beverages
- Sun exposure
- Tobacco use

Physical Health

- Angina/Coronary heart disease
- Asthma
- Auto-immune
- Cholesterol
- Congestive heart failure
- COPD
- Diabetes
- Heart attack
- HIV/AIDS
- Hypertension and high blood pressure
- Other cancer
- Skin cancer
- Stent or bypass
- Stroke

Behavioral Health

- Anxiety and Depression – Diagnosis and medication
- Illegal and legal substance use and abuse
- Suicide

Social Issues

- End of life planning
- Violence

CARROLL COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

EXECUTIVE SUMMARY

Background

The **Carroll County 2021 Community Health Needs Assessment (CHNA)** was prepared to provide valuable information to help determine the direction and structure necessary to continue addressing health needs in the community.

The first broad Health Needs Assessment for Carroll County was conducted in 1997 by a Steering Committee of 44 members, with many partners including Carroll County Government and the Carroll County Health Department. The action plan formed to address those needs after the Assessment called for a new collaborative vehicle that would facilitate the work of creating a healthier Carroll County community. The Partnership for a Healthier Carroll County, Inc. (The Partnership), was incorporated in 1999 to be that vehicle. The new organization was also established by Carroll Hospital as the entity to monitor and assess the health needs of our community on an ongoing basis.

The Partnership led a number of major and minor community health assessment projects between 1999 and 2010. When the Affordable Care Act of 2010 mandated a regular three-year community health needs assessment, The Partnership was already experienced in data collection, organization, and analysis, and well-equipped with the resources to carry out that work.

In October 2011, The Partnership Board of Directors voted unanimously to lead another CHNA for Carroll Hospital in compliance with elements of the 2010 Affordable Care Act. Also, in October 2011, The Partnership's Board voted to serve as the Local Health Improvement Coalition (LHIC) for Carroll County, responsible for the development and implementation of a Local Health Improvement Plan (LHIP) that meets the requirements as proposed in the State Health Improvement Process (SHIP). In September 2012, The Partnership led a review of SHIP and CHNA data, with a collaborative group that included representatives from Carroll Hospital, the Carroll County Health Department and community members. This data review resulted in a Community Benefit and Health Improvement Plan, which after approval by the governance of Carroll Hospital and The Partnership, serves as a major part of each organization's corporate strategic plans.

The CHNA projects of 2012, 2015, and 2018 determined community health improvement priorities and supported the creation of Sharing the S.P.I.R.I.T. - the Carroll Hospital Board-approved Community Benefit and Health Improvement Plans for FY2014-FY2016, FY2017-2018, and the most recent plan for FY2019-FY2021. Beginning in July 2020, The Partnership began a comprehensive community health needs assessment (CHNA)

process to evaluate the health needs of individuals living in Carroll County, Maryland to prepare for planning in 2021.

The Partnership is committed to the people it serves and to our community where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. The CHNA Final Consolidated Report is a compilation of the overall findings of each research component in the CHNA process. The findings from the research will be utilized to prioritize public health issues and develop a community health improvement plan focused on meeting community needs. The CHNA allows The Partnership to take an in-depth look at the Carroll County community and prioritize its health needs. The final step in the CHNA process is forming an implementation plan to address those needs.

Methodology

Assessment research activities examined a variety of health indicators, including chronic health conditions, access to health care, and social determinants of health. Results are presented in two broad categories: 1. Primary data collected by our own staff via surveys and moderated group discussions, and 2. Secondary data acquired from credible local, state, and national organizations based on surveys and data collection that they perform. A brief synopsis of the research components is presented below:

Primary Data Research Components

- Online Community Health Needs Survey
- Key Informant Survey
- Targeted Populations Research

An online Community Health Needs Survey was conducted with Carroll County residents between July and September 2020. The survey was designed to assess their health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. A total of 744 surveys were started with 728 completed throughout the county to promote geographical and ethnic diversity among respondents.

Key Informant Survey sessions were conducted with 56 community leaders and partners between July and September 2020. Key informants represented a variety of sectors, including public health and medical services, non-profit and social organizations, children and youth agencies, and the business community. All sessions were conducted by video conference due to the advisories related to the Coronavirus pandemic.

Ten sessions of Targeted Populations Research were conducted in focus sessions with different community groups including African American (x2), Behavioral Health Consumers (x2), Latino, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer), Transitional Aged Youth, Older Adult (x2), and a lower income population group. All sessions were scheduled between August and September 2020. Research participants were invited to complete a survey to identify specific needs of their community. In addition, The Partnership led a moderated discussion with each group after completion of the online survey with the exception of the LGBTQ group which was completed by online survey only. Three of the groups were moderated virtually.

Secondary Data Research Components

This CHNA Final Consolidated Report also includes extensive secondary data which expands the information available for the final prioritization and planning steps in the CHNA process.

The secondary data sections are:

- Demographics
- Our Community Dashboard
- Healthy Carroll Vital Signs
- State of Maryland Health Improvement Process and Local Health Improvement Plan
- Other Data

Community Representation

Community engagement and feedback are an integral part of the CHNA process. The Partnership sought community input through the online community health needs survey that was available to all residents, key informant interviews with community leaders and partners, and targeted populations research with minority and underserved population groups. Leaders and representatives of non-profit and community-based organizations as well as clergy and faith organization representatives gave their insights on the community, including the medically underserved, low income, and minority populations. Key partners, local experts, and community leaders, including public health professionals and health care providers, will participate in the prioritization and implementation planning process.

Prioritization

The Partnership, its members and community partners will meet on February 9, 2021 to collaboratively prioritize community health needs based on all the information components in this report.

Participants will participate in a virtual meeting to hear an overview of key issues identified in the CHNA, followed by a more in-depth discussion of health items of particular concern to those in attendance and their organizations. Finally, voting on priorities will take place by anonymous electronic polling. A prioritized list of issues will be developed using the total scores from two criteria: significance/pervasiveness of the issue and ability to impact.

An implementation plan will be developed to address these needs. All planning and approval processes will be completed by June 30, 2021.

Top Identified Issues

Of the health issues surveyed, the following were prioritized and ranked as the top priorities for FY2021-FY2023. They are listed in ranked order.

Mental Health

Diabetes

Cancer

Heart Health

Obesity

Illegal Substance Abuse

Alcohol Abuse

Suicide

Prescription Drug Use

Physical Inactivity

Stroke

Oral Health

Alzheimer's / Dementia

The issues that are ranked during the prioritization will be addressed in the Community Benefit Plan, as well as in other agencies' strategic plans, but emphasis will be placed on determining which organizations will play lead roles in those efforts. Furthermore, all issues facing Carroll County residents will be evaluated and plans for progress will continue. While the prioritization process is one in which the top issues are ruled in, all health issues will be

monitored and addressed, as appropriate, to ensure improvements to the health and well-being of all individuals and families in Carroll.

General Findings

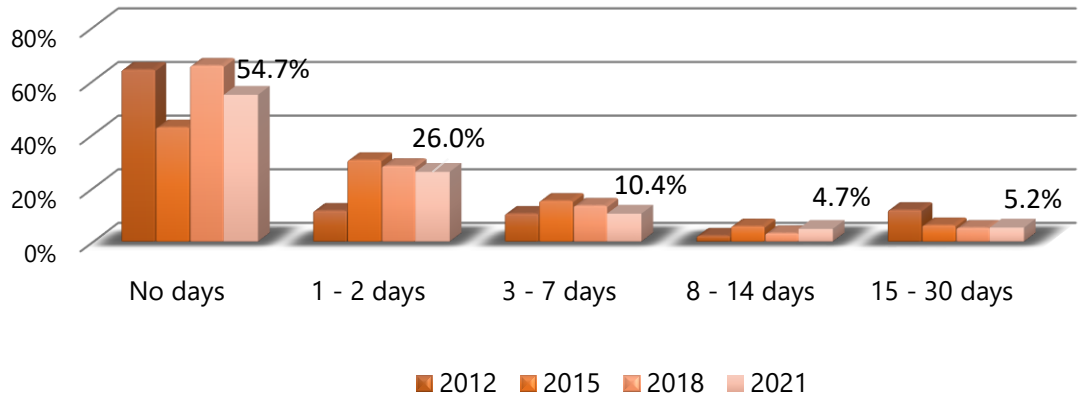
Demographics

- The majority of online survey and focus group respondents were from zip codes 21157, 21158, and 21784.
- In comparison to the Carroll County population, there was a much higher percentage of women (83.3%) than men (16.7%) completing the survey.
- The percentages related to race and age were more comparable to the county, with a majority of respondents indicating White/Caucasian, and more residents 45 years of age or older (67.6%), than those younger than 45 (21.4%).

Quality of Life

- Overall, responders reported a slight increase to their general health status compared with responses in 2018.
    - Self-reported measures of health on the online survey are favorable and in most cases the trends across 2012, 2015, 2018 and 2020 are positive. Approximately 55% say their health is very good or excellent. Although there was a small decrease in those indicating that their health was "very good", this was positively offset by an increase in "good" and a consistent percentage for "excellent". (See chart)
    - 54.7% reported no days in the past month where physical or mental health kept them from doing their usual activities, compared with 65.6% in 2018. This shows a gradual decrease in healthy days from 2018 through 2020. (See chart)
    - Carroll County's ranking remained the same at #2 in Quality of Life out of Maryland's 24 jurisdictions from Robert Wood Johnson Foundation's Health Rankings which reflects this trend.

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



COVID Influence

The COVID pandemic influenced the responses from the community on the 2021 online survey. The impact of COVID-19 showed a reported increase of stress and anxiety (23.9%), feeling depressed (12.2%), and worry about personal health or the health of a loved one (24.5%). In addition, there were 12.1% respondents who reported missing medical appointments. Key Informant groups discussed the recurring theme of the aging population and domestic violence victims not being adequately served being amplified by the COVID pandemic. The influence of the pandemic more than likely extends to regularly scheduled annual/bi-annual appointments.

Health Access

The community online survey focused on accessing services primarily for physical health, whereas the key informant and focus group discussions focused not only on personal health, but also on the health of the community, including social determinants of health such as transportation and paying for services.

- An overwhelming 98.9% of online respondents reported that they have **health insurance**.
    - Over the past years, since the implementation of the Affordable Care Act, the percentage of uninsured Carroll residents has decreased.

- Survey respondents had fairly regular **visits to providers**.
    - The majority of survey participants (92%) reported that they have at least one person they think of as their primary health care provider, and 7.5% of respondents reported not having a personal health care provider. (See chart)
    - 91.1% of respondents reported that they could get an appointment with their provider when they need one.
    - Respondents also reported that they had exams within the past year for both vision (59.5%) and dental (76.7% for adults and 92% for their children), as well as regular wellness visits for their children (97%).
    - 38% of participants reported visiting an urgent care center in the past 12 months with the primary reason cited as wanting to be seen right away. (See chart)

- When asked to pick all answers that apply, participants reported that they are most likely to get health information from two main resources: (See table)
    - Physician/health care provider (68.8%) and online websites (61.4%).
    - The third most frequently cited means was local sources, such as the hospital and/or health department (31.8%). Focus groups identified the same sources for obtaining their information, with family and friends being another frequently identified source. The lowest ranked resources were national sources, health blogs, and television.
    - Many focus group participants recognized the inefficiency of hard copy resources, but the older adult groups said that written materials such as flyers, brochures, directories, and instructions are helpful in many situations.

- Discussions within several of the focus groups included concerns about the **difficulties in getting access to health care** due to transportation, as well as a lack of area providers and the fact that some offices are out of town.

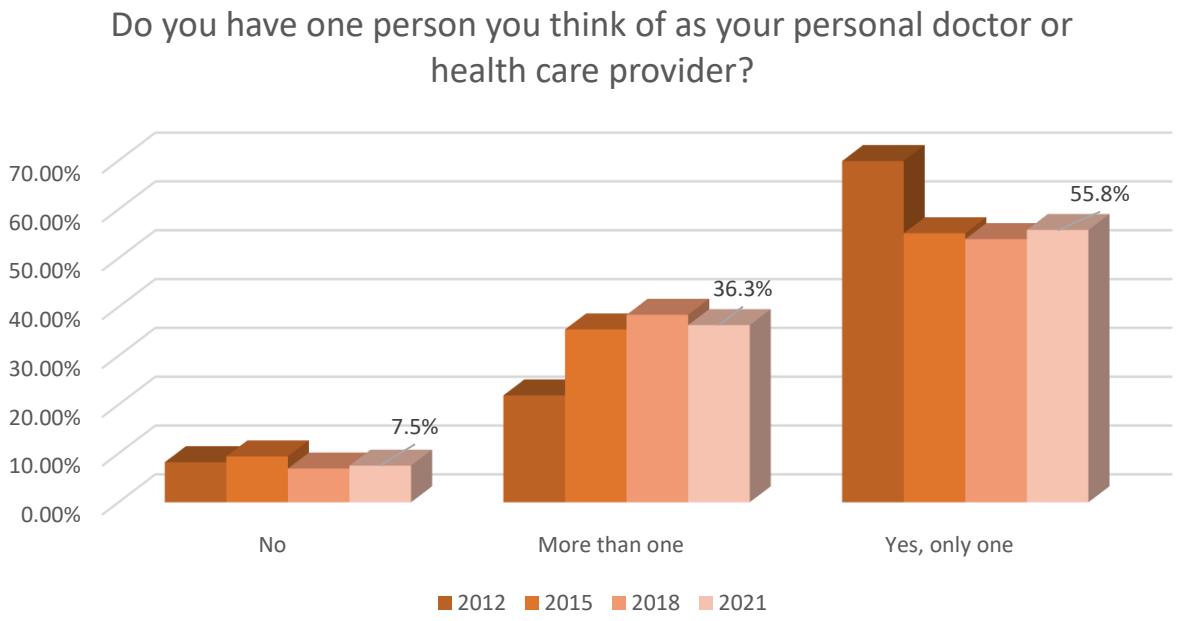
- **Transportation** was discussed at length in all key informant groups but with no consensus on the precise characterization of the problem or solutions.
    - Some key informants saw transportation affecting a small population and therefore consuming a disproportionate amount of discussion and proposed spending.

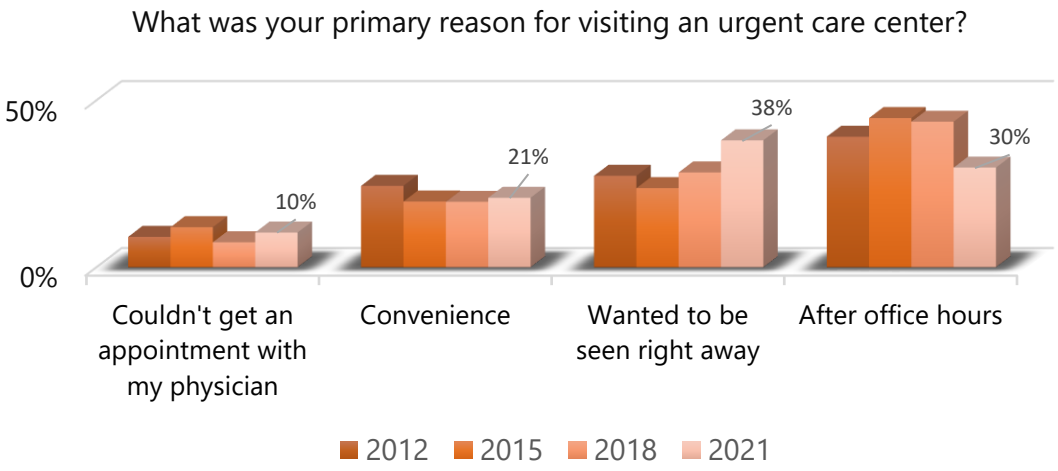
    - Participants on the Community Services Council, who are responsible for direct work with the consumer, saw this issue as a higher need than many other sessions.
    - Certain concerns voiced by participants related more to the logistics of transportation such as cost, scheduling, and designated routes, rather than the availability of transportation. Focus group respondents commented that many residents are not aware of their transportation options.
    - The relationship of transportation to other social determinants of health was recognized, including economic challenges such as employment opportunities and access to medical care.

- Access measures may differ **across different Carroll population groups**.
  Targeted populations have concerns about how their individual **communities have unique challenges** when accessing healthcare services.
    - Of the focus groups, LGBTQ and lower income expressed the most concern that the health provider community does not consistently focus on their needs, including lack of promotion and signage.
    - In the African American and LGBTQ communities, this was seen in some providers' lack of knowledge about medical issues affecting their communities more than others (such as specific skin conditions in the African American community, and endocrine issues related to transgender individuals in the LGBTQ session).
    - In the Hispanic community, there is concern about both language and cultural barriers that exist for some individuals.
    - Even when services are available, older adults expressed a general concern that it is difficult to know which providers in the community are focused on needs of the older adult community and commented that gerontology specialists are needed.
    - Older populations do not like having to see a different care provider each time when seeking care and miss having a doctor who "knows them" and their personal medical history.

- **Health Access** also encompasses being aware of **available resources** within the community and the ability to navigate to the source of those resources. Many requests were made for help in making people aware of resources, navigation within those resources, and cohesion with care coordination and continuum of care. People often do not know where to turn and who to call when experiencing a critical need.

- A lack of **health literacy** was also addressed as a barrier to obtaining needed resources. To address reaching more community residents, it was suggested to providing information on a 5th grade reading level. Also consider including health information programs/packets, including community information to employers for their employees.





The following chart indicates the resources used by respondents to get health information. Responders were able to select more than one answer.

Where online respondents get their health information	
	2021
Your physician/healthcare provider	68.8%
Online website	61.4%
Local sources (i.e. hospital, health dept.)	31.8%
Local providers., organizations/resources	31.0%
Family/friends	26.3%

National sources	26%
Health blogs	10.4%
Television	8.3%

Health Behaviors

Overall, health behaviors are positive with survey respondents, although trends are critical to follow.

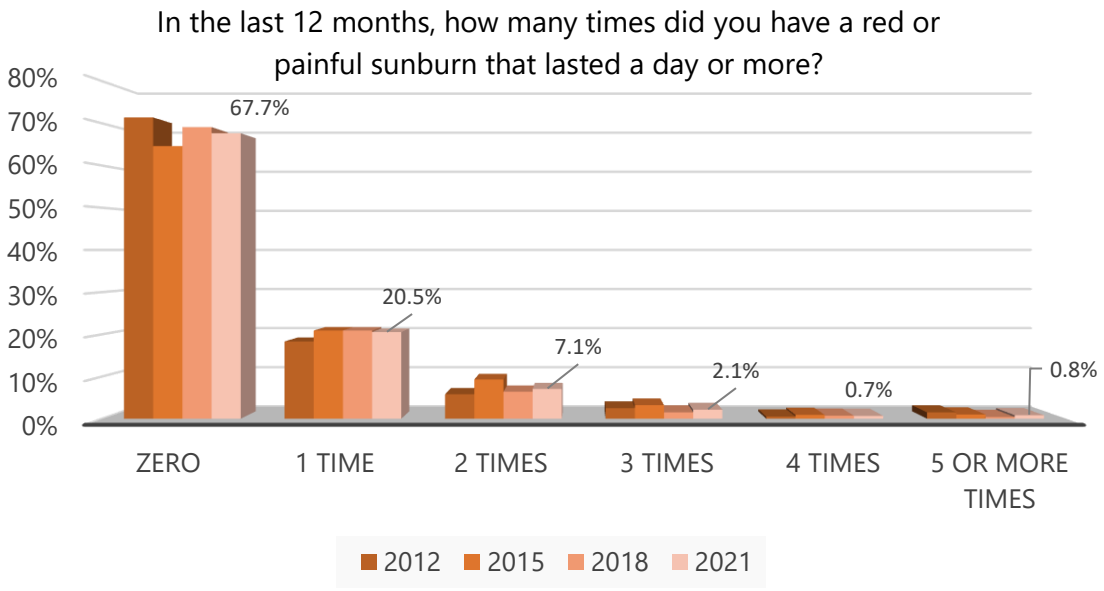
- There are a number of factors considered related to **diet**.
    - 74% of participants, reported eating fast or take-out food once per week. This is a dramatic increase from previous surveys which remained relatively constant from 2012 (41.1%), 2015 (41.0%), and 2018 (40%).
    - The percentage of people that never consume sugar-sweetened drinks in 2021 stayed relatively the same as 2018 at 47%. In addition, almost double, approximately
    - When respondents were asked if they had barriers to healthy eating, almost half said they did not. For those that reported barriers, the top two reasons were time and money. Several focus groups stated a need for obtaining nutritional education and cooking skills to assist with having a healthy diet.

- **Sun safety** is critical as Carroll monitors skin cancer rates.
    - Data from the National Cancer Institute reports the Melanoma incidence rates have increased since 2010 in Carroll County.
    - A promising data point is that a majority of respondents reported not having any painful sunburns in the past 12 months. (See chart)
    - Small increases in the use of protective measures such as hats, lip balm, lotion and avoidance of peak times were noted. (See table)

- Efforts to decrease **tobacco use** nationally and in Carroll have helped to improve this behavior.
    - 95.6% of respondents report that they do not **smoke cigarettes**, and 98.7% do not use smokeless tobacco products, which shows a very slight improvement from the last two assessments in tobacco use.
    - A large number of respondents (48.4%) use electronic vaping products to try and quit other tobacco products.

- Trends in **physical activity** are encouraging.
    - Among respondents who participated in physical activity, the largest percentage of respondents, 61.9%, indicated they exercise for at least 150 minutes of moderate intensity activity or 75 minutes of vigorous intensity activity each week.
    - A majority of respondents (82.6%) reported that they participated in leisure time physical activity during the past month.

- Approximately 77.8% of respondents reported having had a **flu shot or vaccine** in the past year.



Sun Safety Measures		
	2018	**2021**
Sunglasses	80.6%	80.1%
Sunscreen with an SPF of 15 or higher	78.2%	79.8%
Wide brimmed hat	40.3%	44.4%
Lip balm with an SPF of 15 or higher	39.6%	41.7%
Avoiding peak hours of 10 am and 4 pm	28.5%	31%
Sun protective clothing	26.0%	23.8%
Avoiding artificial UV light	24.7%	27.5%
None	5.1%	4.1%
Other	2.9%	2.7%

Physical Health

As guidelines change for frequency of screenings as well as the potential impact of the pandemic, we noticed a significant decrease to some of the previous annual/bi-annual scheduled screenings for women's health. Review of chronic conditions saw an increase in the diagnosis of several stated diseases. Focus groups reflected community-specific concerns. Early intervention and prevention remain a theme from previous assessments that was repeated throughout all key informant groups. Several focus groups expressed concerns about the hereditary aspects of certain diseases, such as diabetes, cancer, and heart disease, and expressed the desire for more education of the same.

- Carroll residents appear to adhere to important early detection through **screening measures**.
    - The percentage of men having prostate cancer screenings continue to increase with each assessment cycle.
    - Respondents were first asked about colon cancer screenings in 2018, and the rate varied little from 2018 (79%) to 2021, with 78.5% of respondents having ever received a colon cancer screening.

- Approximately 9.6% of survey respondents indicated that a provider had ever told them they had **diabetes**, and another 10.9% indicated they had been told they had borderline diabetes (i.e., pre-diabetes). These numbers have remained essentially unchanged since 2015.
    - Supporting these results, Behavioral Risk Surveillance Survey (BRFSS) data show 8.2% of Carroll residents have diabetes which is lower than the state average.
    - The majority of diabetic patients (75%) saw a health professional for management of diabetes, 47.5% twice during the year, and 27% between 3-4 times per year.
    - A new question in 2018 showed that approximately 37% of those who had been diagnosed with diabetes were taking a statin. This figure rose to 64.4% in 2021.
    - In the Hispanic and African American focus groups, diabetes was of particular concern. Given that national data show these groups have higher rates of diabetes, targeted efforts may be necessary to achieve positive outcomes for the community.

- 33% of online respondents had ever been told by a doctor that they had high **blood pressure**, and 10.6% told they were pre-hypertensive. (See chart)
    - Heart health is only listed as a top 5 health issue with two groups – African American and older adults. There was no group that chose heart health when asked which one had greatest impact.
    - A slight decrease was seen in survey respondents who were taking medicine in order to **control their high blood pressure** from 92.2% in 2018 to 91% in 2020, however, that follows an increase from 83.2% in 2015. (See table)
    - Four actions to help lower or control high blood pressure saw slight decreases: those who reported to be making dietary changes such as changing their eating habits, cutting down on salt, taking medicine, and exercising.

- Rates of respondents having their blood **cholesterol** checked within the past two years has increase while those having it checked in the past year has decreased as compared with 2015 and 2018. (See chart)
    - Less than half of those surveyed (40.3%) have been told they have high cholesterol, while 62.7% of those surveyed currently take a statin drug.
    - In 2020, 57.6% of those who had been diagnosed with high cholesterol were currently on medication for this diagnosis compared to 61.5% in 2018.

- Additional chronic health concerns reported by respondents were **arthritis** (41.8%) and **asthma** (14.1%). (See table)

- It most likely requires further investigation, but when respondents who reported having one or more chronic conditions were asked what resources they needed to **manage their conditions,** more than half, 71.9%, indicated "none." Of those who did need help, 5.7% need help understanding directions from their doctor, 5.3% need prescription assistance, and 8.2% need help locating resources.

- **Alzheimer's/Dementia** was among the top General Health issues with the Older Adult focus groups.
    - Newly introduced to the online survey in 2021 was a question regarding witnessing cognition changes in a family member. There was a 33.1% response rate to seeing cognitive decline in a family member.
    - Self-reporting cognitive changes were significantly less than by proxy reporting at 10.7%.
    - Concerns regarding Alzheimer's/Dementia were not only for the patient but also spoke to support and education for the caretaker loved ones.

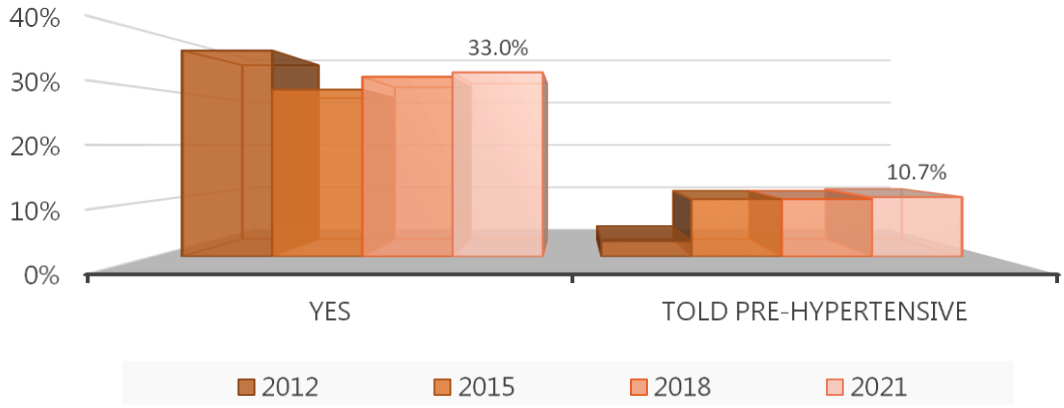
- Although **dental** issues did not necessarily rise to the high level of concern in the online survey, many key informants believed that dental services and/or insurance coverage to pay for dental services were lacking. A majority of online respondents (76.7%) participated in preventative care by having their teeth cleaned within the past year.
    - The Hispanic and Transitional Aged Youth focus groups were the two populations that placed dental services and insurance as a top issue.
    - Two issues were identified: those not having dental insurance, and dentists not taking the insurance that they do have.

- In terms of **medication compliance**, 96.6% of respondents said that cost does not inhibit them from taking medicine.

- The Hispanic focus group along with many participants in key informant groups mentioned **obesity** as a persistent problem in Carroll County, as it is throughout the country.

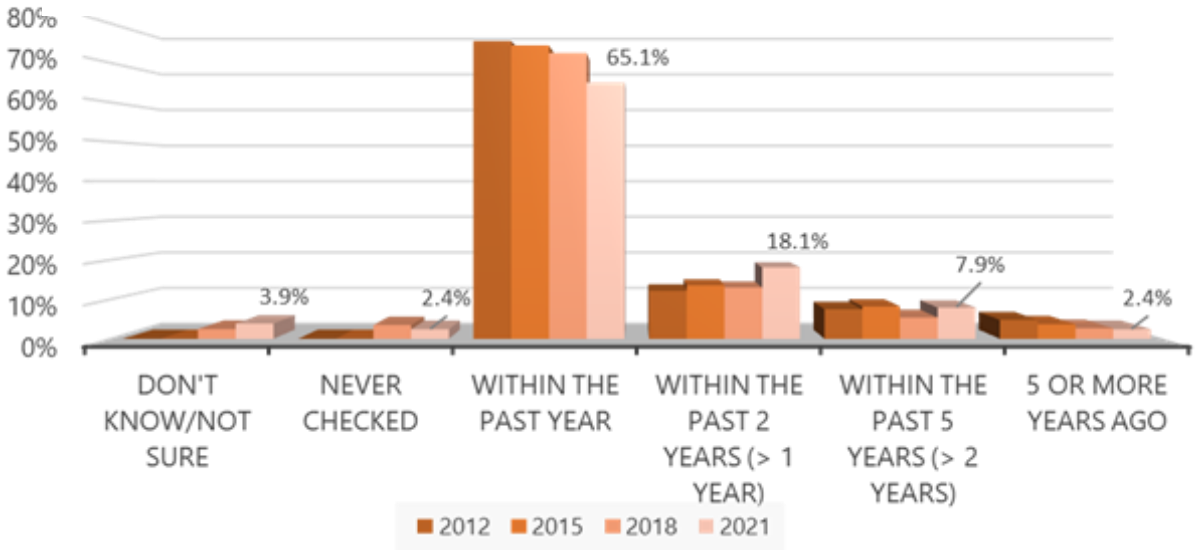
- A direct connection was made between obesity and many acute health issues along with most chronic conditions.
- Discussions supported the consensus that lack of exercise leads to or exacerbates many illnesses, just as regular exercise leads to improved health and quality of life.
- Participants believe it is imperative to continue and even expand programs and services that improve lifestyle in areas such as exercise and diet.

Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?



Actions to Control High Blood Pressure	2021	2018	2015	2012
Taking medicine	91.0%	92.2%	83.2%	87.3%
Changing eating habits	69.5%	70.4%	73.6%	74.1%
Cutting down on salt	63.7%	66.6%	80.1%	82.1%
Exercising	55.0%	60.6%	55.8%	N/A

About how long has it been since you had your blood cholesterol checked?



Chronic Condition	2021	2018	2015	2012
Arthritis	41.8%	38.7%	35.2%	37.1%
Asthma	14.1%	15.1%	16.8%	17.4%
COPD	3.9%	3.0%	3.5%	7.1%
Skin cancer	12.7%	10.7%	6.4%	7.6%
All other types of cancer	12.3%	11.0%	9.0%	8.5%

Behavioral Health

Mental health and illegal substance abuse were chosen as top health concerns throughout all key informant sessions and most focus groups. They are top concerns that affect the friends and family of many respondents, in addition to the community at large.

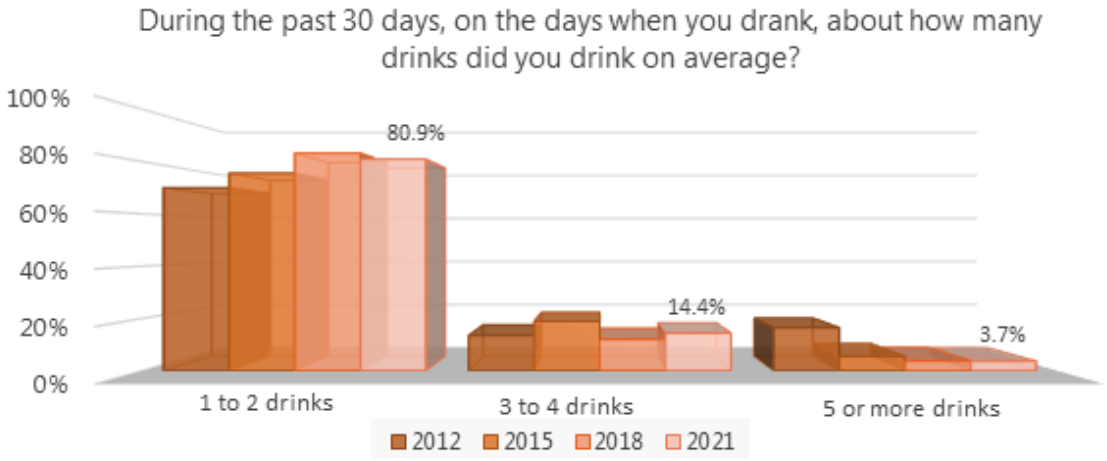
- Key informants and focus group participants identified **mental health** as a matter that is interwoven with a host of other issues, making the problem difficult to define and solutions difficult to implement.
    - The importance of mental health was directly linked as the underlying problem that affects many somatic health conditions and substance abuse issues. People with unaddressed mental health needs tend not to engage in their health care.
    - Responders were concerned that mental health treatment is often combined with substance use treatment. Management of serious mental health disorders may need specialized treatment that is separate from substance use specialists and group therapy focused on dual diagnosis.
    - Participants have personally observed the effects of these issues with loved ones and peers. Mental health is an issue that affects entire families.
    - The **stigma associated with mental illness** was identified as a serious barrier to diagnosing and treating this issue in a majority of focus groups and with key informants.
    - Mental health issues must be properly addressed to differentiate between disease, such as dementia/Alzheimer's or other physical causes or medication interactions. Those with dual diagnosis/intellectual disability often do not get appropriate services.
    - The Hispanic community does not have access to behavioral health resources that understand both the language and the cultural barriers. Participants were especially concerned about mental health being addressed in children.

- A new survey question added in 2021, asked online respondents if they have been diagnosed with an anxiety disorder; 25.9% responded yes and of those, 38% were receiving treatment for a mental health condition or emotional problem.

- Online survey questions were added in 2018 that specifically address **opioid use and abuse**.
    - Similar to 2018, almost all online survey respondents in 2020 (99.5%) reported that they have not personally used opioids that were not prescribed to them and 94.5% responded that they did not have a family member or friend who misused prescription drugs.
    - Multiple focus groups discussed the ease to purchase illegal substances. Some respondents expressed the desire to have greater deterrents in place to make it more difficult to purchase illicit drugs on the streets.
    - Older adults discussed how illegal drug abuse may be affecting their community directly with such things as increased crime.
    - In key Informant groups, substance use/abuse and consumption, particularly the opioid epidemic, is a primary concern and discussions were passionate. The connections between these issues and a wide range of other topics (e.g., mental health, employment, housing, somatic illness) makes it complicated and often overwhelming to address.
    - New in 2021 participants were asked about Marijuana use: 93.5% reported that they did not use marijuana in the last three months. Of those who used marijuana, only 31% had a medical marijuana card.

- Approximately 63.5% of respondents reported consuming **alcohol** within the past 30 days, with an average of 1 to 2 drinks per occasion. Alcohol abuse was singled out as a pressing problem in four of the five focus groups. Only the older adult group did not choose this health issue. (See chart)
    - Some key groups indicated that the intense community messaging concerning opioids may be somewhat obscuring issues related to all other substance abuse issues.
    - Online survey responses indicate that although a somewhat smaller number of people are drinking, there may be an increase in those that are drinking more heavily.
    - Alcohol Abuse was chosen as the most pressing health issue in the low-income group and as the second most pressing issue in the Hispanic community. Both groups referenced that because it is a legal substance, associated problems are often not considered a health issue which leads to lack of treatment.
    - Discussions included the "essential" status of liquor stores during the pandemic which was a trigger for alcoholics and supported alcohol over consumption.

- There were 29 **veterans** who completed the survey, including 8 who had served in a war zone. Of those that served in a war zone, 2 individuals reported that they have been diagnosed with depression, anxiety, or post-traumatic stress disorder.



Social Issues

A reoccurring topic that emerged during our Key Informant sessions was the perceived struggle that the middle class is now experiencing**.**

- Often mentioned was the lack of affordable housing options.
    - In addition to health care, discussions occurred around the correlation between middle class incomes and limited job opportunities and affordable housing.
    - Affordable housing is also coupled with safe and quality housing. Comments were made that landlords are not maintaining properties to be safe for residents.
    - Focus group respondents shared fears of losing their housing not only if unable to meet their needs, but also if they start making too much by getting an increase in pay or hours.
    - Many informants felt that **millennials** not only can't afford to live or buy a home in Carroll County, but they also do not find living in the county as a good option as there are few activities or built environment amenities that are fitting for the younger population.

- A recognition that social determinants of health and **their impact on physical health** has increased exponentially.
    - When the community leaders were asked to name the top three issues, **affordable housing, employment opportunities,** and **quality health access** were named.

    - When asked which social determinants would have the greatest ability to impact health**, affordable housing** was the first choice, followed by **quality health access** and **social support**.

- In all focus groups, the primary social determinants included **quality health access and affordable housing**, with secondary choices being **employment opportunities** and **social support.** Problems within many of these areas reflect the basic need for stability before people have the resources to address health care. The low-income community expressed frustration of being able to obtain job skills because of lack of entry level jobs and not being on the job long enough to gain skills and advance yourself.
    - People must have secure housing in order to live a healthy life without stress.
    - Economic success is a key factor in someone's ability to prevent and manage chronic illness.
    - There was a perception that there is a lack of entry level employment opportunities for unskilled people and a lack of mid-level jobs into which people can progress. Those high skill and high-level jobs that do exist in the county were also seen as having low turnover rates that also affect individuals' decisions to remain in the county.

- The African American, LGBTQ, and Transitional Aged Youth focus groups mentioned **early childhood development** issues as a more concerning determinant than the other groups.

The full 2020 CHNA Consolidated Report contains comprehensive data and information from all survey components. This report is available on The Partnership website, healthycarroll.org, and in hard copy by request.

Community Benefit
& Health Improvement Plan

The Picture of Health FY 2022-2024

CARROLL HOSPITAL
A LifeBridge Health Center
CARE BRAVELY

The Partnership
for a Healthier Carroll County

Table of Contents

Section 1 — Introduction

Mission, Vision & Values

MISSION

Our communities expect and deserve superior medical treatment, compassionate care and expert guidance in maintaining their health and well-being. At Carroll Hospital, our mission is to offer an uncompromising commitment to the highest quality healthcare experience for people in all stages of life. We are the heart of healthcare in our communities.

VISION

Carroll Hospital is a portal of health and wellness. We take responsibility for improving the health of our populations through care management and delivering high quality, low cost services in the most appropriate settings. We engage our community at all points of care and promise to provide a seamless healthcare experience.

Carroll Hospital and The Partnership for a Healthier Carroll County (The Partnership) share the same values, which are clearly defined and integrated in our signage, employment applications, community materials and more. Our values characterize all our actions and experience inspired by personal relationships and genuine compassion.

Our S.P.I.R.I.T. Values include:

Service: *Exceed customer expectations*

Performance: *Demonstrate accountability and achieve excellence in all that we do*

Innovation: *Take the initiative to make it better*

Respect: *Honor the dignity and worth of all with compassion*

Integrity: *Uphold the highest standards of ethics and honesty*

Teamwork: *Work together, win together*

Community Benefit Service Area

Carroll Hospital primarily defines its community benefit service area as Carroll County. The hospital further defines primary and secondary service areas in our Financial Assistance Policy. These communities and zip codes include:

Primary

Finksburg (21048)
Hampstead (21074)
Mount Airy (21771)
Sykesville (21784)
Union Bridge (21791)
Westminster (21157 & 21158)
Keymar (21757)
Manchester (21102)
New Windsor (21776)
Taneytown (21787)
Upperco (21155)
Woodbine (21797)

Secondary

Reisterstown (21136)

The Health Services Cost Review Commission (HSCRC) defines a hospital's primary service area as follows for the mandated community benefit report: "The Maryland postal zip code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each zip code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC." (Source: HSCRC FY 2017 Community Benefit Narrative Reporting Instructions).

By that definition, Carroll Hospital's primary service areas include community members living in the following postal zip code areas:

Westminster (21157)
Westminster (21158)
Manchester (21102)
Eldersburg/Sykesville (21784)
Hampstead (21074)

For the Community Benefit & Health Improvement Plan, we will align the community benefit primary service area definition with the hospital's Financial Assistance Policy definition.

Carroll Hospital Community Benefit Policy

In 2005, the Governing Board of Carroll Hospital established a board-level Community Benefit Policy to clarify and standardize the importance of this element of our mission as a community hospital and as a non-profit organization. A copy is attached in the Appendix.

Section I — Introduction

Community Benefit Planning & Evaluation Committee Membership & Responsibilities

Membership on the Community Benefit Planning and Evaluation Committee is by appointment by the president of Carroll Hospital and includes a diverse group of clinical, financial, compliance, educational and community outreach leaders from the hospital. It also includes representatives from The Partnership, Access Carroll and the Carroll County Health Department.

The committee's charge includes:

1. Developing the Carroll Hospital Community Benefit & Health Improvement Plan for review and approval by the hospital's executive team, the Carroll Hospital Board of Directors and The Partnership's Board of Directors.
    - The plan must be based on information from our recent Community Health Needs Assessment (CHNA) and address verified community needs.
    - The plan must comply with all relevant aspects of the 2010 Affordable Care Act, the HSCRC Community Benefit Guidelines and the IRS 990 guidelines.
    - The Community Benefit & Health Improvement Plan will become an integrated component of the hospital's overall strategic plan and The Partnership's strategic plan.
    - Annual budget projection will include efforts to support Community Benefit & Health Improvement Plan objectives and strategies to address prioritized needs.
2. Reviewing and updating the Carroll Hospital board-approved policy (attached) regarding community benefit fulfillment by our hospital.
3. Providing guidance and assistance regarding the communication of our Community Benefit & Health Improvement Plan either via web, hard copy or other medium.
4. Rolling out and informing the Carroll Hospital Management Forum about the plan.
5. Annually monitoring our organizational compliance with the plan to include the impact we are having on the identified needs and to support required narrative reports to the HSCRC and IRS.
6. Reporting our annual evaluation of our Community Benefit & Health Improvement Plan performance and recommendations to the executive team and board of directors of both Carroll Hospital and The Partnership.

Maryland State Health Services Cost Review Commission

Each year, Carroll Hospital submits a comprehensive community benefit report to the HSCRC, which includes an accounting of community benefit activities conducted by the hospital and a narrative which supplements the financial report. The major categories covered in the report include: community health services, health professionals education, mission-driven health services, research, cash and in-kind contributions, community building activities, community benefit operations and charity care (financial assistance).

The detailed activities and financial data for the report are gathered throughout the year in Lyon Software's CBISA — an online community benefits data and reporting software.

In recognition of the importance of this work, a multi-step review and approval process is incorporated. The Community Benefit Planning & Evaluation Committee members review the preliminary expense report and narrative to consider expenditures in context with activities designed to impact the needs identified. The expense report is then reviewed internally by leaders, including the LifeBridge Health board's community mission committee, the hospital board and, ultimately, submitted to the HSCRC.

A community version of the report is published in the hospital's community newsletter, in its annual report, and on the websites of the hospital and The Partnership. Progress toward the desired health improvement targets and outcomes of all health improvement efforts will be organized via the evaluation responsibilities of the Community Benefit Planning and Evaluation Committee, which will prepare an annual summary report to the board of directors of Carroll Hospital and The Partnership.

Carroll Hospital Former Community Benefit & Health Improvement Plans

A Community Benefit Planning and Evaluation Committee and formal written plan have been in place at Carroll Hospital and The Partnership for several years. The Community Benefit & Health Improvement Plans FY2014 to FY2016 and FY2017 to FY2018 and FY2019 to FY2021, were the previous plans by the hospital and The Partnership to address the 2012, 2015 and 2018 Community Health Needs Assessments, respectively.

See Appendix for a copy of the previous plans.

Section II — Community Health Needs Assessment

In fall 2019, the board of directors of The Partnership voted unanimously to undertake responsibility for a Community Health Needs Assessment (CHNA). The process would assure compliance with all requirements as defined by federal or state authorities and assure the hospital's ability to develop a hospital board-approved Community Benefit & Health Improvement Plan.

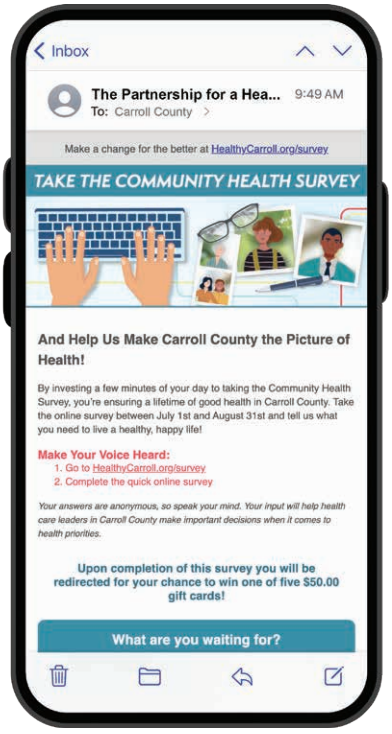
In previous years, The Partnership's Board of Directors assumed responsibility as the "Community Coalition" required in a separate but somewhat similar State Health Improvement Process (SHIP) and continues to build on this responsibility. In 2018, it was determined with the support of Carroll Hospital, the Carroll County Health Department and the board of directors that The Partnership would serve as the backbone organization for community health improvement in Carroll County under the Collective Impact Model. The Community Benefit & Health Improvement Plan as well as the Local Health Improvement Plan will both be components of the Common Agenda.

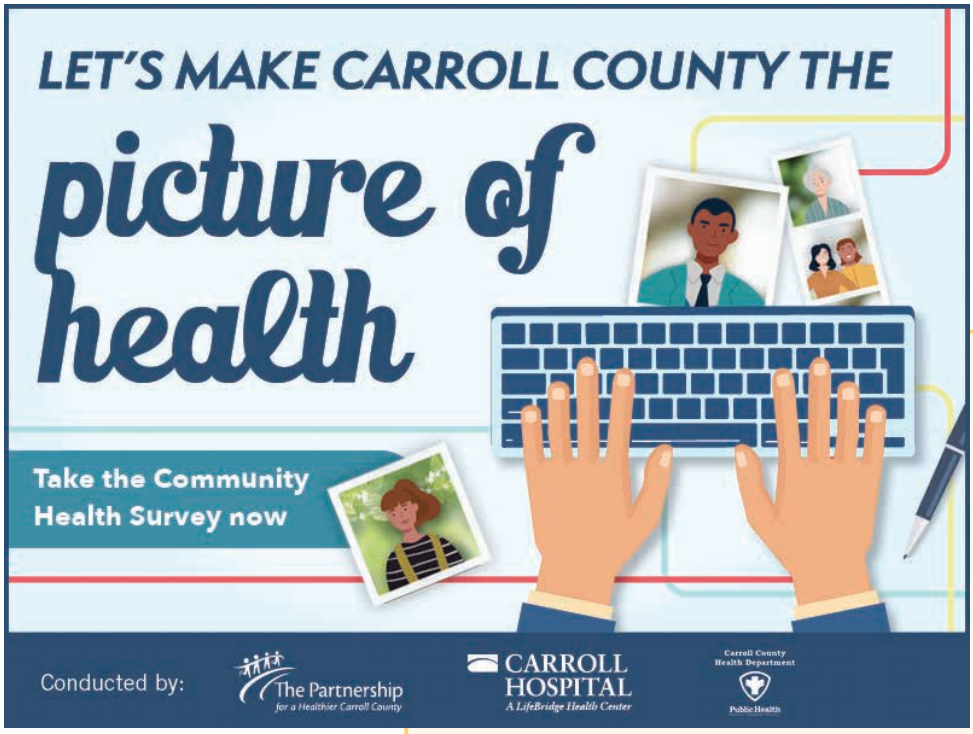
This coordination of efforts has proven to be an extremely successful process. The 2012, 2015 and 2018 Community Health Needs Assessments were used to create seamless plans reaching further than the anticipated Community Benefit and Local Health Improvement Plans. The outcomes were seen in other organizations' strategic plans throughout the county. Community engagement in the plan has been strong, and measurable progress has been captured via our Healthy Carroll Vital Signs data monitoring system.

We continue this process as we move forward gathering more information with each assessment, providing longer term trending reports and measurable results and connecting with additional key informants and target populations while we streamline the efforts.

The Partnership integrates bi-annual measurement processes into all its health improvement work known as "Healthy Carroll Vital Signs (HCVS)." These measures build on national benchmarks and improvement targets and have been nationally recognized for use in community health improvement work. All of this experience enhances The Partnership's ability to lead a process of this importance and exceptional scope.

There continues to be a strong integrated approach by the leaders at the Carroll County Health Department (CCHD) with Carroll Hospital's Sharing the S.P.I.R.I.T. Plan and The Partnership's strategic plan. The creation of a Community Health Plan is underway, which will incorporate both previously mentioned Plans as well as a broader community plan that will include local businesses, nonprofits and government agencies.





Advertising for online Community Health Survey

Section II — Community Health Needs Assessment

Assessment Overview

To assure compliance with all regulatory requirements, a multi-component process was determined necessary.

Components include:

Primary Data:

- An online **Community Health Needs Survey** was conducted with Carroll County residents between July and September 2020. The survey was designed to assess their health status, health risk behaviors, preventive health practices and healthcare access primarily related to chronic diseases and injury. A total of 744 resident surveys were started with 728 completed throughout the county to promote geographical and ethnic diversity among respondents.
- **Three Key Informant Survey sessions** were held between July and September 2020. Key informants represented a variety of sectors, including public health and medical services, nonprofit and social organizations, children and youth agencies, and the business community. Two sessions included community leaders and stakeholders with expert knowledge, and one session was held with mid-level, nonprofit direct service providers. The respondents were asked to complete the survey using their professional knowledge with the populations they serve. A total of 56 key informant surveys were completed during the moderated sessions. All sessions were conducted by video conference due to the advisories related to the COVID-19 pandemic.
- Ten sessions of **Targeted Populations Research** were conducted in focus groups with different community groups including African American (x2), Behavioral Health Consumers (x2), Hispanic/Latino, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer), Transitional Aged Youth, Older Adult (x2), and a lower income population group. All sessions were scheduled between July and September 2020. Research participants were invited to complete a survey to identify the specific needs of their community. In addition, The Partnership led a moderated discussion with each group after completion of the online survey except for the LGBTQ group which was completed by online survey only. Three of the groups were moderated virtually. More than 50 individuals completed the survey and/or participated in a focus group.

Secondary data was collected and reviewed to reinforce and possibly identify any additional needs that may have been uncaptured in our primary data components. This extensive data includes:

From Executive Summary:

- **Our Community Dashboard**
- **Healthy Carroll Vital Signs**
- **State of Maryland Health Improvement Process and Local Health Improvement Plan**
- **Other Data**
    - **County/Community Demographics:** This information was collected from the Carroll County Department of Economic Development. A good understanding of the ethnic diversity, age distribution, education and employment status, poverty status and more is the necessary context for considering all this information.
    - **Our Community Dashboard:** 100+ indicators were selected from a Maryland-specific list of core measures.
    - **Healthy Carroll Vital Signs:** Data indicators are updated twice annually to report on the trending patterns of the plan's priority issues.
    - **State of Maryland Health Improvement Process and Local Health Improvement Plan:** 38 high impact objectives were identified with a per-county profile serving as the baseline document.
- County Health Ranking, which is collected by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.
- Carroll Hospital Data: Using the Horizon Performance Manager, readmission rates were tracked using nine recurring categories.
- *ALICE* Study of Financial Hardship, which is a United Way project. Alice stands for Asset Limited, Income Constrained, Employed.

Section II — Community Health Needs Assessment

Information Gaps

While every attempt was made to design a comprehensive assessment, it may not measure all aspects of health in the community, nor can it adequately represent all possible populations of interest. For example, undocumented residents and members of all minority groups might not be represented in sufficient numbers.

It is important to note that the number of completed surveys and limitations to the sampling method yield results that are directional in nature and may not necessarily represent the entire population within Carroll County.

Summary

Details and findings from each component were combined for a "Consolidated Report," and an executive summary was created for a high-level overview of the assessment results. A great deal of information is available for future reference and online at HealthyCarroll.org.

Prioritization

Working collaboratively, The Partnership's board, Carroll Hospital's board and executive leaders, local officials, representatives from the Needs Assessment Committee and the hospital's Community Benefit Planning and Evaluation Committee took the next critical step of prioritizing our focus for action in the next three years. A joint strategies and prioritization meeting was convened on February 9, 2021 and was facilitated by Edward Gerardo, consultant, after a thorough review of the assessment process, documentation and results.

During the survey process, the key informants and the focus groups were asked questions regarding social determinants of health. This year's process included nine social determinants of health in the presentation and discussion. Listed in alphabetical order:

1. Affordable housing
2. Early childhood development
3. Economic success
4. Educational attainment
5. Employment opportunities
6. Food security
7. Job skills
8. Quality health access
9. Social support

The three social determinants of health believed to be the most important to address are listed below in alphabetical order:

1. Affordable housing
2. Employment opportunities
3. Social support

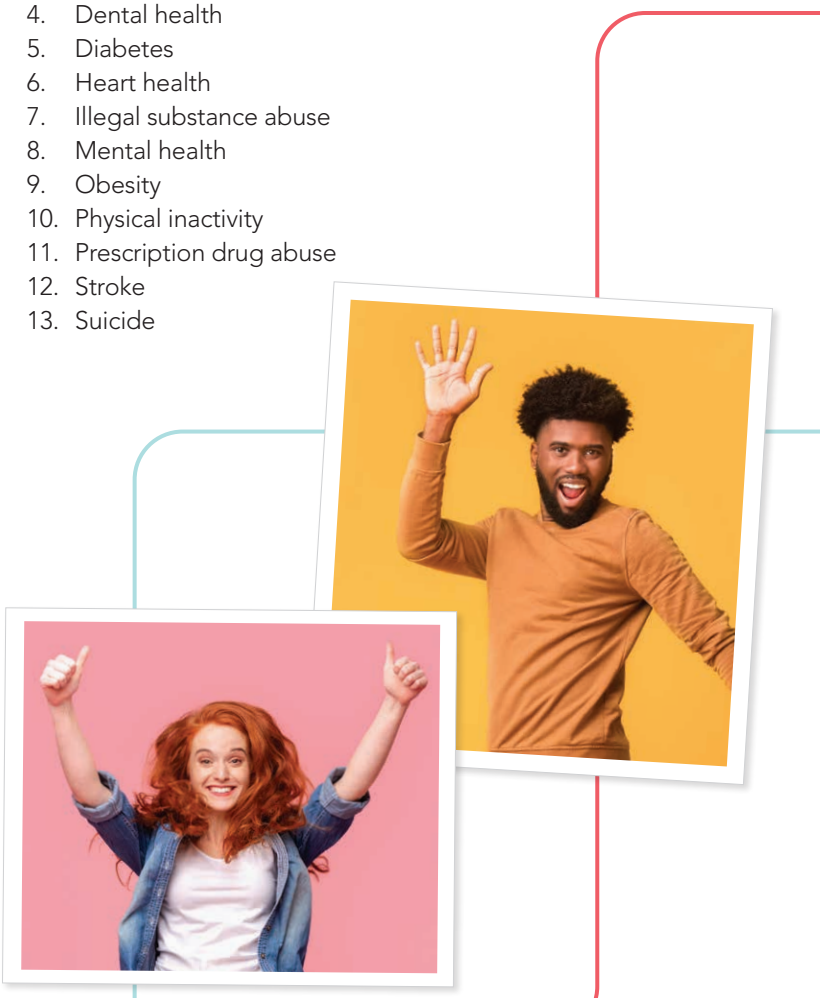
The three social determinants of health identified as having the greatest impact if addressed are as follows:

1. Quality health access
2. Early childhood development
3. Affordable housing

The top 13 health issues identified through survey collection, county data and moderated sessions were included in the prioritization process.

The 13 issues are listed here in alphabetical order:

1. Alcohol abuse
2. Alzheimer's disease/dementia
3. Cancer
4. Dental health
5. Diabetes
6. Heart health
7. Illegal substance abuse
8. Mental health
9. Obesity
10. Physical inactivity
11. Prescription drug abuse
12. Stroke
13. Suicide



Section II — Community Health Needs Assessment

To narrow the topic areas for that prioritization process, we requested active input from attendees into determining the priority needs for the focus of the Community Benefit & Health Improvement Plan from among the list of the 13 items on the previous page.

We used interactive electronic technology to capture the confidential votes of all attendees. The criteria for prioritization were on a 6-point scale. We had two criteria:

Significance/pervasiveness

- How significant is the consequence if we do not address this issue?
- How pervasive is the scope of this issue? Does it affect the majority of our population or only a small fraction?
- Is it getting worse? Negative trend?

Ability to Impact

- Can we make a meaningful difference with this issue?
- What is our ability to truly make an impact?
- Are there known proven interventions with this issue?

Using the highly articulated and repeated themes that occurred during the assessment, we were able to rule in 13 of the health areas as we continued in the prioritization process. Identifying and bringing together our community leaders and stakeholders for each of the 13 health areas afforded us the opportunity to dig deeper into the concentration of efforts, gaps and needs relative to the area.

Key Community Benefit Issues

FY 2022 – 2024

During fiscal years 2022 - 2024, the hospital, The Partnership, health department and other partners will focus internal and external strategies with anticipated primary outcomes in the following top key issues. These were determined in collaboration with our community and local public health experts via the Community Health Needs Assessment Prioritization process described above.

In priority order they are:

1. Mental health
2. Diabetes
3. Cancer
4. Heart health

Obesity efforts that are interrelated with the key issues of diabetes, cancer and heart health will be a main concentration.

These same four key issues will simultaneously be addressed collaboratively with other community partners under the leadership of The Partnership.

Section III — Key Community Benefit Issues Implementation Strategies

Meeting the Need

The three-year plan will allow us to focus on the prevalent and high impact issues identified via our FY2020 Community Health Needs Assessment. We are interested in results, and this plan includes our proposed ideas on how to accomplish positive progress in the prioritized need areas.

To identify the priorities, several values were defined and applied via varied group efforts with key community involvement. Because improving community health requires varied intervention strategies, some identified needs will be met by collaborative strategies addressing not only the community external to Carroll Hospital, but also by focusing on hospital staff, volunteers, and patients and families (a.k.a. internal constituents). By addressing internal constituents alongside those external to the hospital, there is a consistency of message and an increased ability to positively impact the community.

As this is not Carroll Hospital's first Community Health Needs Assessment or our first Community Benefit & Health Improvement planning process, it was affirming to note the alignment of multiple strategic initiatives already underway by various departments in Carroll Hospital and also by our affiliates, The Partnership and Access Carroll.

Working closely with partners has been a hallmark of this community hospital that will continue. *Connecting people, inspiring action and strengthening community* are the distinguishing characteristics of The Partnership, which builds the engagement and active involvement of individuals and organizations toward measurable health improvement results. The Partnership's vision is to be a leader in implementing healthy community strategies.

The Partnership's Board of Directors has assumed the Collective Impact Model for Community Health Improvement. With this action, The Partnership will serve as the backbone organization for Carroll County, and a Common Agenda among our member organizations will be used. This is a very exciting endeavor for our community as we are able to move beyond collaboration and further the ability of the collective. The Partnership also will create a Community-level Health Plan that will not only include the Community Benefit & Health Improvement Plan, the Local Health Improvement Plan, but also our partner organizations' and municipalities' efforts in addressing the prioritized community health needs.

All initiatives identified will be advanced under the accountability of Carroll Hospital except those specifically identified as accountable to The Partnership, Access Carroll or the Carroll County Health Department. All actions identified are expected to require the full three years of implementation to accomplish the desired health improvement impact and the targeted results.

There are obvious cross-relationships among several of the priority needs identified. Mental health, diabetes, cancer and heart health all emerged as prominent health problems and share many risk factors and contributing behaviors. We intend to integrate fitness, nutrition, behavioral health, blood pressure awareness, and cholesterol and glucose screenings into programming whenever possible.

Despite a still relatively homogeneous population, we recognize the importance of ethnic and cultural awareness as well as linguistic sensitivity in all outreach activities.

The following outline arranges the needs, in the priority order determined with our community, and describes the need/key finding, objectives, strategies and anticipated outcomes associated with each priority.

We have also included indicators relative to each need area for use in measuring impact and results. The indicators will be tracked by The Partnership and Carroll Hospital. All will be reported publicly on The Partnership's website, HealthyCarroll.org.

Note: The Partnership will address health and wellness with complementary programming specifically for the growing older adult population. Initiatives will be in place to address the needs of this population. Access to healthcare will be addressed in continuity with The Partnership's Access Leadership Team, which also serves as the Local Health Improvement Coalition. In addition, the Coalition oversees the Local Health Improvement Plan, a component of the Maryland State Health Improvement Plan.

Section III — Key Community Benefit Issues Implementation Strategies

#1 Mental Health BEHAVIORAL HEALTH

Carroll County has a reported 4,554 per 100,000 population emergency department visits due to mental health conditions (2020, Carroll Hospital). This number has been on an upward trend since 2015 when it was 2,949.5. This represents a 54.4% increase from 2015 to 2020 on an average annual growth rate of 10.8%.

The COVID-19 pandemic has presented challenges related to the mental health of community members, such as lack of in-person counseling and physician visits, lack of access to support groups, significant changes in routine, fear, social isolation, anxiety and depression.

Strategies:

a) Partnership with Maryland Department of Health (MDH), The Partnership for a Healthier Carroll County, Youth Services Bureau, the Carroll County Health Department (CCHD), Suicide Coalition and others to improve communication and improve resources for mental health.

b) Mental health provider education and outreach—radio talks on WTTR regarding depression and other top mental health issues.

c) Promote availability of The Partnership's Behavioral Health Resources and Services Directory for the community.

d) Annual *Risky Business* educational conference produced in coordination with other partners including CCHD, The Partnership and others. The goal is to increase awareness of specific local issues related to substance abuse and/or mental health; to build collaborative opportunities for action, and to bring best practices or new ideas to the forefront. Target audience is schoolteachers, guidance counselors and mental health professionals and family members of persons receiving services related to substance abuse or mental health.

e) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus on mental health and wellness. Responding to the identified needs, this team will coordinate, propose, develop and implement the team-determined and agreed upon initiatives. These efforts will include a focus on anti-stigma and education addressing mental health. Existing programming, such as the CARE campaign, can be expanded or modified to best address issues of mental health disorders. This team also serves as the LHIC.

f) Continue to offer complementary health treatments such as acupuncture to use as an adjunct in managing behavioral health issues.

Section III — Key Community Benefit Issues Implementation Strategies

g) In collaboration with the CCHD, continue Peer Support Specialist program within many areas of the hospital, including the emergency department (ED), as well as Access Carroll. Hospital social work staff and Access Carroll's staff have oversight of the program. Direct referrals to mental health resources are provided by the peer support specialist as appropriate.

h) Continue relationship with and access to Shoemaker Center and other local providers.

i) Participation in community fairs to share information on substance abuse issues and resources.

j) Active participation with the Criminal Justice Diversion program.

k) Referrals to the CCHD-funded mobile crisis services for mental health and addiction when needed.

l) Collaboration among Carroll Hospital, CCHD and The Partnership to use consistent messaging, including MDH messaging, to promote an anti-stigma campaign for mental health and substance use.

m) Hospital will continue to employ full-time behavioral health navigator who focuses on the high risk population.

n) Access Carroll and the CCHD continue to offer behavioral health services for at-risk individuals, directly addressing the provider shortage in the community.

o) Continue working with the CCHD and local law enforcement in a collaborative effort between the behavioral health system, behavioral health consumers, family advocates and community services to provide Crisis Intervention Training (CIT).

p) Offer outpatient psychiatry, including telepsychiatry, for behavioral health issues.

q) Continue depression screening in Carroll Health Group primary care offices with the use of the PHQ9 and increasing the availability of social work resources and referrals to outpatient mental health resources.

r) Actively participate in the Greater Baltimore Regional Integrated Crisis System (GBRICS) project through appropriate workgroups or providing data and information when needed to assist in the development of the project components to improve infrastructure and expand availability of behavioral health crisis services.

s) Multi-disciplinary Behavorial Health committee formed.

t) Explore ways to educate and promote screening for mental illness to emphasize importance of prevention (living mentally healthy) and early detection of mental illness.

u) Explore opportunities (including virtual) for mental health education outreach to faith community and workplaces for education, screenings and increasing awareness of community resources that are available.

u) Explore ways to promote National Acupuncture Detoxification Association (NADA) as an adjunct to mental health treatment.

Anticipated Outcome:

- Reduction of avoidable readmissions for patients having high utilization (greater than three annually) of behavioral health unit services related to mental health and or co-occurring diagnosis
- Reduction of avoidable emergency room visits for patients having high utilization (greater than three annually) related to mental health conditions

Indicators:

- Number of patients re-admitted to Carroll Hospital inpatient unit 3+ times/year for behavioral health diagnosis - (Carroll Hospital)
- Suicide mortality—rate per 100,000 (MD Vital Statistics) - (MD Vital Statistics)
- ED visits related to mental health conditions - (Carroll Hospital)
- ED visits for addictions-related conditions - (Carroll Hospital)





Section III — Key Community Benefit Issues Implementation Strategies

#2 Diabetes WITH A SUB FOCUS OF OBESITY

9.1% of Carroll County adults have been diagnosed with diabetes (2019, MD BRFSS) and 29.6% of Carroll County Medicare beneficiaries were treated for diabetes in 2018, according to the Centers for Medicare & Medicaid Services.

The COVID-19 pandemic has presented challenges for individuals with diabetes due to lack of preventative screenings, lack of primary care health visits, fear of seeking medical care, lack of access to fitness facilities and appropriate exercise, and increased stress.

Strategies:

a) Provide diabetes self-management education by physician order.

b) Offer a free Diabetes Basics Class for patients referred to the Diabetes Program that cannot meet their cost obligation.

c) Provide diabetes and prediabetes education programs & screenings in outreach markets, including virtual learning opportunities.

d) Provide free weekly diabetes education calls ("Diabetes Wednes-days") focused on behavior changes to reduce diabetes related complications.

e) Develop and implement a 12-week education and support program ("Balance Diabetes") designed to help people with diabetes achieve clinical indicators and establish behaviors that are known to reduce complications from Type 2 diabetes.

f) Enhance and support automatic, bidirectional referral processes from physician group practices to the Diabetes Program for anyone with diabetes or prediabetes.

g) Explore possibility of offering supplemental diabetes education and support to follow the Diabetes Standards of Care in physician offices.

h) Provide pharmacy support through the Care Transformation Organization Medication Management Pharmacist on diabetic patients to meet Diabetes Standards of Care in the physician offices.

i) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus on health and wellness. Responding to the identified needs, this team will propose, develop and implement the team-determined and agreed upon initiatives. These efforts will include a focus on physical activities and education addressing diabetes and prediabetes with Prescription for

Nutrition as the umbrella program. Existing programming, such as Walk Carroll and Tryvent, can be expanded or modified to best address issues of exercise and nutrition in this population.

j) The Partnership will offer support to municipalities for increased physical activities with a focus on park development and work with the county to support the planning and implementation of the county-wide bicycle-pedestrian master plan.

k) The Partnership and hospital collaborative Carroll's Cooking for Wellness™ classes including sessions directed at a variety of populations and classes potentially held at sites throughout the community.

l) Increase awareness of prediabetes and how to address this health issue with local resourcecs and programs, through communications directing the public to a resource page on healthycarroll.org.

m) Recruited an endocrinologist to join Carroll Health Group in order to provide additional access to care.

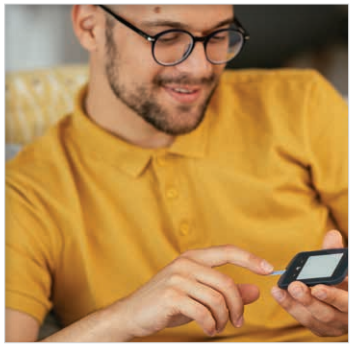
n) The Partnership will partner with community organizations to develop community gardens.

Anticipated Outcome:

- Decrease utilization of ED visit rate due to diabetes
- Adherence with best practice standards for self-management of diabetes will be increased through education

Indicators:

- Percentage of adults with diabetes over age 65 – (Carroll Hospital)
- Age-adjusted death rate due to diabetes/rate per 100,000 – (MD Vital Statistics/OCD)
- Emergency department visit rate due to diabetes – (Carroll Hospital)



#3 Cancer WITH A SUB FOCUS ON OBESITY

Cancer continues to be a leading cause of death in our community. The incidence of lung cancer and colon cancer are greater in Carroll County than the Maryland State averages; early detection screening compliance rates for breast and colon cancer are below the American Cancer Society recommended targets.

A total of 69.3% (2018, MD BRFSS) of adults aged 50 and older have ever had a sigmoidoscopy or colonoscopy exam, and 86.7% (2018, MD BRFSS) of women aged 50 and older have had a mammogram in the past two years.

The incidence and death rates of melanoma in Carroll County are higher than both the United States and Maryland rates. In the past year with the onset of the COVID-19 pandemic, cancer screenings were largely put on hold to prioritize urgent medical needs and to decrease the spread of the virus. As a result, preventative cancer screenings have decreased, which have impacted early diagnosis and delayed treatment. Estimates indicate more than one third of Americans missed routine cancer screenings due to COVID-19-related fears and service disruptions.

Strategies:

a) Provide colon and breast cancer prevention and screening education at health fairs, organizations, faith communities and/or local events.

b) Offer free, one-on-one informational consultation and clinical breast exam screenings with physicians from the Center for Breast Health at Carroll Hospital.

c) Offer skin cancer prevention education and screenings on-site and at outreach locations.

d) Offer Embrace to Win Survivorship program to cancer survivors (all cancer types) to improve health and decrease obesity, which could impact recurrence rates.

e) Provide genetic counseling and genetic testing services both on-site and virtually.

f) Provide nutritional education and counseling services to oncology patients either on-site in the William E. Kahlert Regional Cancer Center or by referral to outpatient nutrition counseling.

g) The Partnership will offer sun safety programs to elementary schools, Head Start, community pools, summer camps, 4-H Fair, The Boys & Girls Club, vacation bible schools, area colleges and health fairs. The Partnership will support skin cancer awareness and prevention programming with an emphasis on children and youth. Current programs include tree plantings to increase awareness of needed shade areas (Safer in the Shade) and use of protective measures for sun exposure including providing sun sails for local swimming venues (Fun in the Sun). Collaborative efforts with local child serving agencies and community pools. The Partnership will support skin cancer awareness as it affects the Healthy Aging Population. Skin cancer prevention, education and identification are the focus.

h) Explore the development of cancer screening protocols within provider practices.

i) Educate on palliative care options to improve quality of life of patients diagnosed with cancer.

j) Educate and promote the use of complementary health therapies that may help with side effects of cancer treatments and improve physical and emotional well-being.

k) Reignite efforts to safely return to having cancer screenings and care in order to raise screening rates to pre-pandemic levels.

l) Collaborate with the cancer center for the Maryland Cancer Fund (to offer financial support to cover the costs of cancer care).

m) Recruit additional providers to join the William E. Kahlert Regional Cancer Center.

Anticipated Outcomes:

- Increase awareness and education of screening guidelines and recommendations as well as prevention for skin, breast, cervical and colon cancers.

Indicators:

- Age-adjusted mortality rate from cancer per 100,000 – (MD Vital Statistics)
- Melanoma incidence rate per 100,000 – (MD Cancer Registry)
- Breast Cancer screening rates (Advanced Radiology)

#4 Heart Health WITH A SUB FOCUS OF OBESITY

Heart disease is the leading cause of death in our community. Carroll County is reporting 172.9 deaths per 100,000 population due to heart disease (2016-2018, MDH) and 46.0 deaths per 100,000 population due to cerebrovascular disease and stroke (2016-2018, MDH), both higher than Maryland and national rates. The Healthy People 2030 national health target is to reduce the stroke deaths to 33.4 deaths per 100,000. Additionally, 30.2% of Carroll County adults have high blood pressure (2019, MD BRFSS) and 34.2% have high cholesterol (2019, MD BRFSS). The COVID-19 pandemic has presented challenges related to heart health in the community due to lack of preventative healthcare visits, lack of availability for elective procedures, lack of screenings for blood pressure, fear of seeking medical care for preventative or early identification of heart conditions, and closure or reduction of fitness facilities.

Strategies:

a) Offer monthly blood pressure screenings at multiple outreach locations, providing education and referrals as appropriate.

b) Offer Lose to Win (nutrition and weight loss program) annually and explore ways to either offer the program more frequently or to more participants to reach a larger audience.

c) Offer telemonitoring services at home to patients with heart failure after hospital discharge or referral from physician or staff.

d) Provide cooking classes both virtually and in-person to address identified needs, [i.e., cooking healthy on a budget, shopping basics, grocery store tours, cooking/ nutrition apps, cooking for specific chronic diseases].

e) Collaborate with the Carroll County Public Library to expand nutrition and cooking classes to the community and targeted populations.

f) The Partnership and hospital collaborative Carroll's Cooking for Wellness℠ classes including sessions directed at a variety of populations and classes potentially held at sites throughout the community.

g) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus on health and wellness. Responding to the identified needs, this team will propose, develop and implement the team-determined and agreed upon initiatives. These efforts (Prescription for Nutrition) will include a focus on healthy eating, physical activities and education addressing cardiovascular health. Existing programming, such as stroke awareness, can be expanded or modified, while new initiatives can be implemented in response to community need.

h) Develop web-linked videos on heart healthy eating.

i) Offer heart health and stroke education at outreach locations including health fairs, organizations, faith communities and local events.

j) Recruited an additional cardiologist to join Carroll Health Group to increase access to cardiac care.

k) The Partnership is currently developing community gardens with partner organizations.

Anticipated Outcome:

- A continued downward trend in age-adjusted death rates for CVA (stroke) and hypertension
- Increased opportunities for physical activity to reduce obesity

Indicators:

- Age-adjusted death rate due to CVA (stroke) rate per 100,000 – (MD Vital Statistics)
- Age-adjusted death rate due to heart disease rate per 100,000 – (MD Vital Statistics)
- Emergency department visit rate due to diabetes – (Carroll Hospital)

Notes:

- Equity focus within programming
- Mental Health primary focus in Behavorial Health area (Sub focus–Substance Abuse)
- Emergency department visit rate due to diabetes – (Carroll Hospital)

Section IV — Financial Assistance

Carroll Hospital is committed to ensuring that financial resources are not a barrier to anyone seeking healthcare in our community. Every effort is made to find a payment method that is fair and equitable to the patient. Flexible and individualized approaches are used to obtain services that are provided without discrimination on the grounds of race, color, sex, national origin or creed.

Through education and financial counseling, the underinsured and uninsured, and those who have declared a medical hardship, are directed to the most appropriate place to receive a reduced cost for medically necessary care.

This is accomplished by providing the following services:

- Screening for all federal/state programs as well as local funding and charitable programs. Payment options are communicated by signage, the patient information sheet, uniformed summary bill and the hospital website.
- Assistance with the application process for Medicaid, Medicare and Social Security Disability Insurance; every patient is assigned an advocate to ensure all necessary requirements are met in a timely manner, removing any barriers to the process such as documentation procurement. All associated fees are paid by the hospital.
- Our financial counselors are Maryland State Certified and recognized as advocates to many programs such as Qualified Medicare Beneficiary (QMB), and the SOAR (SSI/SSDI Outreach, Access and Recovery for people who are homeless) Program, which has an immediate impact and relief for homelessness. As advocates, we are able to complete the application process without the patient having to travel for interviews.
- Provide necessary interpreter services to eliminate any language barrier at no cost to our patients.
- Provide outpatient services through our affiliation with Access Carroll such as unlimited labs, a limited number of high-cost diagnostic studies and many other outpatient services (See Appendix for the matrix in Financial Assistance Policy for additional information).
- Education is provided on pharmacy assistance programs for either drastically reduced or free drug enrollment and assistance is provided with completing the application.
- Assist patients with the COBRA insurance process and when appropriate, provide initial payment for COBRA coverage.
- Financial assistance is provided for either a total reduction of the bill or a sliding scale percentage based on yearly poverty guidelines. Carroll Hospital exceeds the Maryland State requirement of providing a reduction of up to 150% of the Federal Poverty Guidelines by offering a reduction of up to 375%. Once financial assistance is granted, the patient is covered for reduced-cost care for a 12-month period. The financial assistance policy (see Appendix) is reviewed and updated annually.
- Financial assistance is offered to a patient within the service area who qualifies for any means tested Federal or State program, waiving the application process.
- In conjunction with our local health department, community needs are identified and, through a collaborative effort, programs are developed to address the need. As an example, the Best Beginnings program addresses the large population of uninsured and ineligible for insurance community members in need of prenatal care. A sliding scale fee is offered based on income and used for all services necessary, including physician visits, to ensure a healthy pregnancy and ultimately a healthy baby.
- Our financial counselors are trained and updated on the many agencies within our community that potentially provide access to care for services such as drug addictions programs, shelters, etc. As part of a multi-agency collaboration, a yearly educational session is mandatory to ensure an understanding of the many options available to patients.
- The financial counselors work with many different entities on the patient's behalf in an effort to not only take care of the immediate need for services, but also to establish a plan for a continuation of care and remove the barriers that obstruct access.

Section V — Evaluation

Carroll Hospital's mission is to be the heart of healthcare in the community by committing to offer the highest quality healthcare experience for people in all stages of life. The hospital's board of directors recognizes the hospital's charitable mission to the community and governs the organization in a manner that assures that the hospital fulfills that commitment.

Management has sought input from key community stakeholders and the community by conducting a comprehensive health survey. Taking into account the findings of that survey, management has defined key health priorities, objectives and measures of success to advance the health of the community. The board of directors has ratified those priorities.

The president and executive council will assure that the identified priorities are incorporated into the yearly tactical/operational plan and long-range strategic plan of the organization. The board of directors will assume oversight to assure that the hospital carries out the overall strategies identified in the Community Benefit & Health Improvement Plan.

An annual evaluation of the Community Benefit & Health Improvement Plan will be conducted. This evaluation will assess:

- Resources: The sufficiency and allocation of resources available to operate the planned programs
- Activities: Progress toward completion of the proposed strategies
- Outcomes: To the extent an outcome has been established, benchmark progress toward achievement of the desired outcome

Using a standard format for evaluation, the Community Benefit Planning and Evaluation Committee (Committee) will conduct the detailed evaluation by reviewing both qualitative and quantitative information provided by the hospital, The Partnership and other applicable external resources/agencies. Based on the review of progress toward the achievement of Community Benefit & Health Improvement Plan objectives and outcomes, the Committee will make recommendations to continue, discontinue, modify or expand the program.

Additionally, The Partnership conducts a semi-annual review of the indicator measurements, which are then presented to The Partnership board twice a year.

Annually, the Committee will review the report of community benefit expenditures and accompanying narratives related to the Community Benefit & Health Improvement Plan. This report will be submitted to the HSCRC subsequent to that review. The results will also be the basis for information reported on the hospital's annual form 990 tax filing.

The LifeBridge Health board's community mission committee will evaluate the adequacy of the processes in place to validate the accuracy of the community benefit-related expenses and reporting of those results to external parties.

The board has the responsibility for monitoring the hospital's achievement of the individual objectives adopted in the Community Benefit & Health Improvement Plan. As such, the board will receive the results of the annual evaluation performed by the Community Benefit & Health Improvement Plan development team. This report will summarize the hospital's progress toward achievements of proposed strategies and desired outcomes, as well as any recommendations related to future programs.

Review Process Timeline

October/November	Community Benefit Planning and Evaluation Committee conducts evaluation of plan—Outcomes, Expenditures, and Narrative Support.
November	Community mission committee of the board reviews report of expenses and narrative submitted to the HSCRC.
December	The LifeBridge Health and Carroll Hospital boards approve final report. Plan expenditures and narrative reported to the HSCRC in conjunction with annual reporting requirements.
March-May	990 form filing is approved by the risk, audit and compliance committee. Annual budget process/goal development.
June	Annual evaluation of Community Benefit & Health Improvement Plan for fiscal year submitted to the Carroll Hospital board.

Section VI — Committed Resources

Hospital-Based Physicians

Inpatient

A shortage of primary or specialty providers has perhaps posed the most significant challenge in inpatient care delivery. Substantial physician subsidies have become necessary to ensure that all patients requiring anesthesia, pediatric, obstetric, psychiatric, critical care and general medical care have the access they need once admitted to the hospital, including 24/7 coverage. Carroll Hospital has hospitalist programs in each of these areas and allocates a significant amount of resources to sustain the programs. In FY20, more than $10.2 million was spent to ensure care for all patients and recruiting and retaining physicians.

Outpatient

Equally important is access to physicians on an outpatient basis, not just for the uninsured, but for all patients, especially our growing Baby Boomer population. To ensure our community has access to quality physicians, Carroll Hospital continually monitors statistically calculated need in our medical service area by developing a comprehensive medical staff development plan. The report includes both an analysis of the hospital's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties.

The physician needs assessment methodology used is based on a qualitative standard established by the Internal Revenue Service (IRS). The report guides the hospital's recruiting strategy, helps us to prioritize recruiting efforts and allows the hospital to place contingencies on recruited physicians to ensure they see medically underserved, uninsured, Medicare and Medicaid patients. Recruitment priorities for FY20 included endocrinology, cardiology, oncology and hospice/palliative care. obstetrics/gynecology, psychiatry, surgery and neurology.

Coverage in the Emergency Department

While Carroll Hospital cares for patients with no means to pay their medical expenses throughout the hospital, it is seen most acutely in the ED, where many underserved or uninsured patients often come for primary and emergent care.

Since all patients presenting to the ED are treated for any medical condition regardless of their ability to pay for care, the uninsured population poses a significant challenge, not only to the hospital but also to physicians providing care in the hospital and in the ED. Due in part to a lack of or minimal reimbursement, it has become increasingly difficult to find





specialists to provide around-the-clock, on-call services for the ED. The more serious issue is that this trend affects not only our uninsured/ underinsured patients, but all patients seeking treatment in our ED.

The likelihood that patients present more acutely in the low-income population and the accompanying increased potential for malpractice claims also has contributed to specialists choosing not to cover non-paying patients in the ED. That gap is most significant in surgical specialties, including orthopedics, otolaryngology (ENT), general surgery and plastic surgery. There also has been increasing reluctance from other specialties with significant ED volumes, including vascular surgery, neurosurgery and neurology.

To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Carroll Hospital has continued two major costly initiatives to address the gap proactively. First, the hospital contracts with 10 medical specialties to ensure 24/7 coverage in the ED. Implemented in 2006, those specialties include neurosurgery; general, plastic, vascular and oral surgery; orthopedics; urology; podiatry; ophthalmology; and ENT. While payment for ED call may help with the gaps in coverage for the uninsured, it bears a significant financial toll on the hospital. The expense to pay physicians for ED call totaled $1.6 million in FY20.

Access to Care—The At-Risk Population: Access Carroll

Another ongoing significant undertaking in the hospital's mission to continue to provide for the uninsured is our partnership with the Carroll County Health Department to fund Access Carroll, a private, nonprofit healthcare provider that cares for low-income and uninsured people in the area. Many Carroll Hospital affiliated physicians and specialists donate their time to and accept referrals from Access Carroll. In FY20, Access Carroll had 6,339 medical encounters (323 new patients), 2,914 dental encounters (403 new patients) and 9,317 behavioral health encounters (403 new patients) for a total of 18,570 encounters. This practice hopefully will continue to ease the use of the ED as a source of primary care for the uninsured and ensure they have access to general healthcare when they need it, so that health conditions do not worsen due to their inability to pay for services.

Since 2005, Access Carroll has been helping its patients manage chronic diseases, including diabetes, hypertension, respiratory conditions, chronic pain and mental health issues. The practice features seven medical exam rooms, four dental suites, a centralized pharmacy and 4,200 square feet of space dedicated to behavioral health and recovery services.

Accountable Care Organization (ACO) Physician-Hospital Organization (PHO)

The Carroll ACO and Carroll PHO are collaborations among physicians and Carroll Hospital that focus on care coordination and health information sharing to promote better outcomes. Led by physicians, the organizations are designed to solve large and complex challenges that frustrate physicians and their offices. ACOs have been found uniquely effective in delivering better care at lower costs in a manner that also improves the economic health of participating physician practices.

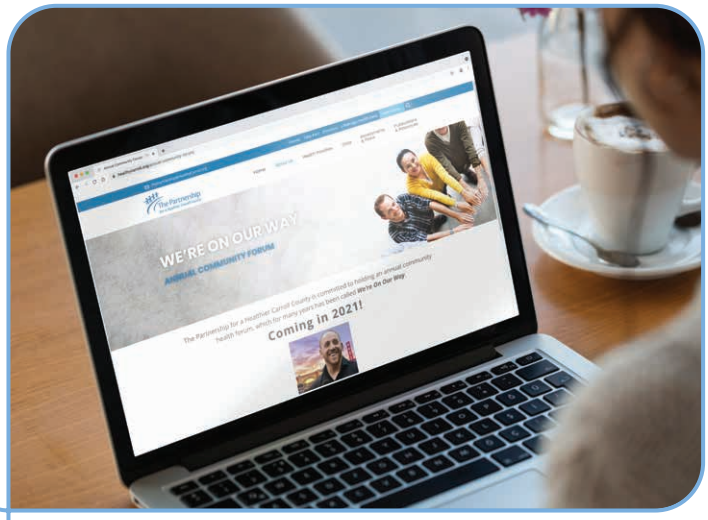
Two of the most significant benefits anticipated are better patient care and better outcomes. By providing care teams with the tool they need to develop evidence-based care plans and by connecting patients to clinical, educational and support resources, both patients and physicians will have the tools they need to improve the care delivery process.

In addition, helping physicians understand and implement the connectivity they need to exchange healthcare information at a state and national level is crucial. Through its members, the ACO/PHO will have the expertise physicians can draw upon to implement systems that will satisfy the Merit-based Incentive Payment System (MIPS) reporting requirements and promote participation in CRISP, Maryland's Health Information Exchange.

We know that the key to success in the future will be collaboration, efficiency, cost reduction and quality. And, while we can never be certain what challenges healthcare will face in the future, what we do know is that it's changing rapidly. We also know that the Maryland Healthcare Commission and Centers for Medicare and Medical Services will continue to pressure providers across the state and throughout the country to find ways to provide more coordinated care and reduce costs. One of the programs the state has developed to support these goals is the Maryland Primary Care Program (MDPCP). This program provides funding and support for the delivery of advanced primary care. The Carroll PHO is participating in this program as a Care Transformation Organization (CTO) to support community practices in this effort.

Carroll Hospital is making significant progress through its ACO/PHO and will continue to develop the organizations to integrate and improve patient care.

Section VII — Communication



Internal Communication

The Community Benefit & Health Improvement Plan will be shared with the boards of Carroll Hospital and The Partnership. The Community Benefit Report is shared with hospital leadership and the board of directors each year before it is submitted to the HSCRC.

An overview of the final report and progress on community benefit outcomes will be presented to management forum regularly and communicated to hospital staff through internal newsletters.

External Communication

The Community Benefit & Health Improvement Plan implementation strategy will be communicated at The Partnership's annual *We're On Our Way* community event, and will be posted on the hospital's and The Partnership's websites by June 30, 2021.

Carroll Hospital publishes the Community Benefit Report in its annual report to donors, distributed January/February each year, as well as the winter/spring issue of *A Healthy Dose*, the hospital's community magazine mailed to more than 50,000 households.

The report also is made available on the hospital's website (CarrollHospitalCenter.org) after February. The Community Benefit tab on the hospital's home page (CarrollHospitalCenter.org/Community-Benefit) links to a comprehensive overview of our various community benefit initiatives and programs. A link to this community benefit strategic plan also will be included on that page.

The HSCRC Community Benefit Report is submitted to the HSCRC in December and published as part of the state's community benefit report. It also is available on the HSCRC's website (hscrc.state.md.us).

Section VIII — Conclusion

This plan is a result of the collaborative work by the Community Benefit Planning and Evaluation Team. Each member's contributions are greatly appreciated.

Needs *not* addressed in our plan and what else we will do

- Four of 20 identified needs were selected as the priorities of this Community Benefit & Health Improvement Plan based on:
  1) Seriousness/Significance/Pervasiveness
  2) Ability to impact
- Information about the other needs, including full copies of all CHNA component results, is included in the Appendix of this plan, posted on the website and communicated to our diverse community partners for their use.
- While impact efforts will target the priorities for results, all of The Partnership's teams and Carroll Hospital will remain aware of the other needs, monitor any changing trends annually and remain open to plan modifications if assessments warrant that action.
- Any opportunity for collateral impact on a need other than the prioritized needs will be explored, measured and celebrated.

Ongoing Commitment to Community Benefit

- Inclusion in Carroll Hospital's and The Partnership's annual goal review and/or strategic planning processes.
- Introduction of Community Benefit & Health Improvement Plan to Carroll Hospital management forum and integration with annual performance review systems for accountability.
- Hardwired system and timeframe for impact expectations, results measurement and accountability.
- Hardwired system for results reporting and accountability to community mission committee of the LifeBridge Health Board, LifeBridge Health and Carroll Hospital boards as well as The Partnership Board.
- Delivery system transformations within Carroll Hospital and its subsidiaries, to address population health including a focus on prevention; continuous improvements in care quality and safety and efforts to advance care quality across the healthcare continuum have potential ability to impact results outside of the top four priority areas.

Section IX — Appendices

FY2019 – FY2021 Community Benefit Plan

FY2017 – FY2018 Community Benefit Plan

FY2014 – FY2016 Community Benefit Plan

Carroll Hospital Financial Assistance Policy

Carroll Hospital Community Benefit Policy

FY2018 Community Health Needs Assessment

Notes:












CARROLL HOSPITAL
A LifeBridge Health Center
CARE BRAVELY

The Partnership
for a Healthier Carroll County

LIFEBRIDGE HEALTH

CARE BRAVELY

Header Information

Participating Organization's: Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital, Grace Medical Center
Policy Category: Finance
Subject: Hospital Financial Assistance
Department Responsible for Review: Revenue Cycle Division
Policy Owner: Senior Vice President and Chief Revenue Officer

I. POLICY

A. Purpose. The purposes of this Policy are to (a) set forth eligibility criteria for receiving Financial Assistance; (b) outline circumstances and criteria under which each hospital will provide free or discounted care for Eligible Services to eligible patients who are Uninsured, Underinsured, patients ineligible for public or government assistance or who are otherwise unable to pay for Eligible Services, (c) set forth the basis and methods of calculation for charging any discounted amounts to such patients, and (d) state the measures to widely publicize this Policy within the communities to be served by the hospital. LifeBridge Health expects that patients will comply fully with the terms of this Policy in the determination of their eligibility for, and any receipt of, Financial Assistance and discounts. LifeBridge Health further expects its patients to apply for Medicaid and other governmental program assistance when appropriate, and to pursue any payments from third parties who may be liable to pay for the patient's care as the result of personal injury or similar claims. LifeBridge Health also encourage individuals to obtain health insurance to the extent such individuals are financially able to do so.

B. Scope. This policy applies to LifeBridge Health State of Maryland regulated hospital affiliates specifically Carroll Hospital, Grace Medical Center, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital and Sinai Hospital (collectively known for this policy as "LifeBridge Health")

C. Policy. It is the policy of LifeBridge Health to provide medically necessary health care services to all patient's without regard to the patient's ability of pay or Protected Class as defined in MD Code, Health-General §19-214.1, at each applicable hospital location (as defined below). Each hospital also provides, without discrimination, care for Emergency Medical Conditions (as defined below) to individuals without regard to such individual's eligibility for Financial Assistance, as more specifically set forth in LifeBridge Health's separate Emergency Medical Treatment & Labor Act (EMTALA) Policy, a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. of this Policy.

D. Adoption of Policy. The Board of Directors of LifeBridge Health and each of its applicable tax-exempt affiliates that provides medically necessary hospital services, has adopted the following policies and procedures for the provision of Financial Assistance.

E. Frequency of Review. This policy is to be reviewed and approved every two years.

II. DEFINITIONS

For purposes of this Policy, the terms below shall be defined as follows:

A. **"AGB"** means the amounts generally billed as defined by IRS Section 501(r)(5) for hospital emergency and other Medically Necessary care to individuals who have insurance covering that care, and calculated in accordance to the State of Maryland Health Services Cost Review Commission (HSCRC).

B. **"Application"** has the meaning set forth in Section III. B. below which shall comply with the HSCRC uniform financial assistance application requirements.

C. **"Assets"** means assets and resources (and the values thereof) of an individual, that would be taken into account and valued in accordance with the Code of Maryland Regulations in determining eligibility specifically excluding such individual's (a) primary personal residence not to exceed an assessed value of $150,000, (b) retirement assets or plans as qualified or nonqualified by the Internal Revenue Service including one or more retirement plans which shall include, without limitation, an individual retirement account (traditional or Roth), profit-sharing plan, defined benefit pension plan, 401(k) plan, 403(b) plan, nonqualified deferred compensation plan, money purchase pension plan, or other retirement plan equivalent to any of the foregoing, (c) one motor vehicle owned by the patient or any family member used for necessary transportation needed, (d) prepaid education assets or plans as defined by the State of Maryland or Internal Revenue Service which include, without limitation, Education Savings Account or 529 plans, (e) any assets expressly excluded in determining eligibility for a Federal or State financial or medical assistance program or plan which include, but not limited to, the Federal Supplemental Nutrition Assistance Program (SNAP), the Maryland Medical Assistance Program, State Energy Assistance Program, or Supplemental Food Program for Women, Infants, and Children, (f) burial space or plot, funds or prepaid burial contracts, and (g) household goods and personal effects.

D. **"CMO"** means Chief Medical Officer at a LifeBridge Health hospital or Chief Physician Executive.

E. **"Eligible Services"** means the services (and any related products) provided by a LifeBridge Health hospital that are eligible for Financial Assistance under this Policy, which shall include: (1) emergency medical services provided in an emergency room setting, (2) non-elective medical services provided in response to life-threatening circumstances that are other than emergency medical services in an emergency room setting, and (3) Medically Necessary Services as defined in this policy.

F. **"Emergency Medical Conditions"** has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. 1395dd) and as stated:

> "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

G. **"Family Member"** means a member of a group of two (2) or more individuals who reside together and who are related by birth, marriage, or adoption, including, without limitation, any individual claimed as a dependent by any such individual on his or her federal income tax return.

H. **"Family Income"** means the gross income of an individual and all of his or her Family Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, scholarships or other educational assistance, annuity payments, payments under or from a reverse mortgage, fees, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.

I. **"Federal Poverty Guidelines"** means poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services in effect at the time of such determination.

J. **"Financial Assistance"** means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to this Policy.

K. **"Financial Hardship"** means an Uninsured or Underinsured patient of a LifeBridge Health hospital who (1) after payment by all third-party payers, is financially obligated to a LifeBridge Health hospital for an amount in excess of twenty-five percent (25%) of such patient's gross annual income and (2) has Assets that total value of which is less than the amount of "Assets", as amended from time to time.

L. **"Hospital Cost Review Commission (HSCRC)"** means an independent agency of the State of Maryland with broad regulatory authority to establish rates to promote cost containment, access to care, financial stability and accountability; including guidelines that govern hospital financial assistance.

M. **"Hospital"** means a facility (whether operated directly or through a joint venture arrangement) that is required by the State of Maryland to be licensed, registered, or similarly recognized as a

hospital. "Hospital" means collectively, more than one Hospital Facility. As it relates to this Policy, applicable locations include:

- Carroll Hospital,
- Grace Medical Center
- Levindale Hebrew Geriatric Center and Hospital
- Northwest Hospital,
- Sinai Hospital

N. **"Medically Necessary"** shall have the same meaning as such term is defined for Medicare (services or its reasonable and necessary for the diagnosis or treatment of illness or injury), or for disputed or less clear cases referred to the CMO or designee to render a decision.

O. **"Policy"** means this "Financial Assistance Policy" of a LifeBridge Health hospital, as amended from time to time.

P. **"Protected Class"** shall comply with the Code of Maryland Regulation specifically representing race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, disability, citizenship status, or any other class, ethnicity or designation not otherwise specified.

Q. **"Provider"** means a LifeBridge Health hospital employed physician, advanced clinical practitioner or licensed professional recognized and granted authority by the State of Maryland to provide health care services.

R. **"Uninsured"** means a patient of a LifeBridge Health hospital who has no level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for the provision of Eligible Services.

S. **"Underinsured"** means a patient of LifeBridge Health hospital who has some level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for provision of Eligible Services, but who nevertheless remains obligated to pay out-of-pocket expenses for the provision of Eligible Services that exceed such individual's financial abilities.

III. GUIDELINES

A. Eligibility. Upon a determination of financial need and eligibility in accordance with this Policy, a LifeBridge Health hospital will provide Financial Assistance for Eligible Services to or for Uninsured patients, Underinsured patients, patients who are ineligible for public or government assistance, or who are otherwise unable to pay for Eligible Services. Financial Assistance

pursuant to this Policy shall be based on a determination of financial need for each individual, regardless of race, sex, age, disability, national origin or religion, or other Protected Class.

B. Application for Financial Assistance. Except as otherwise provided in this Policy, a LifeBridge Health authorized representative will review all information requested and set forth in an application for Financial Assistance (a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. below of this Policy), an in any and all documentation therein requested and provided (the application and such documentation, collectively, an "Application"), as well as any one or more items of the following information, in determining whether an individual will be eligible for and receive Financial Assistance:

1. Publicly available data that provides information about an individual's ability to pay (e.g. credit reports, scores, or ratings; Federal Poverty Guidelines, relevant published federal or state guidelines, bankruptcy filings or orders);
2. Insurance eligibility for public or private health insurance including qualification for other public programs that may cover health care costs;
3. Information relating to such individual's participation or enrollment in, or receipt of benefits from or as part of, (a) any state or federal assistance program enrollment (e.g., Supplementary Security Income, Medicaid, Food Stamps/SNAP, Women, Infants, and Children (WIC) programs, AFDC, Children's Health Insurance Program (CHIP), low-income housing, disability benefits, unemployment compensation, subsidized school lunch, or (b) any free clinic, indigent health access programs, or Federally Qualified Health Center (FQHC).
4. Information substantiating the total gross Family Income and assets owned or held by the individual and liabilities or other obligations of the individual;
5. Information substantiating that such individual is or has been homeless, disabled, declared mentally incompetent or otherwise incapacitated, so as to adversely affect such individual's financial ability to pay; and/or
6. Information substantiating that such individual has sought or is seeking benefits from all other available funding sources for which the individual is eligible, including insurance, Medicaid or other state or federal programs.

It is preferred, but not required, that an individual request Financial Assistance prior to Eligible Services being provided. Any Application may be submitted prior to, upon receipt of Eligible Services, or during the billing and collection process. The information that an individual requesting Financial Assistance has provided will be re-evaluated, verified, and required to be updated at each subsequent time Eligible Services are provided that is more than twelve (12) months after the time such information was previously provided. If such information does change or additional information is discovered relevant to the patient's eligibility for Financial Assistance, it is the patient's responsibility to notify Customer Service at (800)788-6995. Applications will be made available, free of charge, at any hospital Patient Access or Customer Service. Requests for Financial Assistance will be processed promptly, and the hospital will determine eligibility within two (2) business days for probable determination or 14 (fourteen) days for final determination after receipt of a completed Application, submission of all required

information, and make all reasonable efforts to provide written notification to the patient or applicant of its determination within thirty (30) days. Such notification may be in the form of a billing statement which shows the amount of Financial Assistance applied to the patient's account(s), and if the patient is granted 100% Financial Assistance or denied, written notice will be sent in the form of a letter delivered to the patient's or guarantor's mailing address on file.

A LifeBridge Health hospital may deny or reject any Application and/or may reverse any previously provided discounts or Financial Assistance, if it determines in good faith, that information previously provided was intentionally false, incomplete or misleading. Moreover, a LifeBridge Health hospital may, at its sole discretion, pursue any and all legal remedies or actions, including criminal charges, against any person who knowingly misrepresented their financial condition including, without limitation, the amount or value of Family Income and/or Assets.

C. Appeals and Complaints. Patients or Guarantors with applications denied for Financial Assistance covered under this Policy may appeal such decisions or file a complaint.
   1. Appeals must be in writing and describe the basis of reconsideration, including any supporting documentation. Appeals must be submitted to Customer Service within fourteen (14) calendar days of the application decision or otherwise the decision shall be upheld and considered final. Customer Service will make every effort to notify Patients or Guarantors of the appeal decision within thirty (30) calendar days.
   2. Complaints regarding this Policy can be received by mail, email or phone. All complaints are to be reported to LifeBridge Health Compliance Department for monitoring and reporting. Customer Service will respond to each complaint, contact the individual who filed the complaint and notify the LifeBridge Health Compliance Department of the complaint's outcome.

      Patients or Guarantors may also file a complaint with Maryland Health Education and Advocacy Unit using the following contact information:

      Office of the Attorney General
      Health Education and Advocacy Unit
      200 St. Paul Place, 16th Floor
      Baltimore, MD 21202
      Phone: (410)528-1840
      Fax: (410)576-6571
      Email: HEAU@oag.state.md.us

D. Presumptive Financial Assistance. In some cases or circumstances a patient or applicant may appear eligible for Financial Assistance, but either has not provided all requested information or otherwise non-responsive to the application process. In such cases or circumstances, an authorized representative of a LifeBridge Health hospital may complete the Application on the patient's behalf and research evidence of eligibility for Financial Assistance from available

outside sources to determine the patient's estimated income and potential discount amounts or may utilize other sources of information to make an assessment of financial need. As a result of such information, the patient may be eligible for discounts up to 100% of the amounts owed for Eligible Services. In such circumstances, a patient is presumed eligible to receive Financial Assistance for Eligible Services if the patient meets one or more of the following criteria:

1. Eligible for the Maryland Medical Assistance program or Maryland Children's Health Program and:
    i. Lives in a household with children enrolled in the free and reduced-cost meal program;
    ii. Receives benefits through the federal Supplemental Nutrition Assistance Program;
    iii. Receives benefits through the State's Energy Assistance Program;
    iv. Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or
    v. Receives benefits from any other social service program as determined by the Maryland Department of Health and Mental Hygiene (MD DHMH) and the State of Maryland HSCRC.
2. Residence in low income or subsidized housing;
3. Unfavorable credit history, based on the patient's credit report (high risk, low medical score, delinquent accounts);
4. Utilization of third-party predictive modeling based on public record databases and calibrated historical approvals statistically matched to this Policy. Such technology will be deployed prior to bad debt assignment in an effort to screen all patients for financial assistance prior to collection agency placement or pursuing any extraordinary collection actions.
5. Homeless or received care from a homeless shelter, free clinic;
6. Mentally incompetent as declared by a court or licensed professional; or
7. Deceased with no known estate.

E. Eligibility Criteria and Amounts Charged to Patients. Patients who are determined to be eligible, shall receive Financial Assistance in accordance with such individual's financial need, as determined by referring to the Federal Poverty Guidelines as published annually in the Federal Register.

1. Notwithstanding anything in this Policy to the contrary, no patient who is eligible to receive Financial Assistance for Eligible Services will be charged more than allowed by the State of Maryland HSCRC pricing or AGB for emergency or other Medically Necessary care.
2. The basis for determining and calculating the amounts billed an Uninsured or Underinsured patient who is eligible for Financial Assistance is as follows:
    i. Any Uninsured or Underinsured patient eligible for Financial Assistance will first receive the Financial Assistance discount for either 100% of billed charges or a reduced billed amount for those with Family income above 300% of the Federal Poverty Guidelines.

ii. Uninsured or Underinsured patients eligible for Financial Assistance whose yearly Family Income is equal to or less than 300% of the Federal Poverty Guidelines and whose total Assets do not exceed amounts allowed will receive a discount of 100% of their remaining account balance.

iii. Any Uninsured with Family Income above 300%, but less than 500% of the Federal Poverty Guidelines may qualify for a Financial Hardship discount. To qualify total Assets must be less than allowed provided total outstanding medical expenses minus co-payments, coinsurance and deductibles exceed 25% of annual Family Income. The amount of the Financial Hardship discount is any amount that exceeds 25% of annual Family Income. Thus, remaining balance owed excluding co-payments, coinsurance and deductibles if applicable after discount does not exceed 25% of Family Income.

F. Excluded Services. The following healthcare services are not eligible for Financial Assistance under this Policy:

1. Purchases from retail operations, including gift shops, retail pharmacy, durable medical equipment, cafeteria purchases;
2. Services provided by non-LifeBridge Health entities or professional services from physicians or advanced practice providers during hospital visits;
3. Elective procedures or treatments that are not Medically Necessary including cosmetic surgery, bariatric surgery, venous ablation.
4. Services provided at Levindale Nursing, Rehabilitation and Adult Day Care locations and any amounts deemed by Medicaid as patient liability.
5. Existing or pre-established programs to assist patients with defined coverage of services similar to Best Beginnings for undocumented women needing prenatal care or Access Carroll for free clinic care to uninsured and underinsured patient populations in Carroll County.

G. Communication of Information about the Policy to Patients and the Public. LifeBridge Health hospitals will take measures to inform and notify patients and visitors and the residents of the community at large served by the hospital, of this Policy in a manner that, at a minimum, will notify the listener and reader that the hospital offers Financial Assistance and informs individuals about how and where to obtain more information about this Policy. Such measures will include the following:

1. Clearly and conspicuously post signage to advise patients and visitors of Financial Assistance availability including Emergency Department, admission areas and billing departments
2. Make this Policy, the Application, and a plain language summary of this Policy widely available on its website www.lifebrigehealth.org.
3. Make paper copies of this Policy, the Application, and a plain language summary of this Policy available upon request, without charge, in public locations in each hospital including Emergency Department, admission areas, billing department and by mail or e-

mail. Furthermore, Patient Access and Customer Service representatives will notify and inform individuals upon admission or discharge of Financial Assistance and offer a paper copy of a plain language summary of the Financial Assistance Policy.

4. List all Providers, as referenced as Addendum I, whether employed or not employed by the hospital, covered by this Policy and will make widely available on its website www.lifebridgehealth.org.
5. Referral of patients for Financial Assistance may be made by any member of LifeBridge Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors.
6. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws and limitations.
7. Any and all written or printed information concerning this Policy, including the Application, will be made available in each of the languages spoken by the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be encountered or affected by the hospital. The hospital will take reasonable efforts to ensure that information about this Policy and its availability is clearly communicated to patients who are not proficient in reading and writing and/or who speak languages other than those for which information about this Policy are printed or published.

H. Document Retention Procedures. The hospital will maintain documentation in accordance with retention policies sufficient to identify each patient determined to be eligible for Financial Assistance including the patient's Application, any information obtained or considered in determining such patient's eligibility for Financial Assistance (including information about such patient's income and assets), the method used to verify patient's income, the amount owed by the patient, the method and calculation of any Financial Assistance for which such patient was eligible and in fact received, and the person who approved the determination of such patient's eligibility for Financial Assistance.

I. Relationship to Billing and Collections Policy. For any patient who fails to timely pay all or any portion of amount(s) owed, the hospital will follow guidelines set forth in its separate Billing and Collections Policy; provided that, the hospital will not commence or institute any extraordinary collection actions (including garnishments, liens, foreclosures, levies, attachments or seizures of assets, commencing civil or criminal actions, sales of debts to third parties, reporting adverse information to credit reporting agencies or credit bureaus) against any patient for failure to timely pay all of any portion of patient's account, without first, making reasonable efforts to determine whether the patient is eligible for Financial Assistance. Reasonable efforts are set forth in the separate Billing and Collections Policy, including those relating to patient communications and required actions, time periods, and notices of complete or incomplete Application for Financial Assistance. A copy of the Billing and Collection Policy may be obtained free of charge from any one of the sources or locations listed in Section III.K. below.

J. No Effect on Other Policies; Policy Subject to Applicable Law. This Policy shall not alter or modify other policies regarding efforts to obtain payment from third party payers, transfers or emergency care. This Policy and the provision of any Financial Assistance will be subject to all applicable federal, state, and local law.

K. Sources of and Locations for Information. Copies of this Policy, the Application, the Billing and Collections Policy, and the EMTALA Policy, may be obtained from or at any one or more of the following sources or locations:

1. Any Customer Service, Patient Access, or Patient Registration areas;
2. Emergency Department, admission areas or billing department;
3. By calling Customer Service at (800)788-6995; and
4. LifeBridge Health's website at www.lifebridgehealth.org.

From:	David Baker
To:	Hilltop HCB Help Account
Cc:	Sharon McClernan
Subject:	UPDATED: Clarification Required - Carroll Hospital Center FY 21 Community Benefit Narrative
Date:	Wednesday, June 8, 2022 3:05:30 PM
Attachments:	Outlook-euwiwx15.png

Report This Email

Please see additional responses added below in **red** (there was not a place to document them in the Supplemental Survey form).

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
410.469.5170 office | dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

LIFEBRIDGE HEALTH
CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 8:25 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Clarification Required - Carroll Hospital Center FY 21 Community Benefit Narrative

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Carroll Hospital Center. In reviewing the narrative, we encountered a few items that require clarification:

- For Question 44, on page 5 of the attached, your hospital's system-level Senior Executives are listed as assisting in many ways with the CHNA process, but the option "N/A – Position or Department does not exist" is also selected. Please clarify the status of this entity.
  The N/A boxes were selected in error.

- For Question 44, on page 6 your hospital's system-level Clinical Leadership is listed as "N/A – Position or Department does not exist" as well as "N/A – Person or Organization was not involved." For Question 46, on page 7 the same entity is listed as participating in community benefit initiatives in several ways. Please clarify the status of this entity.
  The N/A boxes were selected in error.

- For Question 46, on page 8, in addition to other ways that your hospital's nurses helped with community benefit initiatives, "Other" was selected, but nothing was entered into the text

box to explain the selection. Please provide a description of what other ways your hospital's nurses were involved in community benefit activities during the fiscal year.
The "Other" box pertaining to Nurses should be unchecked here. This was an error. The other checkboxes adequately describe nurses' roles in data collection and program delivery.

- Please respond to Questions 244, 245, 218, 219, and 139 using the following supplementary survey:

https://umbc.co1.qualtrics.com/jfe/form/SV_2bLZ9N5jdVuC7nE?Q_CHL=gl&Q_DL=VRC42tiJpGV0iQV_2bLZ9N5jdVuC7nE_CGC_YdyYBV7aLB1sJeP

Please complete the supplementary survey linked above and provide all other clarifying answers as a response to this message.

Responses to these questions have been submitted via the survey.

- **We request that all hospitals who report physician subsidies complete Questions 218 and 219, as well as Question 139 if applicable.**

  Q218: Please describe the initiatives addressing populations – LGBT.
  The hospital has an LGBTQ+ Employee Resource Group devoted to LGBTQ+ patient and employee concerns and support. Part of this support includes LGBTQ+ Cultural Competency virtual trainings.

  Q219: Please describe the initiatives addressing populations – Men.
  The hospital routinely offers telephonic, video, and in-person community education and screening events targeting men's health, including events focused on prostate cancer.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

To track health disparities in the communities it serves, the hospital collects patient-level information about race, gender, zip code, Area Deprivation Index, and social determinants of health. To reduce health disparities in the communities it serves, the hospital prioritizes outreach to neighborhoods with economic and social disparities in its service area. To help address barriers to health care access among these communities, the hospital brings health care resources to where people live through events in priority neighborhoods--including events focused on chronic disease management and COVID-19 vaccinations. To further its reach and better capture residents in most need of services, the hospital regularly partners with trusted neighborhood-based entities, including churches and community associations and centers. ACCESS Carroll is supported by Carroll Hospital and is designed to address patient and community needs of those with the highest health disparities.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	◉	○	Non-resident house staff and hospitalists
Cardiology	○	◉	
Dermatology	○	◉	
Emergency Medicine	◉	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	○	◉	
Family Practice/General Practice	○	◉	
Geriatrics	○	◉	
Internal Medicine	◉	○	Non-resident house staff and hospitalists
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	◉	○	Non-resident house staff and hospitalists
Oncology-Cancer	○	◉	
Ophthamology	○	◉	
Orthopedics	○	◉	

Ololaryngology	○	◉	
Pathology	○	◉	
Pediatrics	◉	○	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	◉	○	Coverage of emergency department call
Radiology	○	◉	
Surgery	◉	○	Non-resident house staff and hospitalists
Urology	○	◉	
Other. (Describe)	○	◉	

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Physician subsidies have become necessary to ensure that all patients requiring anesthesia, behavioral health, radiology, perinatology and general medicine care have the access they need both on an inpatient and outpatient basis, including 24/7 coverage. Carroll Hospital provides coverage in each of these areas through contracted physicians, House Staff or Hospitalists and allocates a significant amount of resources to sustain these programs. To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Carroll Hospital contracts with various specialists to ensure 24/7 coverage in the ED. Hospital-employed physicians are required to see medical underserved, uninsured, Medicare and Medicaid patients.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q1. Thank you. To edit your answers, please use the "back" button below. To submit your answers, please use the "forward" button below.

This question was not displayed to the respondent.

Location Data

Location: (39.3407, -76.6753)

Source: GeoIP Estimation