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: Meritus Medical Center	◉	○	
Your hospital's ID is: 210001	◉	○	
Your hospital is part of the hospital system called N/A	◉	○	
The primary Narrative contact at your hospital is Allen Twigg	◉	○	
The primary Narrative contact email address at your hospital is allen.twigg@meritushealth.com	◉	○	
The primary Financial contact at your hospital is Allen Twigg	○	◉	David White Manager, Reimbursement & Strategy
The primary Financial email at your hospital is allen.twigg@meritushealth.com	○	◉	David.White@meritushealth.com Ph: 301-790-9138

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.

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

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

In addition to the community health statistics for Washington County linked above, we use: • Demographic and socioeconomic data obtained from Nielsen/Claritas (www.claritas.com) and the US Census Bureau (www.census.gov) • Disease and Mental Hygiene incidence and prevalence data obtained from the Maryland Department of Health and Maryland Vital Statistics Administration (http://dhmh.maryland.gov) • The Centers for Disease Control and Prevention (http://www.cdc.gov) Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Some health related indicators included in this report include BRFSS data collected by the CDC http://www.cdc.gov/brfss/ • CDC Chronic Disease Calculator, available at http://cdc.gov/chronicdisease/resources/calculator/index.htm • The health related indicators included in this report for Maryland are BRFSS data and benchmarks coordinated by the Maryland Department of Health and Mental Hygiene as part of the State's Health Improvement Plan (SHIP)http://dhmh.maryland.gov/ship/SitePages/Home.aspx last updated May 8, 2020• Selected inpatient and outpatient utilization data on primary care sensitive conditions that were identified as ambulatory care sensitive conditions and indicators of appropriate access to health care were obtained from the Meritus Medical Center and Brook Lane Health services quality data • Meritus Health Cancer Registry Cases 2015-2019 • County Health Rankings, A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org focus Washington County, Maryland 2021.

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
- [ ] 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
- [x] 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.

This question was not displayed to the respondent.

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.

- [x] 21711
- [x] 21713
- [x] 21715
- [x] 21719
- [ ] 21720
- [ ] 21721
- [x] 21722
- [x] 21733
- [ ] 21734
- [x] 21740
- [ ] 21741
- [x] 21742
- [ ] 21746
- [x] 21750
- [ ] 21755
- [x] 21756
- [x] 21758
- [x] 21767
- [x] 21769
- [x] 21779
- [x] 21780
- [ ] 21781
- [x] 21782
- [x] 21783
- [x] 21795

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?

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

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

  Appendix A of the Meritus Medical Center GBR agreement identifies all Washington County zip codes as the Primary Service Area. Source: Meritus 2017 GBR agreement (effective 09/13/16)

- [ ] Based on patterns of utilization. Please describe.

- [x] Other. Please describe.

  The unchecked ZIP codes are PO box locations and do not include demographic data.

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

https://www.meritushealth.com/about-us/mission-vision/

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

The FY19 CHNA process defined the PSA using the fact that more than 78% of Meritus Medical Center discharges reside in a zip code located within Washington County, Maryland. Both the CHNA and GBR agreement definitions of the PSA are the same; Washington County, Maryland in it's entirety, serving approximately 150,000 people. The PSA makes up a representative cross section of the county's population including those considered ''medically underserved,'' as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured, or other access issues and disparities.

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)

05/10/2019

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

https://www.meritushealth.com/documents/chna/FY2019-CHNA-Report-FINAL-Rev.pdf

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

FY2019 CHNA Report FINAL.pdf

5.9MB
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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Executive Director, Behavioral & Community Health
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Chief Health Officer
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Board of Directors member and Full Board reviewed CHNA approved plan of action
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Termed "Community Health" staff
	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) Medical Director Physician Practices	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	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)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	

	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 (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: Brook Lane Hospital	☐	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	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: Washington 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: Healthy Washington 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: Wash Co. Mental Health and Addictions Authority	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	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: Wash. Co. 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
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: Washington County Public Schools	☑	☑	☑	☑	☐	☐	☑	☑	☐	☑	☑	☑	☑	☑
	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: Hopkins School of Public 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
Behavioral Health Organizations -- Please list the organizations here: Shepherd Waystation	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	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: The United Way	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐
	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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	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: Bester Community of Hope	☑	☑	☑	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.

03/28/2019

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

https://www.meritushealth.com/documents/CHNA/CHNA-FY19-Appendices.pdf (see pages 304 - 306)

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

FY2019 CHNA Meritus Action Plan - FINAL.pdf
231.4KB
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.

Some action items such as children's after school health program were necessarily suspended due to Covid-19. In such cases, those resources were reallocated in our Covid community response. An update to the FY19 Action Plan includes FY21 outcomes in drop box below.

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

FY2019 CHNA Meritus Action Plan - FY21 Evaluation.xlsx
25.2KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

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	Reduce substance use	Decrease number of overdose fatalities in Washington County by 10%	Fatalities have increased 26% through FY2021	County overdose fatalities
Initiative B	Reduce substance abuse	Decrease number of opioid prescriptions by 25%	Morphine equivalent prescriptions decreased by 37%	Total mrophine eq prescribed per encounter
Initiative C	Reduce substance abuse	Decrease ED visits for addictions related conditions by 5%	SUDs ED visits down 44% from F19 through F21	# ED visits by diagnostic code
Initiative D				
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	Improve cancer survival rates	Increase 5 yr. survival rates for head and neck cancer diagnosis by 5% (65% baseline 2018)	Exceeded, 78% survival rate 2021	Meritus Oncology Service line database
Initiative B	Improve cancer survival rates	Increase 5 yr. survival rates for colon cancer by 5% (59% baseline 2018)	Exceeded, 68% survival rate 2021	Meritus Oncology Service line database
Initiative C	Improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10% (baseline 158 cases)	Exceeded, 145 cases in 2021 (8.2% reduction)	Meritus Oncology Service line database
Initiative D	Improve earlier detection and diagnosis	Reduce Stage III & IV diagnosis of colon cancer by 10% (baseline 45 cases 2018)	Exceeded, 37 cases in 2021 (17.7% reduction)	Meritus Oncology Service line database
Initiative E				
Initiative F				
Initiative G				
Initiative H				
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.

	Health Conditions - Chronic Pain Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2% (baseline 10.7)	Decreased rate of new diabetes diagnosis by .4% (10.3% for 2021)	MD Vital Stats
Initiative B	Improve management of diabetes and reduce mortality	Decrease the diabetes mortality rate by 2% over three years (baseline 35.9)	Decreased by 11% to 32 per 100k	MD Vital Stats
Initiative C	Improve management of diabetes and reduce mortality	Reduce # of ED visits for diabetes by 5% (baseline 778)	830 ED visits, +6.3% wrong direction	# ED visits by diagnostic code
Initiative D	Improve management of diabetes and reduce mortality	85% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%	Improved to 79.4% from baseline	EHR audit report
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	Reduce heart disease mortality	Decrease age-adjusted mortality rate from heart disease by 1%	Decreased to 184.6 per 100k	MD Vital Statistics
Initiative B	Reduce heart disease mortality	Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months (baseline 2%)	Increased to 5%	Smoking cessation class data
Initiative C	Improve management of hypertension	Decrease the # of ED visits for hypertension by 5%	Data shows 1734 ED visits HTN 2021; need to filter for primary dx	# ED visits by diagnostic code
Initiative D				
Initiative E				
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	Improve access to mental health care	Decrease ED visits related to mental health conditions by 7%	Decreased ED visits by 18%	# ED visits by diagnostic code
Initiative B	Improve access to mental health care	Decrease BH 30 day readmits by 5% FY20 - FY22	Decreased by 2% through FY21	# of 30 day readmissions to BHU
Initiative C	Improve access to mental health care	Screen 75% of adults for depression in primary care practices annually	32% screened during FY21	EHR audit of PHQ2/9 completion
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

Health Conditions - Oral Conditions Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

Health Conditions - Overweight and Obesity Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Achieve Healthy Body Weight	Decrease the percentage of obese adults by 2% (34% baseline)	Rate of obesity increased 3%	CDC rate of obese adults
Initiative B	Achieve Healthy Body Weight	Decrease the percentage of overweight adults by 2% (28.2% baseline)	Rate of overweight increased 3.3%	BRFSS rate of overweight adults
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

Health Conditions - Pregnancy and Childbirth Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Health Conditions - Respiratory Disease Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

	Health Conditions - Sexually Transmitted Infections Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Health Behaviors - Child and Adolescent Development Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				

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

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

	Health Behaviors - Drug and Alcohol Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
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	Promote consumption of healthy diet	Children increase consumption of fruits & vegetables in CATCH program by 50%	Suspended FY21 due to Covid	CATCH after school, primary data
Initiative B	Promote consumption of healthy diet	Decrease percentage of food insecurity	New measure est. in 2020 Food Insecurity rating for Wash. Co. 151.93	Conduent Healthy Communities is ameasure of food access that is correlated with economic and household hardship
Initiative C				
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	Improve physical activity among adults	Decrease percentage of adults who are physically inactive by 2%	Percentage of inactive adults increased by 2%	2021 RWJ County Health Rankings inactive adults
Initiative B	Improve physical activity among children	Increase measure of daily physical activity	Suspended FY21 due to Covid	CATCH after school, primary data
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	Improve wellness and quality of life	Screen 10% of adult PCP population per month	Screened SDOH for 17% of PCP pop / month	EHR audit report SDOH screens completed
Initiative B	Improve wellness and quality of life	Implement community wellness and healthy lifestyle strategies within 3 workplaces	Assisted 41 community organizations to establish Do, Eat, Believe health program	# of community partners
Initiative C	Improve wellness and quality of life	Decrease the proportion of adults that report that they smoke tobacco by 6% (18.8% baseline)	Through FY21 decreased to 16.4% (-2.4%)	MD BRFSS
Initiative D	Improve wellness and quality of life	Improve early identification of student health intervention needs	Suspended FY21 due to Covid	Meritus School Nursing primary data
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.

	Health Behaviors - Tobacco Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
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.

	Populations - Adolescents Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Populations - Children Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Populations - Infants Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

	Populations - Older Adults Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives				

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.

	Settings and Systems - Community Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Settings and Systems - Environmental Health Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

	Settings and Systems - Health Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
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.

	Settings and Systems - Hospital and Emergency Services Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Settings and Systems - Housing and Homes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
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.

	Social Determinants of Health - Education Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
Initiative B				
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.

	Social Determinants of Health - Neighborhood and Built Environment Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

	Social Determinants of Health - Social and Community Context Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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 - Chronic Pain, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Overweight and Obesity, Health Conditions - Pregnancy and Childbirth, Health Conditions - Respiratory Disease, Health Conditions - Sexually Transmitted Infections, Health Behaviors - Child and Adolescent Development, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Tobacco Use, Health Behaviors - Vaccination, Populations - Adolescents, Populations - Children, Populations - Infants, Populations - Older Adults, Settings and Systems - Community, Settings and Systems - Environmental Health, Settings and Systems - Health Care, Settings and Systems - Health Insurance, Settings and Systems - Hospital and Emergency Services, Settings and Systems - Housing and Homes, Settings and Systems - Transportation, Social Determinants of Health - Education Access and Quality, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Neighborhood and Built Environment, Social Determinants of Health - Social and Community Context
Other:

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

- ☐ Access to Health Services: Health Insurance
- ☐ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Access to Health Services: Outpatient Services
- ☐ Adolescent Health
- ☑ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☐ Behavioral Health, including Mental Health and/or Substance Abuse
- ☐ Cancer
- ☐ Children's Health
- ☑ Chronic Kidney Disease
- ☐ Community Unity
- ☑ Dementias, including Alzheimer's Disease
- ☐ Diabetes
- ☑ Disability and Health
- ☐ Educational and Community-Based Programs
- ☑ Environmental Health
- ☑ Family Planning
- ☐ Food Safety
- ☐ Global Health
- ☐ Health Communication and Health Information Technology
- ☐ Health Literacy
- ☐ Health-Related Quality of Life & Well-Being
- ☐ Heart Disease and Stroke
- ☑ HIV
- ☐ Immunization and Infectious Diseases
- ☑ Injury Prevention
- ☑ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal and Infant Health
- ☐ Nutrition and Weight Status
- ☐ Older Adults
- ☑ Oral Health
- ☐ Physical Activity
- ☑ Respiratory Diseases
- ☑ Sexually Transmitted Diseases
- ☑ Sleep Health
- ☐ Telehealth
- ☐ Tobacco Use
- ☑ Violence Prevention
- ☑ Vision
- ☑ Wound Care
- ☐ Housing & Homelessness
- ☐ Transportation
- ☐ Unemployment & Poverty
- ☐ Other Social Determinants of Health
- ☐ Other (specify) _____

Q132. Why were these needs unaddressed?

As a community hospital, Meritus Medical Center purposefully incorporates our commitment to community service into our internal management and governance structures as well as strategic and operational plans. Meritus conducts a community health needs assessment every three years to identify and prioritize community health needs and service gaps. An action plan of initiatives and goals are developed to address the prioritized health needs. The action plan is reviewed by the Meritus Board Strategic Planning committee and approved by the Meritus Board of Directors. The most recent prioritized community health needs from FY2019 Meritus CHNA includes: #1 Substance use; to improve access to care and reduce overdose deaths. Screening for substance use disorder to identify, intervene and link patients with treatment and supportive resources. Providing an inpatient consultative team and Peer Recovery Support program which has successfully help patients establish a plan of recovery. Have continued crisis stabilization, management of withdrawal and follow up treatment for hospitalized patients, transferring directly to drug rehab when indicated. Continued participation in a Neonatal Abstinence Syndrome Collaborative to intervene with mothers of drug-affected newborns, improve inpatient treatment and partner to support our community treatment providers. Providing free support group and education services to family members of persons with addiction. We are exploring gaps around crisis stabilization and prompt access to treatment when desired by the patient. #2 Mental health; improve access to care, earlier identification and to reduce stigma. Meritus provided targeted mental health education and support groups to decrease stigma, increase awareness of behavioral health issues and provide practical mental health education and support at no cost. Continued integration of behavioral health professionals in primary care practices to help support depression screening, mental health evaluation, crisis stabilization and linkage. Partnered to provide case management services to help link patients at high-risk for a return to the ED with needed community resources. Provides expedited access to timely psychiatry evaluation to avoid ED visit or higher level of care when indicated. New efforts include partnering with community organizations, law enforcement and community rescue to expand mobile crisis response in the community. #3 Weight status; reduce obesity by increasing physical activity and eating a healthy diet. . Provides a bi-weekly community weight loss support group led by a registered dietitian that is open to the public and free of charge. Offered BMI screening, health and nutrition information at virtual events with a focus on diet, nutrition and exercise. Strategic planning in January 2020 resulted in setting a bold health goal to lose 1 million community pounds by 2030. A 10-year population health campaign was launched in October 2020. At the end of June 2021 we had 40 committed community partners with 11,200 pounds lost. #4 Wellness; promote healthy lifestyles with healthful nutrition, exercise, tobacco cessation and stress reduction. Meritus has offered non-traditional, alternative health interventions that have demonstrated positive health benefits. Expanded access to primary and behavioral health care during the Covid-19 pandemic via telehealth visits. Provided wellness checks and general health screenings to provide patients with understanding of their health status. Has partnered with local health improvement coalition and partners to provide the community-based One for Good initiative with focus on making healthier food choices, increasing physical activity, stop smoking and taking medication as prescribed. Increase participant awareness to contemplate need to make lifestyle changes. Provided wellness education for practical, applicable information to current health topics including infectious disease precautions, exercise, how to decrease sense of isolation, stress reduction, physical activity, healthy diet, etc. and trends. Provided support groups that cover a wide range of health related issues including cancer, stroke, stress and grief. Incorporating wellness into the bold health goal of lose 1 million pounds campaign under the headings "DO' increase physical activity, "EAT" health, balanced nutrition and "BELIEVE" introducing stress management techniques including mindfulness, balance, and recovery from behavioral health issues. #5 Diabetes; reduce diabetes disease burden through prevention, improved management, access to care and education. Meritus provides targeted diabetes education to patients through care management support directly in PCP offices. We provide the evidenced-based Living Well diabetes education series for disease management in the community at no cost. Attained certification and establishment of a National Diabetes Prevention Program to teach lifestyle changes and reduce risk of developing Type II diabetes. Continued to provide Diabetes Self-Management Education services. Continued partnership with a local church as a “health hub” in at risk neighborhood providing diet, nutrition counseling, health education and support groups that ensure direct communication with a physician. Currently collaborating with regional partnership to develop comprehensive response aligned with the MD Diabetes Action Plan. #6 Heart disease and hypertension; improve cardiovascular health through prevention, management of blood pressure and early identification of risk. Conduct blood pressure screenings at health outreach events, in churches and community neighborhoods to identify persons with hypertension, provide education and refer to medical management. Continue the community wide blood pressure awareness to change the community culture to focus on personal health status. Sponsored heart healthy activities and events that promoted heart health education. Provided telehealth support and monitoring to persons with Congestive Heart Failure to improve overall management. At the conclusion of the CHNA data assessment it was recognized that many more needs were identified and exist than can be successfully met by the hospitals alone due to limited, finite resources. The prioritization criterion helped narrow the focus to directly address the issues that would have the greatest impact for improving the health of people in our community. Whenever other community organizations have a mission aligned to meet the CHNA needs that were identified, the need was scored as a lower priority for Meritus Medical Center, avoiding the duplication of existing community services and providing an opportunity to coordinate the linkage of patients to alternative services whenever appropriate. Our community providers are using the results of the CHNA to help target these unmet needs based on strengths, expertise and resources of individual organizations, and where interests are shared, new collaborative relationships between organizations will be formed.

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

We track SDOH county level updates to the CDC's Social Vulnerability Index (last updated 2018) and American Community Survey Social Determinants of Health Data by Zip Code (2014-2018), but obviously the data is significantly lagging. We have established a metric to complete SDOH screening in ambulatory practices as part of our strategic health aims. The patient population has SDOH screened and documented as unique patients with visits each month in the Epic EHR. At the end of FY2021 17% of the patient population seen at Meritus Medical Group had been screened each month. The data is being used to both link patients to resources in real time as well as develop new strategies for the health system to bridge gaps and help meet identified social needs in our community. Through the www.CommunitySolutionsHub.org website we have access to the 2021 SocioNeeds Index, created by Conduent Healthy Communities Institute, calculated using data from Claritas, 2021. The SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need) helping us target community neighborhoods where needs are the greatest.

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:

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

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

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
- [ ] 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?

- [x] Yes
- [ ] No

Q63. Please describe the community benefit narrative audit process.

The internal audit consists of a series of checks and balances. Reporters from across the health system submit Community Benefit activities on a monthly basis. Each occurrence is reviewed and entered into CBISA by the system administrator, office of Community Health. The Community Benefit team made from members of Finance and Community Health, collaborate to review all submissions, associated expenses and works to obtain any missing information. All information is reconciled in the CBISA system and multiple reports are generated for review by the CB team (including a three year comparison). Once the financial expenses are finalized the Executive Director of Community Health coordinates the written CB narrative. Upon completion of the draft narrative all members of the Community Benefits Committee review the narrative for comparison with the financials to ensure accuracy and completion. Upon approval by the CB team, a final version is presented to the Chief Financial Officer who completes final review and sign off. The Community Benefit report is audited as part of the HSCRC Special Audit on an annual basis.

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

- [x] 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?

- [x] 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?

- [x] Yes
- [ ] No

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

As a community hospital, Meritus Health purposefully incorporates our commitment to community service in our internal management, governance structures, strategic and operational plans. Meritus Health conducts a community health needs assessment every three years to identify and prioritize community health needs and service gaps. An action plan of initiatives and measurable goals are developed to address the prioritized health needs. The Community Health Needs Assessment data, prioritized health needs and recommendations are shared with the Senior Executive Team and Board of Directors. The action plan is reviewed by the Meritus Board Strategic Planning committee and approved by the Meritus Board of Directors. This information along with other hospital data and information was used to develop the health system's 10 year strategic plan, 2030 Bold Goals. Using the quadruple aim framework, the 2030 Bold Goals were created to improve the health of people in our community, improve health care, having joy at work and medical care that is affordable for our community. The Bold Goal to Improve Health was determined to be Lose 1 Million Pounds by 2030. Three year strategies include 1) increase physical activity, 2) improve access to care for all residents, and 3) reduce and manage stress. Strategic planning occurred with the Board of Directors from October 2019 to January 2020. Through the office of Community Health, the Director aligns priorities between the CHNA Implementation Strategy and the Strategic Plan as a component of community benefit planning. Priority actions for 2020 – 2021 included: Blood pressure screening and education, Social Determinants of Health screening, Mindfulness-based stress reduction, Reduce ED wait times, Increase telehealth visits, Engage 25 community partners pledged to achieve 1 million pound goal, Lose a total of 10,000 pounds, Collaborate with community providers to offer services and events that increase physical activity, and Explore feasibility of establishing a wellness center. Community benefit strategies will help support these initiatives through the implementation of community and population health programs over the next year.

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

N/A

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
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] 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.

Adults not overweight or obese Increase physical activity Suicide rate Overdose fatality rate Cancer mortality ED visits for diabetes, hypertension, mental health Adults who smoke were all described in CHNA action plan and initiatives

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.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	○	◉	
Cardiology	○	◉	
Dermatology	○	◉	
Emergency Medicine	◉	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	○	◉	
Family Practice/General Practice	○	◉	
Geriatrics	○	◉	
Internal Medicine	○	◉	
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	○	◉	
Oncology-Cancer	○	◉	
Ophthamology	○	◉	
Orthopedics	○	◉	
Otololaryngology	○	◉	
Pathology	○	◉	
Pediatrics	○	◉	
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	○	◉	
Surgery	○	◉	
Urology	○	◉	
Other. (Describe) Hospitalists	◉	○	Non-resident house staff and hospitalists

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.

Meritus Medical Center subsidizes the Hospitalist program in response to a community need for this service. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured population necessitated the need for a Hospitalist program subsidized by the Hospital. Meritus Medical Center subsidizes the Emergency On-call program in response to a community need for timely access and response to emergent care. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with higher volumes of uninsured/underinsured population in the Emergency Department has necessitated the need for an Emergency On-call program subsidized by the Hospital.

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

Q140. Section VI - Financial Assistance Policy (FAP)

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

Financial Assistance.pdf
145.3KB
application/pdf

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

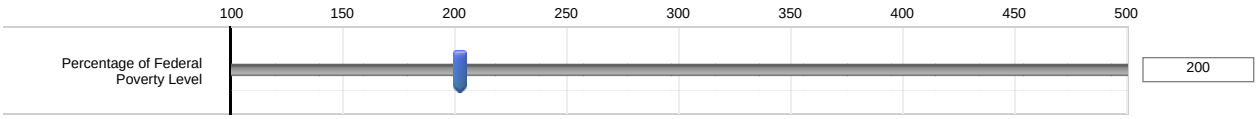
https://www.meritushealth.com/patients-visitors/financial-assistance-asistencia-financiera/

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:

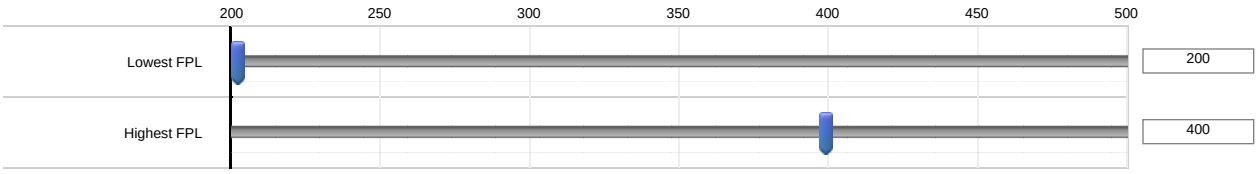
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



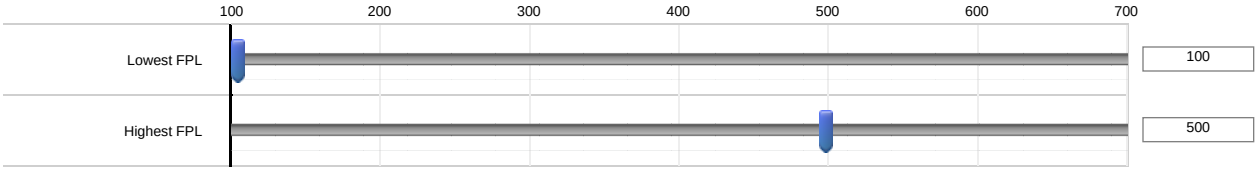
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

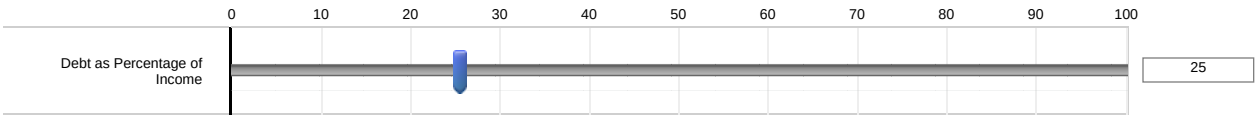


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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)
- [ ] Other (Describe)

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: (39.661407470703, -77.691497802734)

Source: GeoIP Estimation

FY2019 Community Health Needs Assessment
















Healthy
WASHINGTON COUNTY

Table of Contents

This document has been produced to benefit the community. Healthy Washington County encourages use of this report for planning purposes and is interested in learning of its utilization. Comments, questions and suggestions are welcome and can be submitted to:

Mary Rizk, Executive Director
Corporate Communications for Meritus Medical Center
mary.rizk@meritushealth.com

The FY2019 Community Health Needs Assessment for Washington County, Maryland is available for review at:

- Brook Lane http://brooklane.org/
- Meritus Medical Center http://www.meritushealth.com/
- United Way of Washington County http://www.unitedwaywashcounty.org/
- Washington County Chamber of Commerce http://www.hagerstown.org/
- Washington County Health Department https://washcohealth.org/

A printed copy of the report may be obtained upon request to:

Meritus Medical Center
Allen Twigg, Executive Director of Behavioral and Community Health Services
allen.twigg@meritushealth.com

Brook Lane Health Services
Curt Miller, Director of Public Relations
curt.miller@brooklane.org

Acknowledgements

The Executive Steering Committee would like to thank the countless individuals who have contributed to the success of this community assessment including all the survey participants and all those who contributed directly to writing and editing the final report

INTRODUCTION

Message to the Community

Healthy Washington County is proud to present the FY2019 Community Health Needs Assessment report for Washington County, MD. This report includes a comprehensive review and analysis of the data regarding health issues and needs of people living in the Washington County region.

This study was conducted to identify the health strengths, challenges and opportunities unique to our community and to provide useful information to health care providers, policy makers, collaborative groups, social service agencies, community groups and organizations, churches, businesses, and consumers who are interested in improving the health status of the general population. The results enable our health systems and other providers to strategically establish priorities, develop interventions and commit resources to improve the health status of our service region.

Improving the health of the community is foundational to the missions of Brook Lane Health Services and Meritus Medical Center and should be an important concern for everyone in the county, individually and collectively. In addition to the education, patient care and program interventions provided through our health systems, we hope the information in this study will encourage additional activities and collaborative efforts to improve the health status of the community over time.

To demonstrate our strong community collaboration, this Community Health Needs Assessment was developed and promoted by Healthy Washington County (HWC). Healthy Washington County is a coalition of public and private organizations working to improve the health of people living in this community. The coalition strives to achieve this through raising awareness around personal health status and healthier behaviors. Bringing people and organizations together around health issues that affect quality of life in the region, we raise awareness, create opportunities for networking, and support finding solutions. Ultimately, Healthy Washington County aims to provide the means by which individuals can achieve their healthiest potential.

Purpose

A Community Health Needs Assessment (CHNA) is a report based on epidemiological, qualitative and comparative methods that assess the existence of health issues within a defined community and the health services, gaps and disparities that people may encounter related to those health issues. This CHNA report includes findings, survey results, conclusions and an implementation plan that has been made widely available to the public via Meritus Medical Center, Brook Lane Health Services, and Washington County Health Department websites.

The express purpose of the FY2019 CHNA was to complete a comprehensive assessment of the health status and healthcare access needs of residents living in the Washington County healthcare region. The objectives of the assessment include:

- Review the FY2016 health needs and determine what progress has been made
- Identify the current health status of community residents to include baseline data for benchmarking and assessment purposes
- Identify the availability of treatment services, strengths, service gaps and opportunities
- Determine unmet community health needs and target priorities
- Develop a plan to direct community benefit and allocation of resources to meet targeted needs
- Enhance strategic planning for future services
- Meet the CHNA requirements for Brook Lane Health Services and Meritus Medical Center as not-for-profit hospitals

Brook Lane

Brook Lane is a private, not-for-profit mental health facility with a 115-acre main campus near Leitersburg, Maryland and three satellite campuses in Hagerstown and Frederick. The 57-bed hospital provides treatment focused on crisis intervention and stabilization. Day treatment programs for children and adults provide a structured, therapeutic program yet allow the client to return home each evening. Outpatient therapy for all ages is available at three locations. Laurel Hall School provides education and therapy for students with emotional and behavioral challenges. Stone Bridge Residential Program provides a home-like environment for children who are in crisis without an appropriate place to stay. The THRIVE Program assists children in building relationships and developing positive coping and communication skills. InSTEP, the substance abuse treatment program, addresses the increasing need for the treatment and support of addiction in our community. Brook Lane also provides School Based Mental Health Services, free of charge, in all middle and high schools in Washington County, Maryland.

Meritus Medical Center

Meritus Medical Center is the flagship facility of the health system, Meritus Health, the largest health care provider in the region. The state-of-the-art, Joint Commission accredited hospital opened in 2010. Not-for-profit in nature, the current census offers 257 single-patient, licensed beds from the state of Maryland within the hospital's walls. More than 500 physicians and advanced practice providers representing close to 40 specialty areas serve the population of western Maryland, southern Pennsylvania and eastern West Virginia – a tristate area. Comprehensive, quality care and service is provided at Meritus Medical Center in the following areas of health and wellness:

- Bariatric surgery
- General surgery
- Behavioral health
- Cancer - accredited with commendation by the Commission on Cancer
- Cardiovascular – Named a high-performing hospital in heart failure and chronic obstructive pulmonary disease by U.S. News & World Report and cardiac cath lab named by the American Heart Association a silver-plus recognized facility for STEMI patients
- Emergency - A level III trauma center and EMS Base Station as designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS)
- Joint replacement
- Labor and delivery
- Rehabilitation – A CARF-accredited inpatient rehabilitation unit
- Stroke care – A certified primary stroke center and the recipient of the American Heart Association/American Stroke Association's Get With The Guidelines® Stroke Gold Plus Performance Achievement Award
- Wound care and hyperbaric medicine

Meritus Medical Center received its first Magnet® Recognition in April 2019, making it the only hospital in western Maryland and the tristate region it serves, to receive professional nursing's highest honor. The hospital received two exemplary citations with the Magnet® Recognition, including one for transformational leadership to improve workplace safety and enhance security and one for exemplary care of stroke patients. A rare eight percent of hospitals nationwide earn Magnet® Recognition, with only seven hospitals in total in Maryland.

Meritus Medical Center was built as a direct link to Robinwood Professional Center, creating a campus where health care providers, outpatients, visitors and families can move easily from one service area to another. With the addition of the hospital, the one-million-square-foot combined campus represents the largest health services footprint in the state of Maryland. Meritus Medical Center is committed to caring for the community and has done so for more than a century.

Executive Steering Committee

An executive steering committee was formed as an advisory group composed of organizations and community leaders who represent the core of healthcare infrastructure in the Washington County region. These individuals provided immeasurable guidance throughout the CHNA process and are committed to continuing collaborative efforts to develop and implement community strategies to improve the health needs that were identified in the assessment.

Allen Twigg, Director Behavioral & Community Health Services, Meritus Medical Center – Chair
Douglas Brown, Clinical Coordinator Physician Assistant Program, Frostburg State University
Joelle Butler, Media and Communications Coordinator, Meritus Medical Center
Susan Delauter, Benefits & Wellness Administrator, City of Hagerstown
Diana Gaviria, MD, Medical Director, Maryland Department of Health
Michele Goldman, Executive Director, Community Free Clinic
Erin Hershey, Board Member, Meritus Medical Center Board of Directors
Susan Lopp, Administrative Director, John R. Marsh Cancer Center
Rod MacRae, Director of Health Planning & Strategic Initiatives, Washington Co. Health Department
Curt Miller, Director of Public Relations, Brook Lane Health Services
Jon Noyes, Executive Director of Strategic Planning, Meritus Medical Center
Rick Rock, President, Washington County Mental Health Authority
Guinn Rogers, President and CEO, United Way of Washington County
Brad Sell, President and CEO, Community Foundation of Washington County
Douglas Spotts, MD, Chief Population Health Officer & VP, Meritus Health, Inc.
Shelley Steiner, Director of Strategic Initiatives, Hospice of Washington County
Cynthia Terl, Community Engagement Director, Wells House, Inc.
Fred Thursfield, Executive Director, Meritus Health Foundation
Susan Walter, CEO, Tristate Community Health Center (FQHC)

A full listing of the Executive Steering Committee membership and organization information is included in **Appendix A.**

EXECUTIVE SUMMARY

The FY2019 Community Health Needs Assessment (CHNA) was conducted to identify primary health issues, status and needs and to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results will enable healthcare providers and organizations in our region to strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community.

In January 2018, in an effort to improve the health of Washington County residents and to align their process with the Maryland State Health Improvement process, the Washington County Health Improvement Coalition (WCHIC) known as "Healthy Washington County" with leadership from Meritus Medical Center and Brook Lane Health Services determined that a Community Health Needs Assessment would be completed during 2018 to 2019. The WCHIC commissioned an executive steering committee of key stakeholders to oversee the process. Representatives from Meritus Medical Center, Brook Lane Health Services, Washington County Health Department, the George W. Comstock Center, the United Way, the YMCA and other community organizations were included. The steering committee developed the goals, objectives and timeline to conduct a community health needs assessment and recommend a plan of action to address prioritized health needs.

The research and data analysis of this effort began in spring 2018. The primary service area was defined as Washington County, Maryland. The steering committee began a review of the most recent CHNA (2015/2016), the community health initiatives, and progress improvement. Next, secondary health data from national, state and local sources was reviewed. A subcommittee was then appointed to develop a community survey for the purpose of obtaining direct input regarding the health needs of people living in the primary service area. The survey consisted of thirty-three (33) questions related to health, status, and behaviors and six (6) demographic questions.

The community survey was publicized and widely distributed throughout the county, with an endorsement from Washington County Government and Washington County Public Schools. A representative sample of 1,514 people completed the survey and provided input between June 25, 2018 and September 14, 2018. Upon review of data, the steering committee coordinated three (3) public focus groups to help drill-down specific information on topics including nutrition and physical activity, mental health and substance abuse specific to men and senior's health needs. Two (2) series of focused interviews were conducted with the Meritus Medical Center health experts, specifically physicians and the care management department to help identify primary diagnoses and barriers to treatment. One (1) focus group was conducted to obtain specific information about African-American healthcare needs and one (1) series of focused interviews was conducted to learn more about the health needs of our Hispanic and Latino community members.

Analysis of all the primary data was reviewed and summarized by the steering committee, concluding on October 25, 2018. On November 20, 2018 the leadership of Healthy Washington

County met with members of the coalition, Meritus Medical Center, Brook Lane Health Services, other invited community leaders, and members of the public to review the data, findings, needs, and issues identified in the Community Health Needs Assessment process. Upon reviewing all the key data and findings, attendees participated in a prioritization exercise to weight and rank the community's health needs.

The top health needs identified for Washington County were prioritized as:

1. Substance Abuse
2. Mental Health
3. Obesity and Weight loss
4. Wellness
5. Diabetes
6. Heart Disease and Hypertension
7. Adverse Childhood Events
8. Senior Elder issues
9. Cancer
10. Nutrition and Healthy Eating
11. Transportation
12. Homelessness
13. Recreation and Exercise
14. Access to Health Care
15. Poverty
16. Teenage Pregnancy
17. Dental
18. Education
19. Affordable Health Care
20. Smoking
21. Medication
22. Child health
23. Employment
24. Crime
25. Affordable Housing
26. Vision / Hearing

The Community Health Needs Assessment provides a framework for community action, engagement, and accountability in addressing the health needs of our county's citizens. Its significance as a resource to community organizations is paramount as it prioritizes our health needs and initiatives. The steering committee developed a draft implementation plan of action

based on the identified health needs, community strengths, resources, and new initiatives. On January 8, 2019 the top health priorities were reviewed by Healthy Washington County, the identified community body responsible for the coordination of resources to help address the identified needs and to measure outcomes.

Based on the findings of the CHNA and the prioritization exercise, the Healthy Washington County submitted an outline of priority health needs and goal direction to Meritus Medical Center and Brook Lane Health Services. The respective hospitals developed an implementation strategy, outlining objectives, action steps and draft goals that will address the prioritized community health needs and identified resources to commit towards improvement. The FY2019 CHNA Action Plan was adopted by the Meritus Medical Center Board of Directors on March 28, 2019 (see **Appendix Q**). The FY2019 CHNA Action Plan was adopted by the Brook Lane Board of Directors on April 16, 2019 (see **Appendix S**).

On May 7, 2019 the Healthy Washington County formally recommended adoption of the joint implementation strategy and action plans as received from the respective hospital Boards of Directors. The hospital plans are being incorporated into a comprehensive strategy to address the top health priorities of people living in our community.

Following the approval of the Action Plans, the FY2019 CHNA report was published May 10, 2019 and was made widely available to the public as posted on the following websites:
www.brooklane.org
www.meritushealth.com
www.unitedwaywashcounty.org
www.hagerstown.org
www.washcohealth.org

Printed copies of the FY2019 CHNA are available onsite at Brook Lane Health Services, Meritus Medical Center and the Washington County Health Department. In addition, a printed copy will be made available upon request.

The top health initiatives for Healthy Washington County will include:

BEHAVIORAL HEALTH

#1 Substance Abuse

Objective: Improve substance abuse prevention, education and reduce substance abuse to protect the health, safety, and quality of life for all residents

Goal direction: Prevention, improve access to care, reduce overdose deaths

#2 Mental Health

Objective: Improve mental health through prevention and ensure access to appropriate, quality mental health services

Goal direction: Timely access to care, crisis stabilization, education, early identification, reduce stigma

WELLNESS and QUALITY OF LIFE

#4 Wellness

Objective: Improve the lives of residents by supporting wellness through the empowerment of citizens to make healthier choices

Goal direction: Promote four enablers of wellness; healthier food choices, exercise, smoking cessation and medication adherence

#3 Nutrition and Weight Status

Objective: Promote health and reduce chronic disease risk through the consumption of healthful diet and achievement and maintenance of healthy body weight

Goal direction: Reduce overweight and obesity by increasing physical activity and promote eating a healthy, balanced diet

HEALTH MANAGEMENT

#5 Diabetes

Objective: Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM

Goal direction: Education, prevention, behavior changes,

#6 Heart Disease and Hypertension

Objective: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart disease

Goal direction: Early detection, education, management blood pressure and cholesterol, changes

The top community health priorities for Meritus Medical Center implementation plan include:

1. Reduce substance abuse and overdose fatalities to protect the health, safety and quality of life for all
2. Improve mental health through prevention and by ensuring access to appropriate, quality mental health treatment
3. Promote health and reduce the risk of chronic disease by consuming a healthy diet and achieving desired body weight
4. Improve health related quality of life and well-being for persons living in the community
5. Improve the management of diabetes and reduce mortality
6. Reduce heart disease mortality and manage hypertension
7. Reduce the mortality of cancer cases and improve earlier detection and diagnosis

The top community health objectives for Brook Lane Health Services implementation plan include:

1. Lessen substance abuse to improve the health safety and welfare of all
2. Improving mental health through prevention, early intervention and education

METHODOLOGY

Community Health Needs Assessment Requirements

The Patient Protection and Affordable Care Act (ACA), enacted March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements the Internal Revenue Code 501(r) set forth by the ACA. The ACA defines a hospital organization as an organization that operates a facility required by a state to be licensed, registered, or similarly recognized as a hospital; or, a hospital organization is any other organization that the Treasury's Office of the Assistant Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under section 501(c)(3).

The steering committee reviewed and followed the requirements for the FY2019 CHNA from 26 CFR Parts 1, 53 and 602, as published by the Treasury Department ("Treasury") and the Internal Revenue Service (IRS) in the Federal Register Vol. 79 No. 250 (December 31, 2014). This CHNA report includes the following:

- The identification of all organizations and persons with which the hospitals collaborated, including their title;
- A description of the community served;
- A description of the process and methods used to conduct the CHNA, including:
    - A description of the sources and dates of the data and the other information used in the assessment; and,
    - The analytical methods used in assessing the community's health needs;
- A description of how the hospitals took into account input from persons who represented the broad interests of the community served, including those with special knowledge of or expertise in public health and any individual providing input who was a leader or representative of the community served by the hospitals;
- A description of information and service gaps that impact the ability to assess the health needs of the community served;
- A prioritized description of all of the community health needs identified through the CHNA and a description of the process and criteria used in prioritizing those needs;
- A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA; and,
- A description of the strategic plan of action developed to collaboratively address prioritized community health needs.

Community Health Needs Assessment and Planning Approach

In January 2018, the Washington County Health Improvement Coalition (WCHIC) known as Healthy Washington County announced the intention to conduct a CHNA. A full list of the 2018 WCHIC membership is included in **Appendix B**. As the local not-for-profit hospitals, Meritus Medical Center and Brook Lane Health Services worked collaboratively through the Healthy Washington County coalition to conduct the CHNA, as required of all not-for-profit hospitals in accordance with the ACA of 2010 and the final regulations published in the Federal Register by the Internal Revenue Service and the Treasury Department on December 31, 2014 (Federal Register Vol 79, No.250).

The general guidance for conducting a CHNA was obtained from Community Health Rankings and Roadmaps as diagramed in **Figure 1**.

Figure 1. Community Needs Assessment Cycle

Community Health Needs Assessment Timeline

Healthy Washington County invited community stakeholders to be involved in the Community Health Needs Assessment Steering Committee. The key dates and highlights are outlined in **Table 1**.

Table 1. FY2019 CHNA Timeline and Milestones

Date	Meeting Location	Highlights
January 9, 2018	Washington Co. Health Dept.	Announced that the local Washington Co. Health Improvement Coalition known as Healthy Washington County would conduct a CHNA during 2018 - 2019
January, 2018		Executive Steering Committee formed
February 22, 2018	Meritus Medical Center	Defined purpose and scope, CHNA requirements, reviewed SCIP and FY2016 CHNA priorities, defined service area, developed timeline, established survey and data subcommittees
April 17, 2018	Meritus Medical Center	PSA demographics, reviewed secondary data findings, primary survey plan, survey distribution strategy developed, employer survey considered
April 17 – May 31, 2018		Designed primary data collection and survey methodology
May 31, 2018	Meritus Medical Center	Reviewed findings from FY16 CHNA audit, continued review of secondary data trends, approved primary survey design, content and methodology, developed strategy for survey distribution and reaching underrepresented groups
June 25, 2018 – September 14 , 2018	Survey	1,514 survey responses collected from community
August 28, 2018	Williamsport Fire Hall	Senior health focus group conducted
September 6, 2015	The Greens at Hamilton Run	Men's health focus group conducted
September 23, 2018	Hagerstown Fairgrounds Park	Hispanic focused interviews conducted
October 2-19, 2018	Meritus Medical Center	Physician focused interviews conducted
October 9, 2018	Zion Baptist Church	African-American focus group conducted
October 29, 2018	American Red Cross	Behavioral health focus group held
October 18 – November 2, 2018	Meritus Medical Center	Care management focused interviews conducted
November 20, 2018	Robin Wood Medical Campus	Public meeting to review all data, present findings and rank health need priorities in our community
December 3, 2018 - January 14, 2019	Washington Co. Health Dept.	Healthy Washington County developed objectives and goals for a plan of action
January 8 - March 5, 2019	Meritus Medical Center and Brook Lane	Meritus Medical Center and Brook Lane Health Services developed implementation plans

March 5, 2019	Washington Co. Health Dept.	Local Health Improvement Coalition approved a draft community plan of action
March 28, 2019	Meritus Medical Center	Meritus Medical Center Board of Directors approved a final plan of action and implementation
April 16, 2019	Brook Lane Health Services	Brook Lane Board of Directors approved a final plan of action and implementation
May 7, 2019	Washington Co. Health Dept.	Healthy Washington County voted to accept the action plans from the local hospitals and approved a joint community action plan to address health needs.
May 10, 2019	Washington County	The FY2019 Community Health Needs Assessment was published and made widely available to the public.

Data Collection

To collect the most relevant information to assess the health needs of our community, the steering committee used qualitative and quantitative methods for data collection and analysis. Qualitative methods asked exploratory questions used in conducting interviews and focus groups. Quantitative data is information that can be displayed numerically. Both primary and secondary data sources were collected during the process.

The steering committee determined that the data collected would be defined by hypothesized needs within the following general categories:

- Environment
- Access to Quality Health Care
- Healthy Lifestyle
- Chronic Disease
- Mental Health
- Substance Abuse
- Healthy Children
- Tobacco Use

The CHNA process included participation and input from key leadership at the Washington County Health Department. As members of the community who have specific knowledge of local health needs and trends, health department leadership were included as members of the steering committee; specifically, the Washington County Health Officer, and the Director of Health Planning & Strategic Initiatives/Public Information Officer.

Secondary Data

Collection and review of secondary data began in February, 2018, and continued through May, 2018. As information was obtained it was reviewed, summarized and analyzed by the steering committee. Principal secondary data sources included use of the Maryland Department of Health (MDOH), State Health Improvement Plan (SHIP) data and resources, the Centers for Disease Control (CDC) data, and Maryland Vital Statistics. The secondary data collection process focused on information specific to Washington County when available. Secondary data includes geographic, population, socio-economic, disease prevalence, health status, and environmental factors:

- Demographic and socioeconomic data obtained from the US Census Bureau (www.census.gov)
- Disease and Mental Health incidence and prevalence data obtained from the Maryland Department of Health and Maryland Vital Statistics Administration (http://health.maryland.gov)

- The Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov) conducts an extensive Behavioral Risk Factor Surveillance Survey (BRFSS) each year. The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The health related indicators included in this report include BRFSS data collected by the CDC http://www.cdc.gov/brfss/
- The health related indicators included in this report for Maryland in 2018 are BRFSS data and benchmarks coordinated by the Maryland Department of Health as part of the State's Health Improvement Plan (SHIP) (see **Appendix C**) http://ship.md.networkofcare.org/ph/index.aspx
- In 1979, the Surgeon General began a program to set goals for a healthier nation. Since then, Healthy People have set 10 year science-based objectives for the purpose of moving the nation toward better health. When applicable, the available Healthy People 2020 goals are included in this report as related to Washington County health needs http://www.healthypeople.gov/2020/default.aspx
- Selected inpatient and outpatient utilization data on primary care sensitive conditions that were identified as ambulatory care sensitive conditions and indicators of appropriate access to health care were obtained from the Meritus Medical Center and Brook Lane Health services quality data
- The National Institute on Drug Abuse (NIDA) http://www.drugabuse.gov
- The Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/
- Maryland Department of Planning Washington County Projection (see **Appendix D**)
- Meritus John R. Marsh Cancer Registry 2006-2017
- Meritus Medical Center 2016 Physician Needs Assessment
- Maryland Health Connection https://www.marylandhealthconnection.gov/
- The Healthy Washington County FY2013 and FY2016 Community Health Needs Assessments
- 2018 County Health Rankings, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org
- 2016 Maryland Youth Risk Behavior Survey / Youth Tobacco Survey for Middle and High School students
- The 2017 ALICE report from the United Way of Washington County, Maryland http://www.unitedwaywashcounty.org/alice-project
- Community Opportunity Map from the Casey Family Programs http://caimaps.info/caseyfamily/Home?county=Washington&state=Maryland

The steering committee reviewed and summarized the existing secondary data, highlighting the key health drivers, conditions with significant variance from benchmarks and averages, and health disparities.

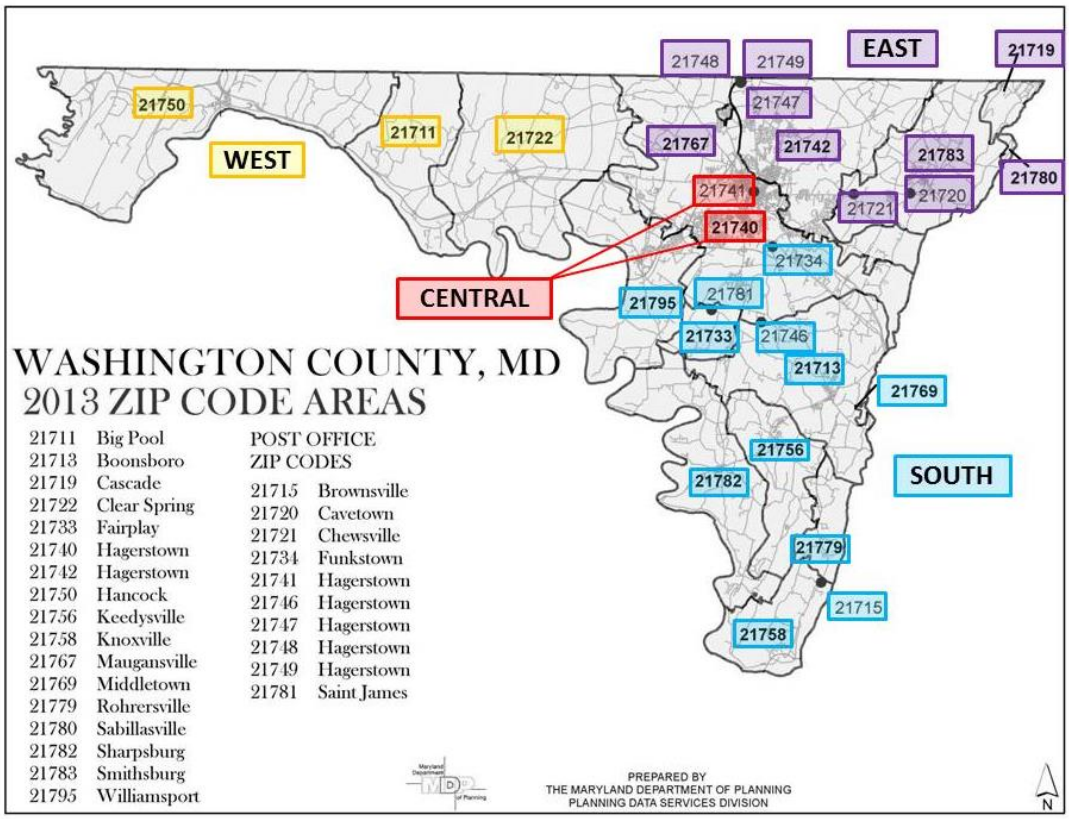
Primary Data

The primary data collection process included the development of a health needs survey that was designed, approved, and distributed by the steering committee throughout the community. The survey questions were developed based on the Behavioral Risk Factor Surveillance Survey (BRFSS) questions asked in the most recent Healthy Washington County FY2016 CHNA Survey, and were similar or identical to questions used in national and state Behavioral Risk Factor Surveillance System Surveys (BRFSS). That allowed comparison of our results with data from the most recent BRFSS surveillance information as collected by the Maryland Department of Health and Centers for Disease Control. In addition, feedback from the membership of the local health improvement coalition was considered in the development of questions designed to obtain more detailed explanations of barriers that prevent people from accessing health care services; finances, transportation, hours of operation, social needs, limitations, etc.

The community survey was written in English (see **Appendix E**) and translated to Spanish (see **Appendix F**) and was distributed both electronically via email and websites as well as via written copies. The survey period was open from June 25, 2018 – September 14, 2018.

To help ensure that the true needs of the county were analyzed and understood, the steering committee hypothesized that the geography and the demographics of the county suggested that socio-demographic and health status differences may exist in different sub-regions of the county. As a result of this discussion, Washington County was divided into four quadrants with the plan to sample an equal representation of the population living in each area. This information is most useful in understanding where needs are greatest and gaps in service or disparities might exist. The four regional quadrants are represented in **Figure 2**.

Figure 2. Survey Sub-region by Zip Code



Survey Results

A representative sample of 1,514 Washington County adults responded and completed the survey questionnaire. The final data yields a margin of error of +/-3% in the response answers. The survey process was designed to obtain a sample that mirrored the census population, racial/ethnic and socio-demographic components. This was accomplished by coordinating the promotion of the survey county-wide by the health systems and providers, government, school system, social service organizations and the local chamber of commerce.

Focus Groups and Interviews

To help ensure that key persons with unique knowledge of community needs and health topics were included in the study, a series of targeted focus groups were scheduled, promoted, and conducted in locations that would accommodate under-represented populations and reach community stakeholders.

A series of four community focus groups were conducted to obtain more specific information from persons having expertise, knowledge or interest in the following topics:

- Nutrition and physical activity
- Mental health and substance abuse
- Seniors health issues
- Men's health issues

Two focus groups regarding access to health care were conducted with Meritus Medical Center Care Management employees and focused interviews were conducted with practicing physicians. Based on direct care experience, these health care providers shared their unique insights regarding care delivery and the barriers that patients encounter in the procurement of health services in our service area.

Multiple focused interviews were conducted at the Zion Baptist Church and during the Hispanic Festival to learn more about the unique needs of our Black and Hispanic / Latino populations and how to best engage with these growing community populations.

COMMUNITY ASSESSMENT

Service Area Definition

At the time that this Community Health Needs Assessment process was conducted, more than 78% of Meritus Medical Center discharges and 60% of Brook Lane Health Services patients resided in a zip code within Washington County, Maryland. While both organizations provide services to people living throughout a 60 mile radius of the quad-state region, the geographic boundaries of Washington County was designated as the Primary Service Area (PSA) for the purposes of the CHNA. Washington County residents served by these health systems make up a representative cross section of the county's population including those considered ''medically underserved'' as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

The majority of patients served by our health systems live in Washington County, MD, which includes the following zip codes outlined in **Table 2**:

Table 2. Washington County, MD Zip Codes

21711	Big Pool	21782	Sharpsburg
21713	Boonsboro	21783	Smithsburg
21719	Cascade	21795	Williamsport
21722	Clear Spring	**Post Office Zip Codes**	
21733	Fairplay	21715	Brownsville
21740	Hagerstown	21720	Cavetown
21742	Hagerstown	21721	Chewsville
21750	Hancock	21734	Funkstown
21756	Keedysville	21741	Hagerstown
21758	Knoxville	21746	Hagerstown
21767	Maugansville	21747	Hagerstown
21769	Middletown	21748	Hagerstown
21779	Rohrersville	21749	Hagerstown
21780	Sabillasville	21781	Jamestown

Demographics of the Community We Serve

In 2018, the population of Washington County was estimated to be 150,578. The overall population of Washington County is growing at a slower rate than Maryland overall. The growth rate has remained positive, expanding by an estimated 2.1% since the last U.S. Census in 2010.

Washington County has less population density (322.1 persons per square mile) compared to the state (594.8). The county's residents are somewhat older and have a smaller proportion of the population under age 18 at 22.1% as compared with the state. More than 16% of the population is age 65 or older. The median age of persons in Washington County is 40.6 years old. Washington County remains less diverse than the state of Maryland. The majority of the population of Washington County is white (83.5%), representing a much higher percentage of the population compared with the state of Maryland. Other race and Hispanic origins include Black or African American (11.4%), Hispanic (4.7%), Asian (1.9%) and American Indian (0.3%).

The education level of Washington County residents continues to increase, but a slightly smaller percentage of the population are high school or college graduates (86.9%) compared with the state average (89.6%). The average travel time to work (at 29.2 minutes) is comparable with the rest of the state (32.4). Households in Washington County consist of an average 2.51 persons per household, similar to the state, 2.67. Housing is more affordable in Washington County with a median value of owner-occupied housing units averaging $198,900 compared to the state average of $290,400. The median household income of $56,316 rose less than 1% from 2015 and remains less than the state average, $76,067. A higher percentage of persons live in poverty in Washington County (13.2%) than the state average (9.7%).

Table 3. Annual Employment Rates for Washington County, Maryland 2010 - 2016
Employment History Chart

Employment*	2016	2015	2014	2013	2012	2011	2010
Civilian Labor Force	76,591	76,022	69,318	70,780	69,065	69,463	69,567
Employment	72,588	71,045	64,500	65,704	63,152	62,668	62,017
Unemployment	4,003	4,444	4,839	5,263	5,914	6,795	7,550
Unemployment Rate	5.2%	5.8%	7.0%	7.4%	8.6%	9.8%	10.9%

*Annual averages. Data are not seasonally adjusted. Figures represent the number of county residents employed, including those working outside of the community.
SOURCE: http://hagerstownedc.org/agricultural-marketing/facts-figures (accessed 04/03/2018)

The local economy carried a higher rate of unemployment and generally lagged in the recovery until 2011 when the percentage change in private nonfarm employment increased 3.9% at a rate higher than the rest of Maryland. For years 2010 – 2016 the rate of unemployment continued to be slightly higher than the state of Maryland. The number of minority-owned

firms doubled (12.6%) and women owned firms increased by 10% (36%) as compared to three years ago. Retail sales per capita at $16,474 remains higher than the state average of $12,980.

Demographics Tables

Unless otherwise noted, the source for all data references is the Annual Estimates of the Resident Population: April 1, 2010, to July 1, 2017, from the U.S. Census Bureau, Population Division.

The population of Washington County is growing at a slower rate than that of Maryland overall, although the estimated population growth is positive as demonstrated in **Table 4.** The county percentage of adults over age 65 is higher than the state while the population under age 18 is comparable.

Table 4. Population Statistics

	Washington County	Maryland
Population, 2018 estimate	150,578	6,042,718
Population, 2010 (April 1) estimates base	147,430	5,773,798
Population, percent change - April 1, 2010 to July 1, 2018	2.1%	4.7%
Population, 2010	147,430	5,773,552

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018 Source: U.S. Census Bureau, Population Division

The population of Washington County at various age subgroup thresholds is illustrated in **Table 5.** The current median age of persons in Washington County is 41, slightly older than the U.S. median age of 37.7 years. Our community is growing older with a projected 25% increase in persons age 65 and older between 2015 to 2025 (see **Appendix D**).

Table 5. Age and Sex

	Washington County	Maryland
Persons under 5 years, percent	5.8%	6.1%
Persons under 18 years, percent	22.1%	22.3%
Persons 65 years and older, percent	16.8%	14.9%
Female persons, percent	49.1%	51.5%

Sources: U.S. Census Bureau, Population Estimates Program (PEP). Updated annually, 2018

Table 6 illustrates that Washington County continues to be much less racially diverse than the state of Maryland. The majority of the population of Washington County is white at 83.5% which is 24% higher than seen in the state of Maryland. However, there is a continued increase in racial and ethnic diversity with the total percentage of white persons having decreased, while those identified as black or Hispanic origin living in Washington County has increased overall since 2010.

Table 6. Race and Ethnicity

	Washington County	Maryland
White persons, percent, 2017	83.5%	59%
Black persons, percent, 2017	11.4%	30.8%
American Indian and Alaska Native persons, percent, 2017	0.3%	0.6%
Asian persons, percent, 2017	1.9%	6.7%
Native Hawaiian and Other Pacific Islander persons, percent, 2017	0.1%	0.1%
Persons reporting two or more races, percent, 2017	2.8%	2.8%
Hispanic or Latino, percent, 2017	4.7%	10.1%
White persons not Hispanic, percent, 2016	79.8%	50.9%

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017 Source: U.S. Census Bureau, Population Division

Table 7 represents residency, income and education. There has been a 0.3% increase in languages other than English being spoken at home. High School graduate rates have gained 1% and are now only slightly lower than the Maryland average. Washington County continues to have significantly fewer bachelor's degree college graduates at 21.5% compared to the rest of the state, 38.4% with a 0.5% increase over the past three years. Average travel time to work is comparable with the state average.

Table 7. Residency and Education

	Washington County	Maryland
Living in same house 1 year & over, percent, 2009-2013	85.7%	86.3%
Language other than English spoken at home, percentage age 5+, 2012-2016	7.2%	18%
High school graduate or higher, percent of persons age 25+, 2012-2016	87%	89.8%
Bachelor's degree or higher, percent of persons age 25+, 2012-2016	21.5%	39%

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017 Source: U.S. Census Bureau, Population Division

Table 8 outlines that the households in Washington County are slightly smaller compared with the state, and the median household income is much less in Washington County than the state average as is the per capita money income. A higher percentage of persons live in poverty in Washington County at 13.2% compared with the state, 9.7%.

Table 8. Housing

	Washington County	Maryland
Households 2013 – 2017	55,999	2,181,093
Owner-occupied housing unit rate, 2013-2017	64.5%	66.8%
Median value of owner-occupied housing units, 2013-2017	$205,300	$296,500
Median selected owner costs with a mortgage, 2013 – 2017	$1,513	$1,954
Median gross rent, 2013 – 2017	$889	$1,311
Persons per household, 2013-2017	2.51	2.68
Median household income, 2012-2016	$56,316	$78,916
Persons in poverty, percent, 2009-2013	13.7%	9.3%

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017 Source: U.S. Census Bureau, Population Division

As outlined in **Table 9**, the economy of Washington County has continued to steadily improve each year since 2012.

Table 9. Business Quick Facts

	Washington County	Maryland
Total employment, 2016	60,322	2,282,725
Total annual payroll, 2016 ($1,000)	2,296,451	121,952,023
Non-employer establishments, 2016	8,625	487,540
Total number of firms, 2012	10,639	531,953
Men-owned firms, 2012	5,409 50.8%	276,630 52%
Women-owned firms, percent, 2012	3,830 35.9%	209,119 39.3%
Minority-owned firms, percent, 2012	1,342 12.6%	203,394 38.2%

Source: U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners

Table 10 indicates that Washington County is has less population density compared to the state.

Table 10. Geography Quick Facts

	Washington County	Maryland
Land area in square miles, 2010	457.78	9,707.24
Persons per square mile, 2010	322.1	594.8

Source: U.S. Census Bureau: State and County QuickFacts

Poverty is identified as the most important determinant of health worldwide according to James Plumb, MD, MPH of Thomas Jefferson University[1]. Most recent poverty data was based on 2016 – 2017 statistics and is summarized in **Table 11.** Families living in Washington County at or below the poverty level are 12.9% compared to 9.9% of families living in the state of Maryland. National estimates of families living in poverty in the U.S. are 11.7%. The Maryland Alliance for the Poor has documented a 38.7% increase in the rate of poverty in Washington County between 1990 – 2016.[2] More than forty percent (41%) of all area households do not have a sufficient income to cover the monthly costs of living[3] (see **ALICE Project**, page 104).

Table 11. Income and Poverty

		Washington County	Maryland
Median household income	2013 – 2017	$58,260	$78,916
Per capita income in past 12 months	2013 – 2017	$28,742	$39,073
Below poverty, $24,300 family of four	2012 – 2016	12.9%	9.9%
Below 200% of poverty $48,600 family of four	2012 – 2016	29.7%	23.0%
Incomes below 50% of poverty line	2012 – 2016	46.0%	47.9%

Source: Census Bureau, American Community Survey 5-Year Estimates 2012-2016 and 2013 - 2017

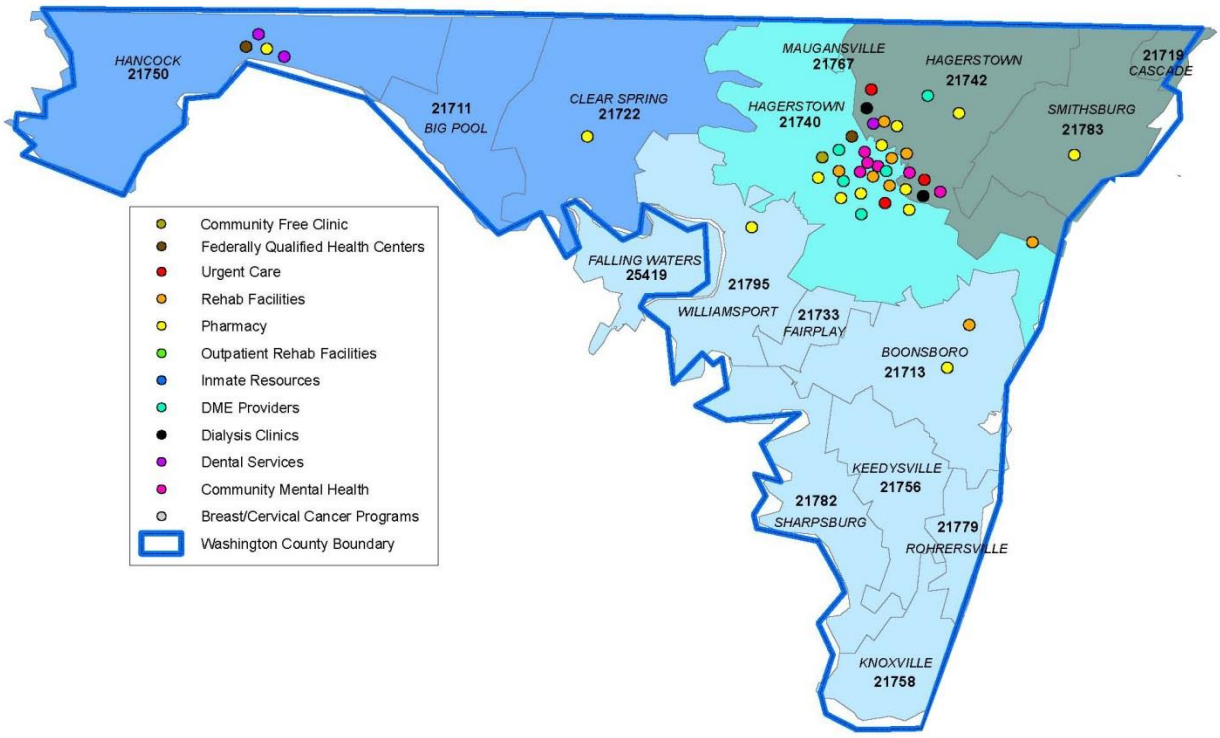
[1] http://jdc.jefferson.edu/phlink/vol3/iss5/1
[2] http://mapadvocacy.org/wp-content/uploads/2019/01/Maryland-Poverty-Profiles_2018_10-5-2018.pdf
[3] http://www.unitedwaywashcounty.org/alice-project

Community Asset Inventory

In order to outline the existing health care facilities and resources within the community that are available to respond to the health needs of the community, the Washington County Health Coalition completed an inventory of community assets and resources in and around Washington County, MD.

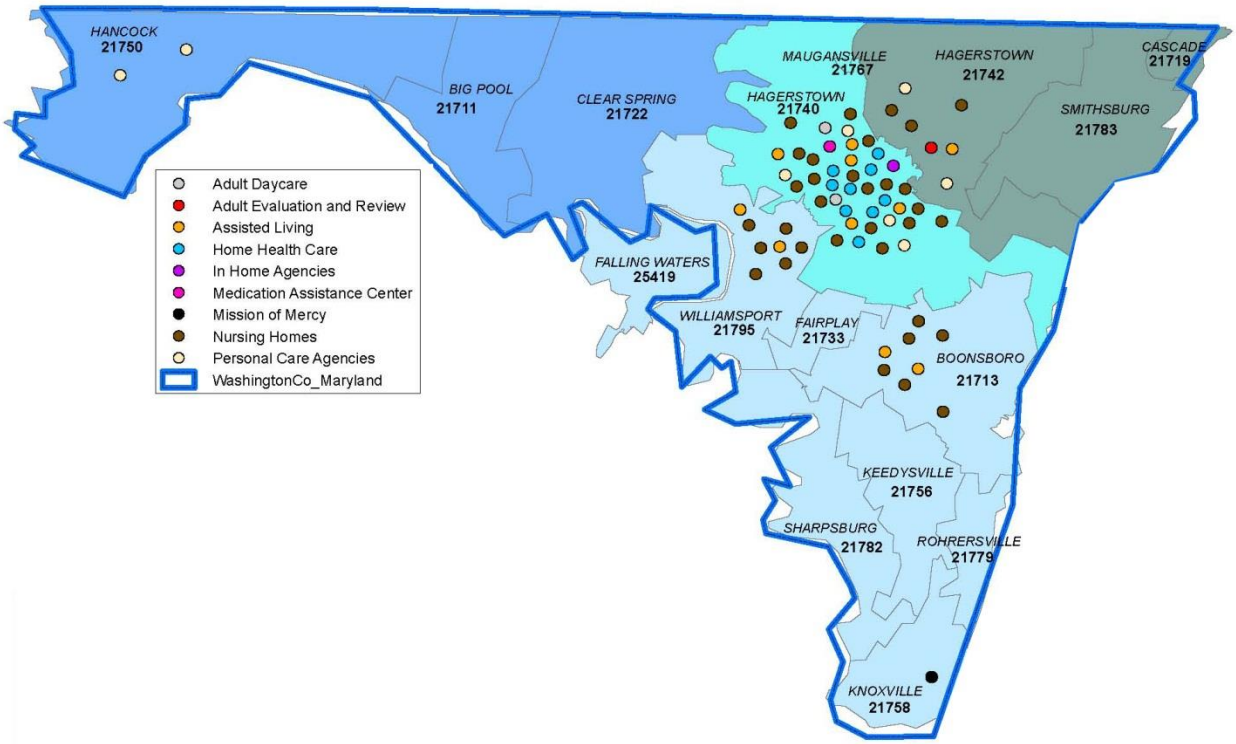
Community resources are categorized into two major areas: Medical Care Services and Senior Services. Medical Services includes, but are not limited to, Urgent Care facilities, Cancer treatment programs, Dental Services, Dialysis Centers, Durable Medical Equipment (DME) providers, Pharmacies, Outpatient Rehab Centers, Rehab Facilities, and Community Mental Health providers. The geographic locations of the Medical Service assets by category are illustrated in **Figure 3.**

Figure 3. Washington County Community Assets: Medical Services



Senior Services include, but are not limited to, Adult Day Care, Assisted Living facilities, Commission on Aging, Evaluation and Review services, Home Health services, Hospice, In-Home Support services, Ambulance, Nursing Facilities, Personal Care Homes, and Medication Assistance. The geographic locations of the Senior Service assets are illustrated in **Figure 4**.

Figure 4. Washington County Community Assets: Senior Services



Asset Inventory

A comprehensive listing of Washington County community health assets and resources are included in **Appendix G.**

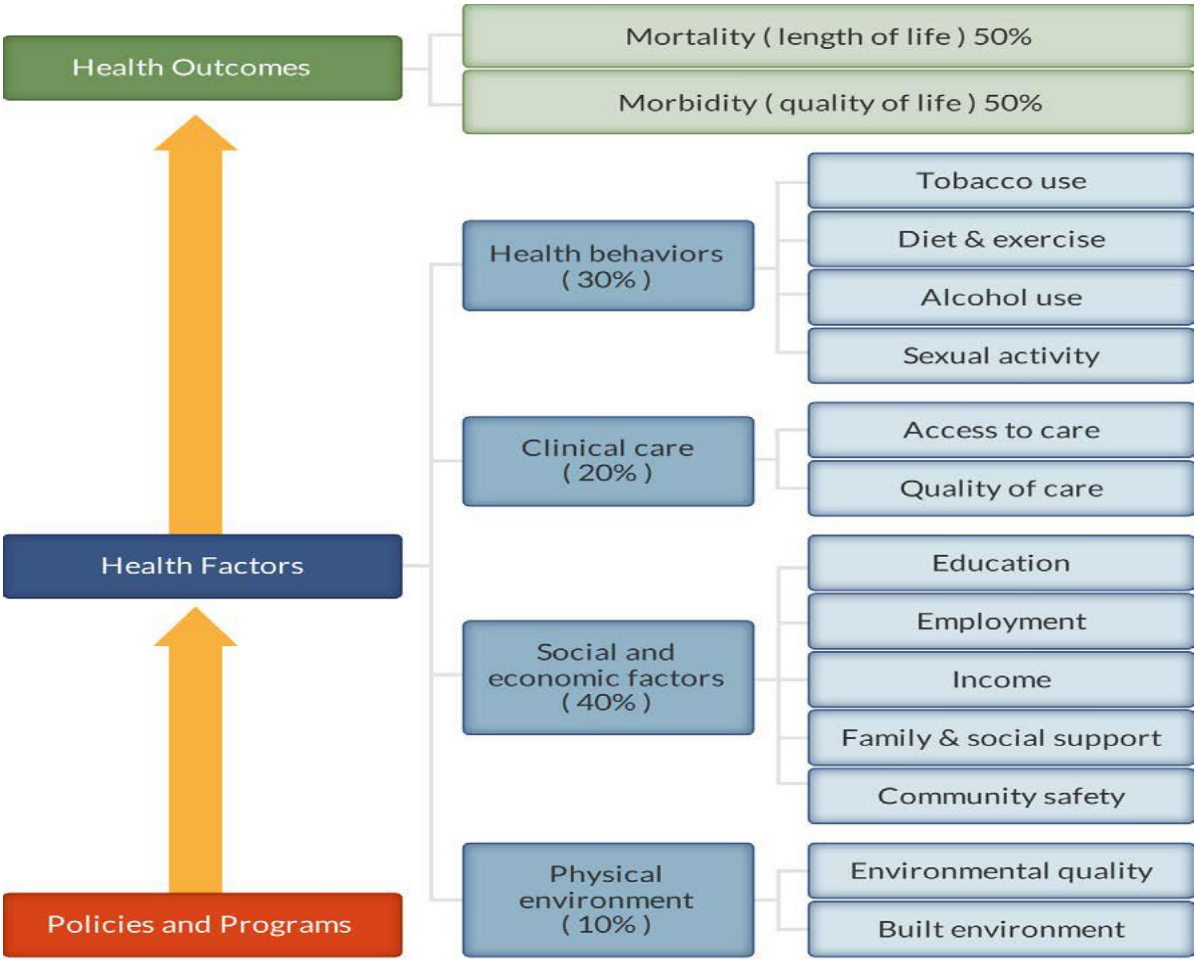
Health Services Gaps

- Timely access to substance abuse treatment when a person desires help; specifically the lack of detoxification, inpatient treatment levels of care, and medication assisted treatment
- Availability of diet and nutrition consultation believed to be lacking due to poor reimbursement by health insurance
- Timely access to outpatient psychiatry services and lack of mental health crisis beds
- Adequate transportation to all medical services that can reach all parts of the county

County Health Rankings

The County Health Rankings & Roadmaps program is based on collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings is based on a model of population health (see **Figure 5**) that emphasizes the many factors that can help make communities healthier places to live, learn, work and play.

Figure 5. County Health Rankings model



County Health Rankings model ©2012 UWPHI

The County Health Rankings measure the health of nearly all counties in the nation and rank them within states. The Rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights to provide a good snapshot of how health is influenced by where we live, learn and work. The standings also provide an excellent overview of a community's health status and were used as a starting point for the FY2019 CHNA assessment.

The overall ranking for Washington County was 18th out of 24 among counties in the state of Maryland (see **Table 12**).

Table 12. County Health Rankings Maryland 2012 vs. 2018

Rank	Health Outcomes			Rank	Health Factors		
	2012	2018			2012	2018	
1	Howard	Montgomery		1	Howard	Howard	
2	Montgomery	Howard		2	Montgomery	Montgomery	
3	Queen Anne's	Carroll		3	Frederick	Carroll	
4	Frederick	Calvert		4	Talbot	Frederick	
5	Carroll	Frederick		5	Carroll	Calvert	
6	Calvert	St. Mary's		6	Calvert	Queen Anne's	
7	St Mary's	Anne Arrundel		7	Anne Arundel	Talbot	
8	Talbot	Harford		8	Harford	Harford	
9	Harford	Queen Anne's		9	Queen Anne's	Anne Arrundel	
10	Anne Arrundel	Talbot		10	Baltimore	St Mary's	
11	Charles	Charles		11	Charles	Baltimore	
12	**Washington**	Worcester		12	St Mary's	Charles	
13	Baltimore	Baltimore		13	Kent	Kent	
14	Worcester	Prince George's		14	Garrett	Garrett	
15	Prince George's	Garrett		15	Worcester	Worcester	
16	Garrett	Kent		16	**Washington**	Prince George's	
17	Kent	Cecil		17	Prince George's	**Washington**	**-1**
18	Cecil	**Washington**	**-6**	18	Allegany	Allegany	
19	Wicomico	Wicomico		19	Wicomico	Wicomico	
20	Caroline	Allegany		20	Cecil	Cecil	
21	Somerset	Dorchester		21	Caroline	Caroline	
22	Dorchester	Caroline		22	Dorchester	Dorchester	
23	Allegany	Somerset		23	Somerset	Somerset	
24	Baltimore City	Baltimore City		24	Baltimore City	Baltimore City	

Source: Robert Wood Johnson Foundation County Health Rankings 2018

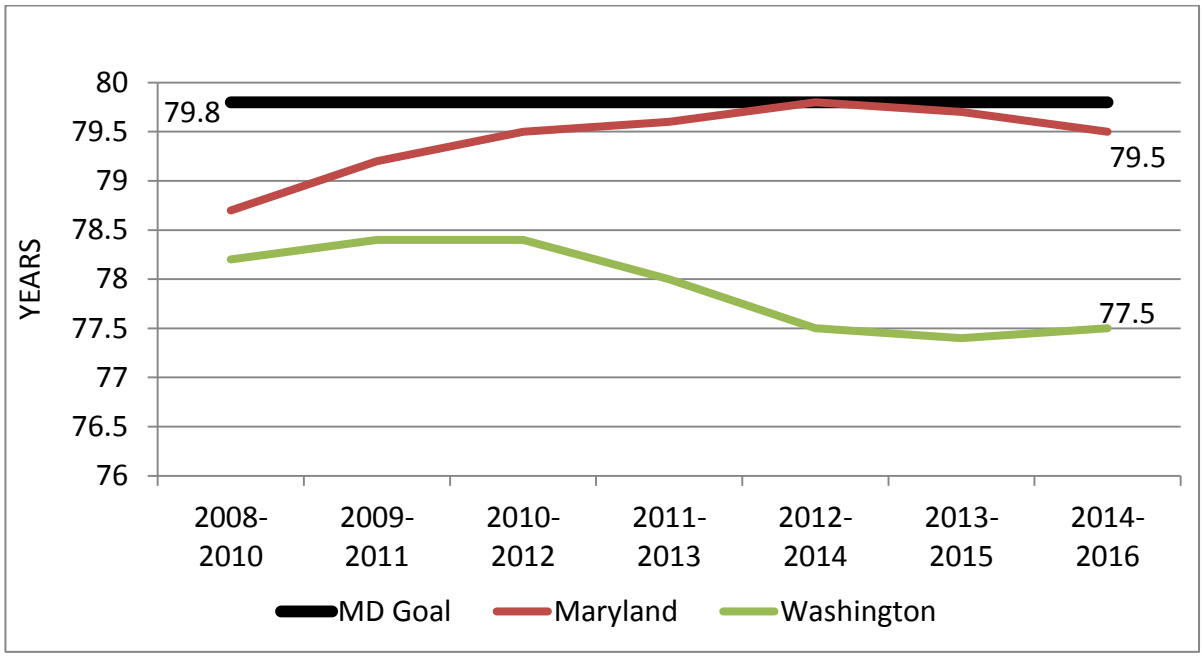
When comparing 2012 to 2018 standings, the greatest contributing factor was Washington County dropping six ranked positions due to a decline in Health Outcomes. Health Outcomes includes the length of life (premature death) and the quality of life (poor or fair health, poor physical health, poor mental health and low birth weight).

The Health Factors ranking for Washington County declined one place from 16th in 2012 to 17th in 2018. Health Factors are attributed to clinical care 20%, health behaviors 10%, social, and economic determinants 30% and the physical environment 10%. Improving Washington County trends include rates of uninsured are lower, better diabetic monitoring and management, lower rates of violent crime and air pollution. Declining trends include adult obesity rates, sexually transmitted infections, lower rates of mammography screening and children living in poverty.

The full 2018 County Health Rankings report for Washington County is included in **Appendix H.**

Previously, life expectancy along with infant mortality and causes of death were seen as a sufficient basis for assessment of population health status.[4] While the quality of life has gained increased importance, overall life expectancy remains an important general indicator. A decreased trend is observed for Washington County beginning in 2010-2012 and the state of Maryland in 2012 – 2014 (see **Figure 6**). The overall decline is explained by an increase in drug overdose fatalities among younger people. In addition, Washington County has a higher age-adjusted rate of suicide per 100,000 persons. The lower trend seen in Washington County is consistent with the national trend, attributed to increased rates of overdose deaths and suicide.[5] The years of potential life lost in Washington County is calculated as 8,100 years with an 11% higher rate of disparity noted among Blacks (9,100 years).[6]

Figure 6. Life Expectancy in Maryland and Washington County



Source: Maryland State Health Improvement Process (SHIP) Healthy Living Data, 2008 - 2016

[4] World Health Organization, *Health Expectancy Indicators*, http://www.who.int/bulletin/archives/77(2)181.pdf (Aug. 9, 2015)
[5] Centers for Disease Control and Prevention, *CDC Director's Media Statement on U.S. Life Expectancy,* https://www.cdc.gov/media/releases/2018/s1129-US-life-expectancy.html (Jan. 11, 2019)
[6] County Health Rankings and Roadmaps, http://www.countyhealthrankings.org/app/maryland/2018/rankings/washington/county/outcomes/overall/snapshot (Jan.24, 2019)

Community Survey

The primary data collection process included the development of a health needs survey that was designed, approved and distributed by the steering committee throughout the community.

The survey was comprised of 30 health needs questions and 6 demographic queries. The health related questions were developed based on questions previously asked in the Healthy Washington County (HWC) FY2016 CHNA Survey that were originally similar or identical to questions used in national and state Behavioral Risk Factor Surveillance System Surveys (BRFSS). The survey responses were compared to those collected by the most recent Maryland Department of Health (MDOH) and Centers for Disease Control and Prevention's (CDC) national BRFSS data. This primary data collection helped to establish benchmarks, variance, comparison with state and national goals when applicable, and, most importantly, unmet needs.

In addition, feedback from the membership of the Healthy Washington County Local Health Improvement Coalition was considered in the development of the questions that were designed to obtain more detailed explanations of barriers preventing people from accessing timely health care services: finances, transportation, hours of operation, social needs, limitations, etc.

The survey was written in English (see **Appendix E**) and translated to Spanish (see **Appendix F**) and was distributed both electronically via email and websites as well as via written copies.

The survey was opened from June 25, 2018 – September 14, 2018. Private, public, and government organizations worked together to widely publicize and distribute the survey throughout our community. A talking points memo that helped explain the purpose and use of the survey was provided at the points of distribution (see **Appendix I**). The complete survey results and comments are included for reference in **Appendix J.**

The following organizations mailed a survey web-link to their email address lists:

- Healthy Washington County
- Commission on Aging
- Society for Human Resource Management (SHRM) local chapter
- Hagerstown Area Religious Council (HARC)
- Herald-Mail Media
- Washington County Public Schools

In addition, organizations also posted a link to the CHNA survey and promoted participation on their public websites as detailed in **Table 13**.

Table 13. Online Promotion CHNA survey

Organization	Website
Brook Lane Health Services	www.brooklane.org
Community Action Council	www.wccac.org
Community Free Clinic	www.cfcwc-md.org
YMCA Hagerstown	www.ymcahagerstown.org
Washington County Chamber of Commerce	www.hagerstown.org
Healthy Washington County	www.healthywashingtoncounty.com
Meritus Medical Center	www.meritushealth.com
Herald Mail newspaper article	Meritus Health seeking input for community health-needs assessment - Herald Mail Media: Local ...

A printed, paper version of the survey was distributed and made available at the following locations:

- Meritus Medical Center
- Community Free Clinic
- H.E.A.L. / Hagerstown YMCA
- Washington County Health Department
- A.H.E.C. West
- Western Maryland Health Connection
- Family Healthcare of Hagerstown
- Washington County Chamber of Commerce
- Department of Social Services
- Washington County Commission on Aging
- Johns Hopkins University School of Public Health Comstock Center
- Tri-State Community Health Center
- Wells House

The survey was officially closed September 14, 2018 and no additional responses were accepted after that date.

To help ensure that the true needs of the county were analyzed and understood, the steering committee hypothesized that the geography and the demographics of the county suggested that socio-demographic and health status differences may exist in different sub-regions of the

county. As a result of this discussion, Washington County was divided into four quadrants with the plan to sample an equal representation of the population living in each area.

This info is most useful in better understanding where needs are greatest and gaps in service or disparities might exist. The four regional quadrants are represented in **Figure 7.**

Figure 7. Washington County Sub-regions

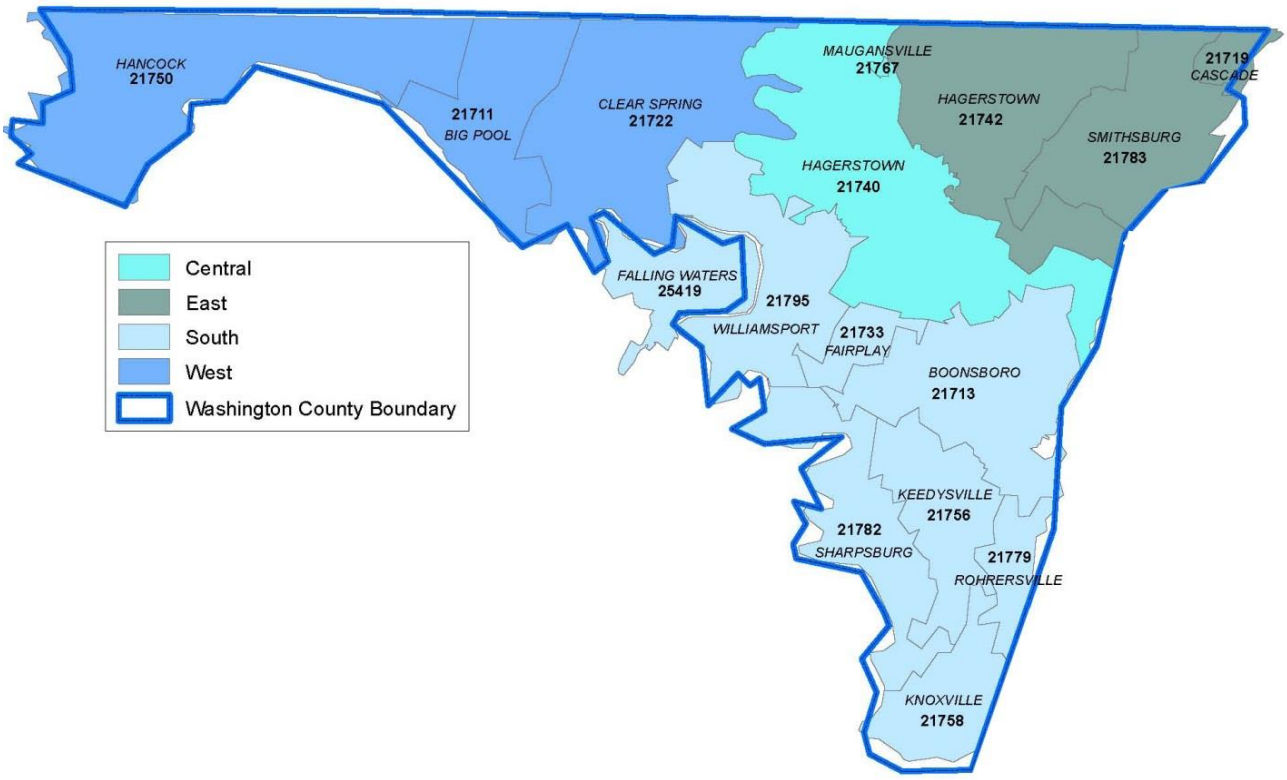


Table 14 outlines the population and changes by zip code for each of the four sub-regions that were surveyed. Most areas demonstrated modest increases in total population with the exception of Hancock and Smithsburg which showed small declines.

Table 14. Sub-regions by Zip Code

Sub-region and Zip Code	City	2000 Pop	2010 Pop	Net change	Percentage of County Population
West		**10,228**	**10,340**	**+1%**	**6.9%**
21750	Hancock	4,017	3,766	-6.2%	
21711	Big Pool	1,012	1,029		
21722	Clear Spring	5,199	5,545		
South		**28,507**	**33,511**	**+14.9%**	**22.3%**
21795	Williamsport	8,250	9,233		
21733	Fairplay	1,008	1,163		
21713	Boonsboro	8,033	9,502		
21782	Sharpsburg	3,791	4,097		
21756	Keedysville	2,704	3,612		
21779	Rohrersville	819	983		
21758	Knoxville	3,902	4,921		
East		**37,246**	**44,738**	**+16.7%**	**29.7%**
21767	Maugansville	576	991		
21742	Hagerstown	24,093	31,444		
21783	Smithsburg	9,423	9,130	-3.1%	
21719	Cascade	1,536	1,548		
21780	Sabillasville	1,618	1,625		
Central/City		**56,776**	**61,859**	**+8.2%**	**41.1%**
21740	Hagerstown	56,776	61,859		
Total			**150,448**		

Survey Results

A representative sample of 1,514 adults responded and completed the survey questionnaire. It is acknowledged that there is always statistical error associated with the act of collecting data from a sample of the population and assuming that the sample truly represents the population. A confidence interval was calculated from the population sample.[7]

Based on the adult population of ~116,264 in the primary service region with a limit of 99% certainty, the survey sample response of 1,514 provides a +/- 3.2% margin of error. The result tells us that we are confident that the true population response lies within 3.2 percentage points above or below the sampled response. Survey data responses are presented throughout the CHNA report when the data has relevance to specific health issues.

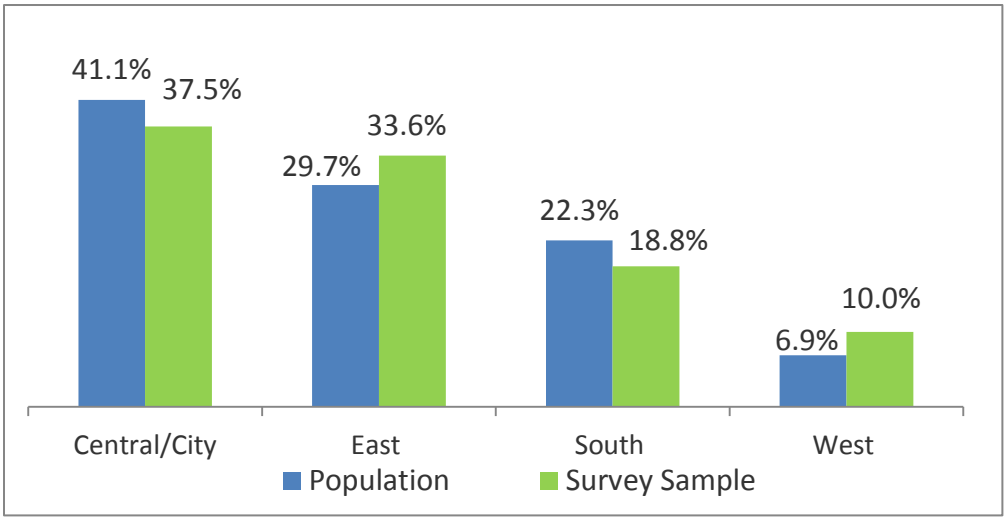
Whenever possible, answers and data from the current CHNA process were compared to the results of the survey conducted three years ago. The sample size of the 2018 survey was slightly larger (1,514) than prior surveys in 2015 (1,472) and 2012 (819). Survey responses were obtained from adult participants who represent all four quadrants of the service area. An intentional effort was made to ensure that a representative sample of all persons living in the county was provided the opportunity to be surveyed and have input in identifying our community's health needs. Current survey results are considered to have external validity and generalizability to the population at large. All data displayed in the **Figures** that follow was sourced directly from survey results unless otherwise noted.

> ***"Washington County has so much to offer!***
>
> ***It's a great place to live!"***
>
> Focus group participant

[7] http://www.surveysystem.com/sscalc.htm

The response rates were proportionally similar to the census population found in each of the four geographic locations as seen in **Figure 8**.

Figure 8. Geographic Census Population vs. Survey Sample (Question 1. What is your zip code?)



More women than men completed the survey at the rate of greater than 3:1 (**Figure 9**). This rate was slightly more representative than the FY2016 survey when the ratio was disproportionately skewed towards being completed by women, 82% to 18% men.

Figure 9. Q. 35. What is your gender?

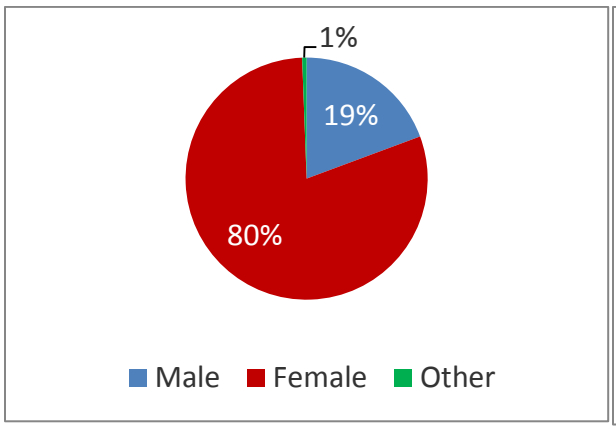
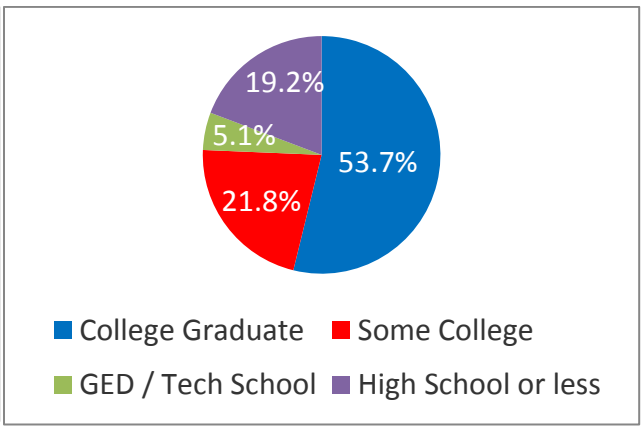


Figure 10. Q 37. What is your highest level of education?



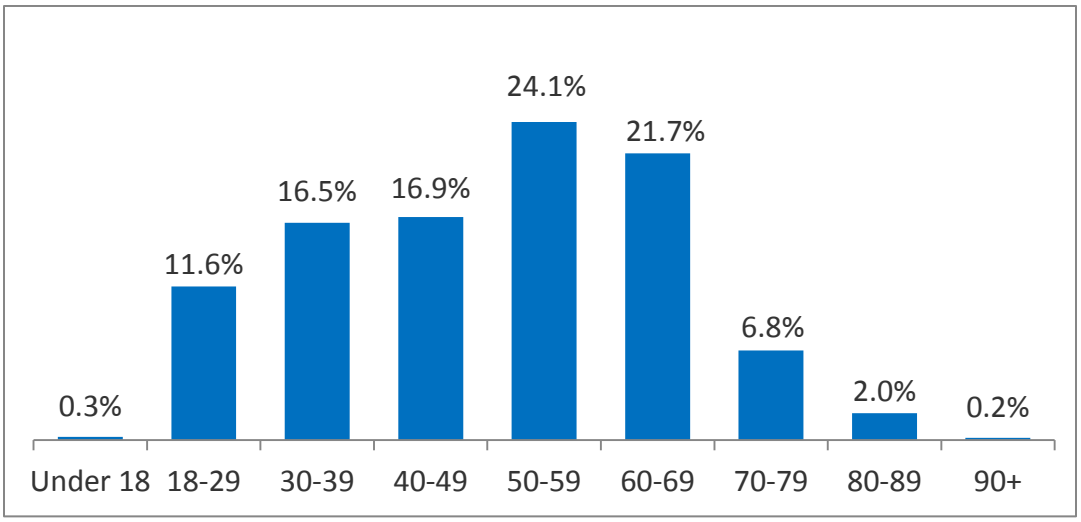
The majority of participants in the 2015 survey were college graduates (55.5%) seen in **Figure 10**. The college completion rate among adults taking the 2015 survey is higher than the rate of colleges graduates found in the general population (19.5%). College graduates also represent a higher rate than those who responded three years ago (29.8%).

We acknowledge that a greater percentage of women and college graduates represent the greatest opportunity for bias to have occurred in the survey response data. However, women

in the United States make approximately 80% of the health care decisions for their families.[8] The answers provided by participants were for the most part consistent with health status findings in the secondary data.

It was determined that the largest response came from persons ages 40 – 49 (27.9%), consistent with the mean age of 41 for Washington County adults. A majority of respondents were over the age of 40 (74.2%), similar to adult age demographics. The total responses by age group results form a bell-shaped distribution that closely mirrors the Washington County population census data seen in **Figure 11**.

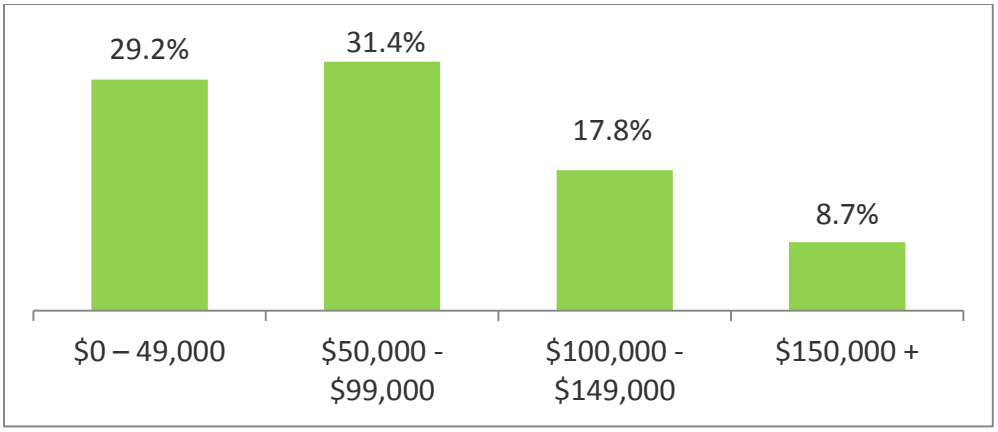
Figure 11. Question 36. What is your age?



The total household income also indicated a similar distribution to that found in the Washington County census data with the modal income bracket of $50,000 – $74,999 being similar to the median household income of $55,609 (2013). The 10.9% of survey respondents with a total annual household income of less than $25,000 is within the margin of error compared to the county's 13.7% poverty rate. The slightly higher distribution of household incomes over $75,000 is consistent with the higher rate of response by persons with college education. Also of note, 150 participants or 12.9% chose to not provide an answer to this question. These responses are presented in **Figure 12**.

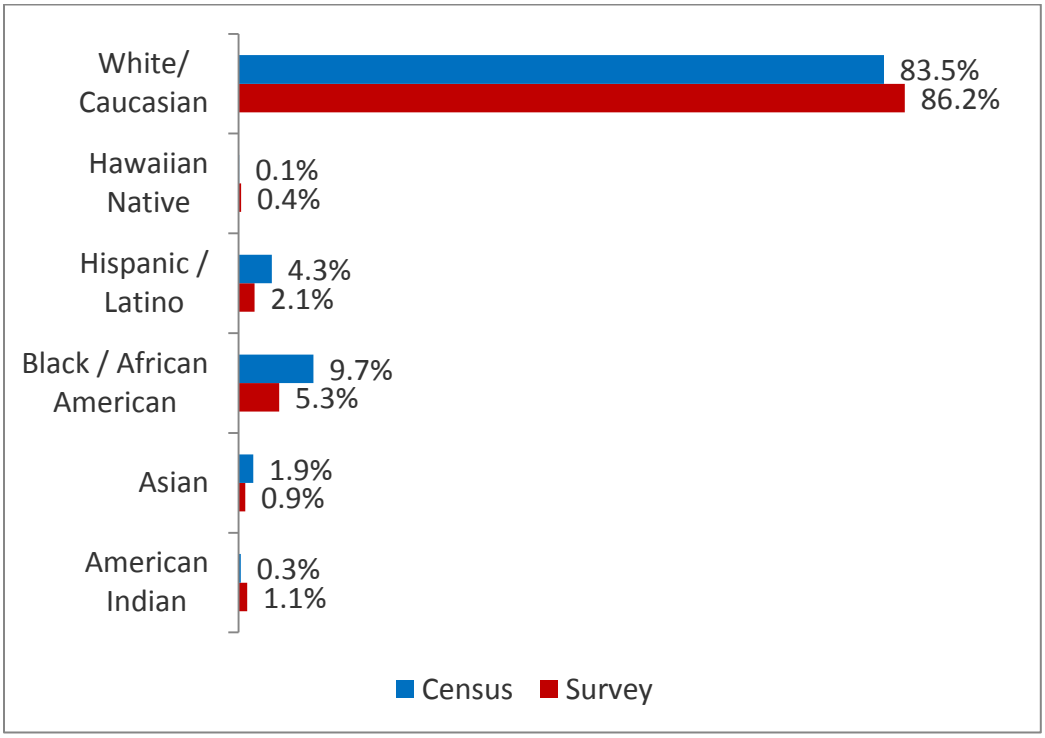
[8] Women as health care decision-makers. (2014). Journal of Health Care for the Poor and Underserved, Volume 25, Number 4. Johns Hopkins University Press, pp. 1507-1513.

Figure 12. Question 39. How much total combined money did all members of your HOUSEHOLD earn last year?



Based on all primary responses and comparison with secondary health status, we concluded that health risks and disease processes exist among all Washington County cohorts, without regard to age, gender, education or income. This suggests that future risk and trajectory for chronic illness is higher for all persons if no lifestyle changes are made. The survey sample is well within the margin of error and is highly consistent with the racial and ethnic population distribution in Washington County as a whole (see **Figure 13**). The data review found disparities among Black adults with regard to hypertension, diabetes and respiratory disease treatment.

Figure 13. Question 40. What is your race/ethnicity?



Health Status Indicators and Data

Health indicators are quantifiable characteristics used as supporting evidence to describe and define the health of a given population. The World Health Organization (WHO) defines health needs as "objectively determined deficiencies in health that require health care, from promotion to palliation."[9] Whenever possible, standardized health indicators for Washington County were used to provide us with comparison and benchmarks to the prior FY2013 and FY2016 CHNA results, county, state, national averages, and Healthy People 2020 targets. Both primary and secondary data sources were used. Participant responses from the community survey were included with relevant health indicators for ease of readability and understanding.

The health indicator topics include:
Health Status
Access to Quality Health Care
Healthy Lifestyle
Weight Status
Chronic Disease
Mental Health
Substance Use Disorder
Tobacco Use
Dental
Child Health
Adverse Childhood Experiences
Senior Health

[9] *Expert Committee on Health Statistics. Fourteenth Report.* Geneva, World Health Organization, 1971. WHO Technical Report Series No. 472, pp 21-22.

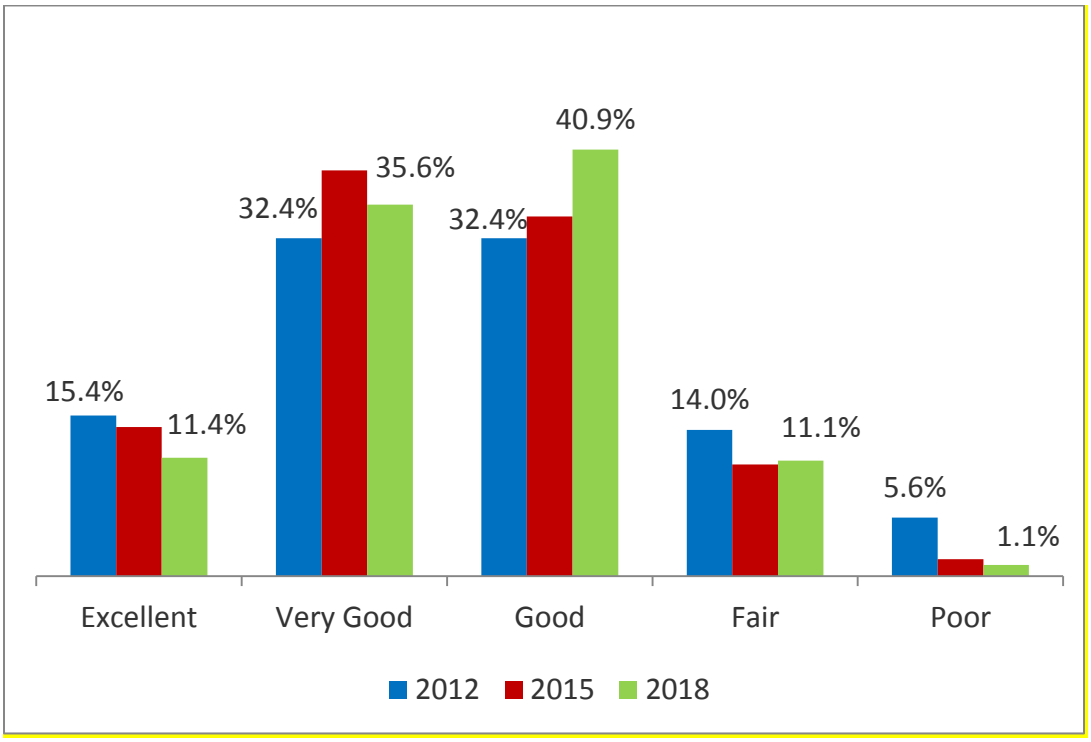
Health Status

Regarding "overall health" the survey participants were asked to rate their personal health. Self-reported health status is a general measure of health-related quality of life within the Washington County population. The question was "In general how would you rate your overall health?" with the answers categorized as "excellent", "very good", "good", "fair" and "poor."

For the 2018 survey 40.9% rated their health as "good." Only 11.4% rated their health as excellent as compared to 15.4% in 2012, a slight decreasing trend. Also fewer survey respondents rated their health as "poor" 1.1%.

Combining "excellent" and "very good" results are very similar between 2012, 47.8% and 2018, 47%. The combined "fair" and "poor" categories resulted in 7.4% fewer respondents describing their health using these terms.

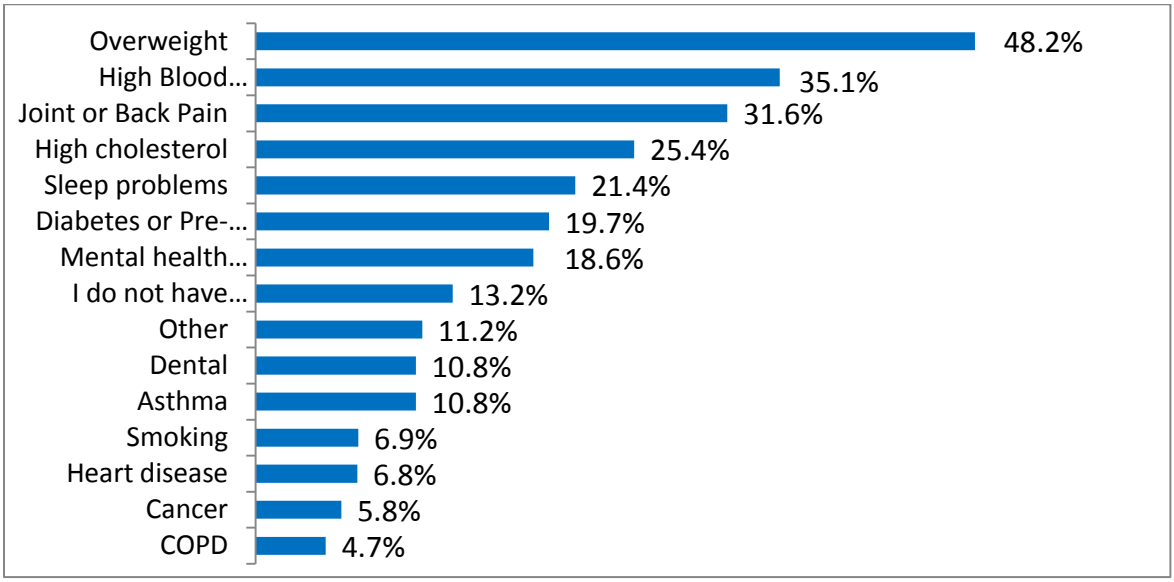
Figure 14. Question 2. In general, how would you rate your overall health?



Survey participants were asked to identify all the health concerns that they face. The most frequent health concern reported was being overweight, 48.2%. It is significant that this response was 8.3% higher than three years ago (39.9%). In addition to "overweight" as a health concern the other top seven concerns included high blood pressure (35.1%), joint or back pain (31.6%), high cholesterol (25.4%), sleep problems (21.4%), diabetes (19.7%), and mental health

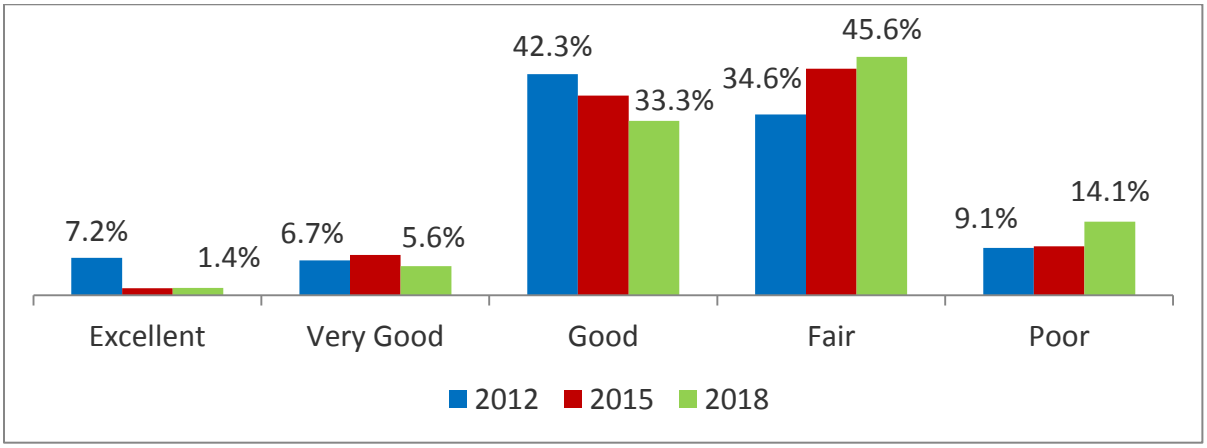
(18.6%). Having high blood pressure overtook joint and back pain as the #2 health concern reported in the current survey. All other concerns were in the same order as 2015. Additional areas of concern include dental, asthma, smoking, heart disease, cancer, and COPD.

Figure 15. Question 3. Please select all health concerns that you face



When asked to rate the health status of the community, of 59.7% of respondents rated the status as "fair" or "poor." These answers demonstrate an increasing trend over seven years and are a total of 16% higher than when the question was first asked in 2012. Conversely, 7% of survey answers classify the health of the community as "excellent" or "very good" in the current survey year compared to 13.9% of respondents in 2012, a decreasing trend. In general, a majority of the survey participants increasingly perceive the community in be in "fair" or "poor" health.

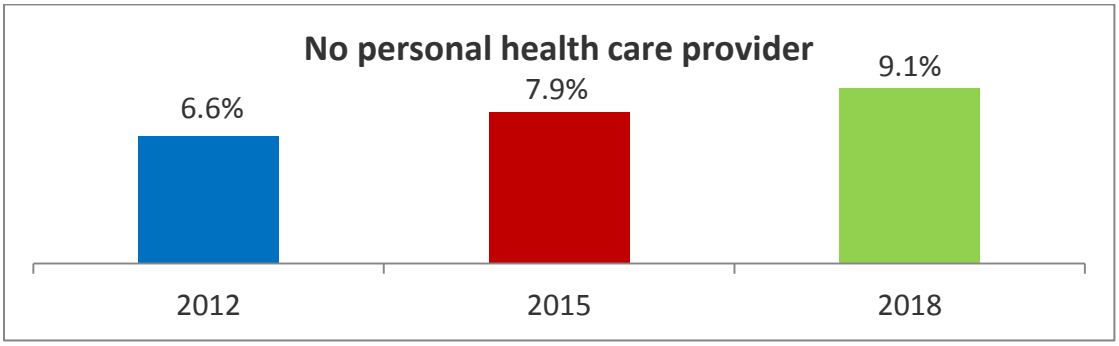
Figure 16. Question 4. Overall how would you rate the health status of the community?



Access to Quality Health Care

A majority of participants reported having a regular healthcare provider (90.9%). There is an increasing trend in the percentage of persons who report not having a regular healthcare provider, 9.1% (2018), compared to the first community survey, 6.6% (2012). It was expected that more persons having health insurance would translate to more people having a regular healthcare provider and greater access to care. It was determined that the majority of persons who do not have a regular healthcare provider are the generally healthy 18 – 29 year old group.

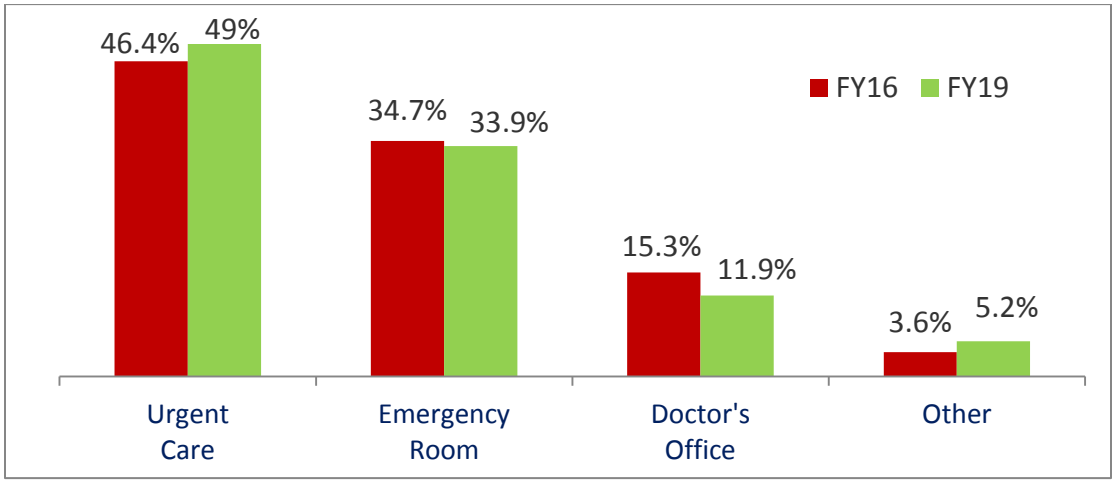
Figure 17. Question 28. Do you have a regular healthcare provider?



The majority of survey participants report going to their doctor's office for routine health care (80.9%). The Community Free Clinic (7.5%), Urgent Care (2.3%), Family Healthcare of Hagerstown (1.5%), and Tri-State Community Health Center (1.3%) were other frequently identified health providers.

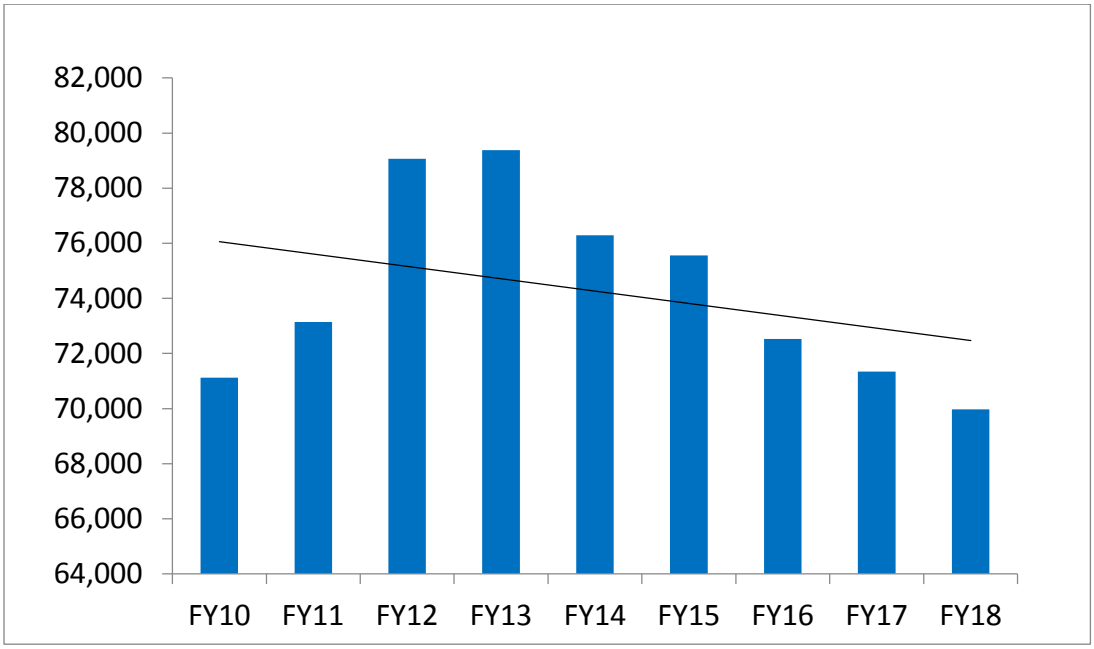
For the treatment of "immediate medical needs", survey respondents would most often seek care at one of the Urgent Care providers in Washington County (49%) versus the Emergency Room (34.7%) as illustrated in **Figure 18**.

Figure 18. Question 6. If you experienced an immediate medical need where would you go?



Although the Emergency Department (ED) offers immediate 24 hour, 7 days per week access to medical treatment without requiring payment or co-pay at the time of service, overall ED utilization has decreased 5.2% since 2012. A slight increase is seen in "other" which includes telemedicine access.

Figure 19. Total ED Visits and ER to Inpatient Trend

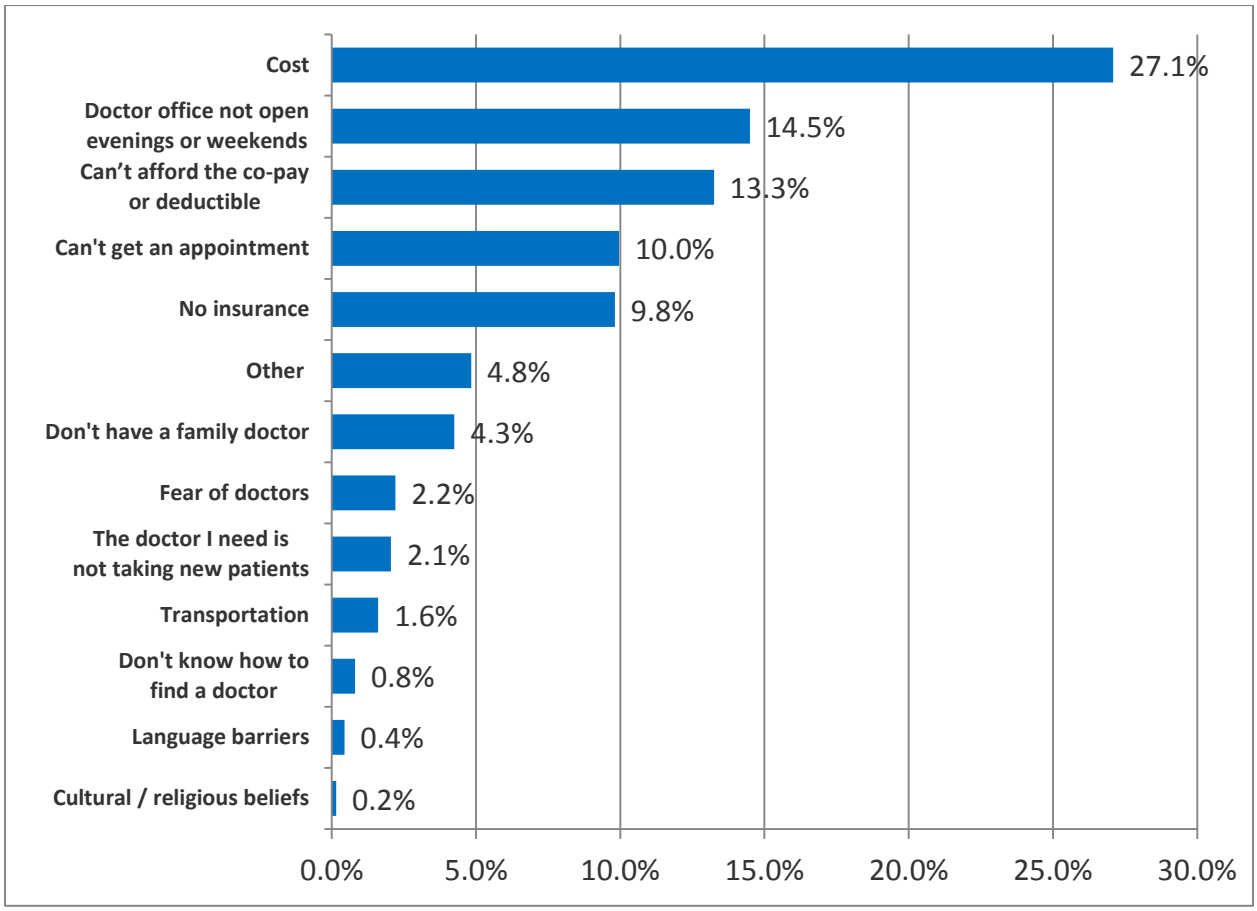


Source: Meritus Medical Center ED data 2009 - 2018

While total Emergency Department visits have trended down for the past five years, 13% of people who come to the ED have acute care symptoms that require hospitalization, a slight decrease of 1.4% since 2010 when an average of 14.4% of people were admitted from the ED. More than 80% of persons coming to the ED did not require hospitalization and were either treated in a lower level of care, transferred or safely discharged.

Economic factors are consistently identified as significant barriers to accessing timely healthcare services and treatment. Healthy Washington County seeks to better understand what factors prevent people in our community from accessing health services. When asked "what issues prevent you from receiving care when needed?" the top responses were "cost" 27.1% (up 6%) and the inability to afford co-pays or deductibles 13.3% (up 0.4%).

Figure 20. Question 7. Are there any issues that stop you from getting care when you need it?



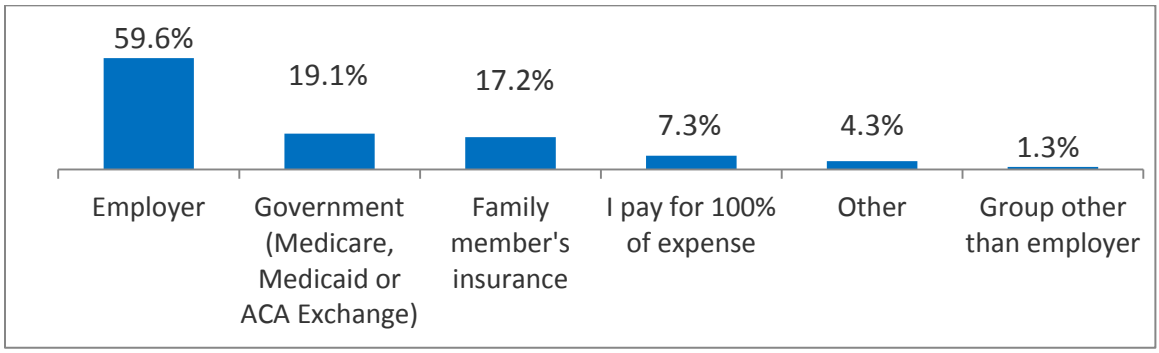
Greater access to healthcare has occurred with more adults having become insured between 2012 and 2018. In 2012, 18.5% of our survey sample reported being uninsured. This percentage has dropped to 11.2% in our current survey. The County Health Rankings & Roadmaps estimates current rates of uninsured for Washington County at 7% in 2018.[10]

In our survey sample, 59.6% of respondents reported that their employer helped pay for health insurance coverage a reduction of 12.6% since 2015 (see **Figure 21**). Persons who have health coverage provided or subsidized by the government increased 2% since 2015 to a total of

[10] http://www.countyhealthrankings.org/app/maryland/2018/rankings/washington/county/outcomes/overall/snapshot

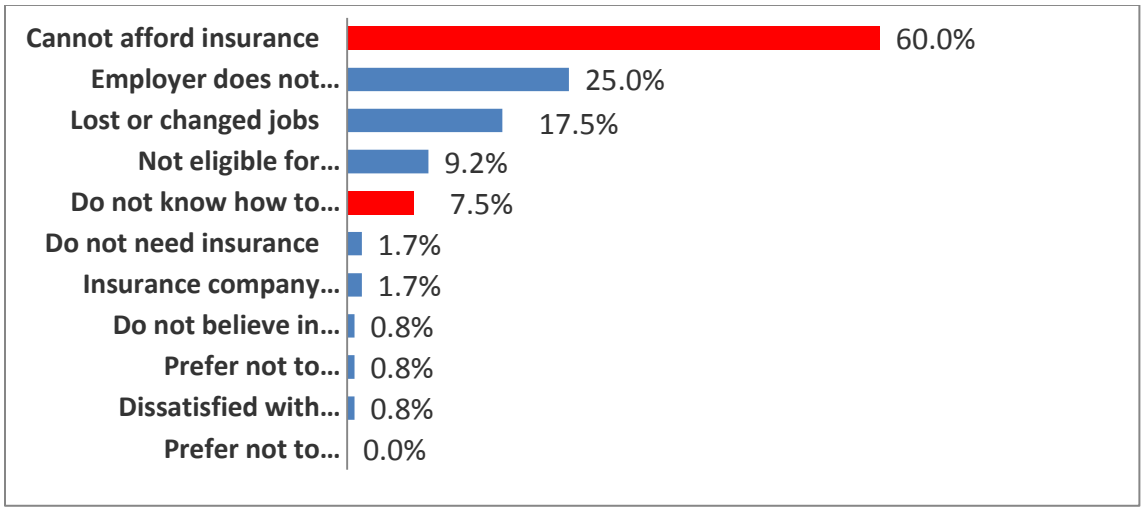
19.1%. Individuals who receive no financial assistance and pay for total cost out of pocket equated to 7.3% of respondents, roughly the same as the 2015 survey (7.1%).

Figure 21. Question 30. Who helps pay for your health insurance?



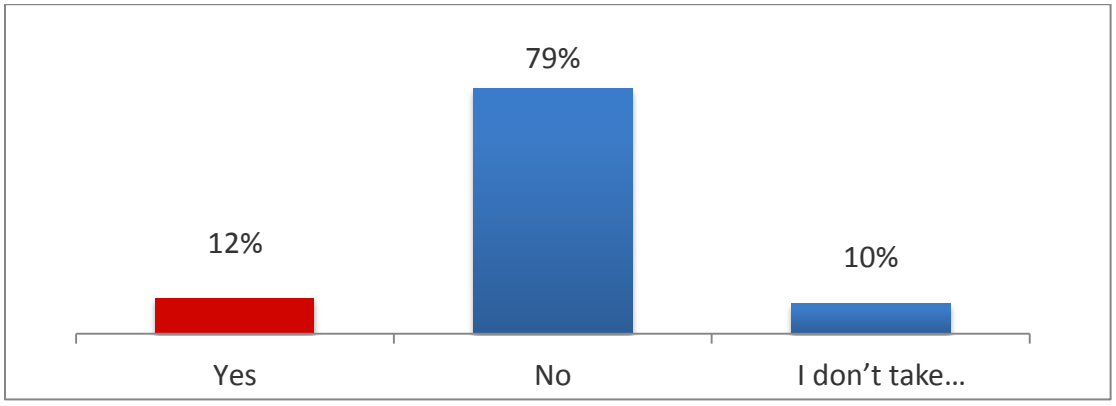
Although more people in Washington County have health coverage than ever before (93%), the survey reason most often cited for not having coverage remains "*cannot afford coverage*" as seen in **Figure 22**. The sample of uninsured persons who are unable to afford coverage increased 26% between 2012 and 2018. Another significant change was a 23% increase in the report that the employer does not help pay for health coverage (2012 – 2018). The reason for not carrying health insurance due to a lost or changed job was lowered to 17.5%. This is consistent with the reduced rate of unemployment in Washington County that has decreased steadily since 2012. Of interest, 7.5% of the survey sample without health coverage reported not knowing how to obtain coverage. The Maryland Health Connection, the state health change has worked extensively with outreach in Washington County to reach as many uncovered persons as possible, demonstrating a positive 23% enrollment between 2017 - 2018 (MD Health Exchange Executive Data Report 12/31/2018 see **Appendix K**).

Figure 22. Question 31. Reason No Health Insurance



Despite the fact that a greater number of adults are now insured, 12% of respondents have gone without prescribed medication in the past year because they could not afford it. This result also demonstrates a small increased trend since 2012 when 10.5% of survey respondents reported that they had gone with medication due to cost. Having health coverage alone does not guarantee access to prescribed medications as plans can vary greatly in covered benefits. The cost of prescription medicines continues to be a health barrier for parts of our population.

Figure 23. Question 8. In the past 12 months, have you gone without medicine or not taken medicine as prescribed because you could not afford it?



Survey questions did not assess the level of health coverage, co-pays or deductibles. The Community Free Clinic has identified a trend of formerly uninsured persons who have obtained an affordable health coverage plan but also must meet large deductibles and/or co-pays. New patients are accessing free health care at the Community Free Clinic who may have coverage but are considered "underinsured." High rates of deductibles and co-pays pose a new barrier to accessing specialist care for the asset-limited sector of Washington County.

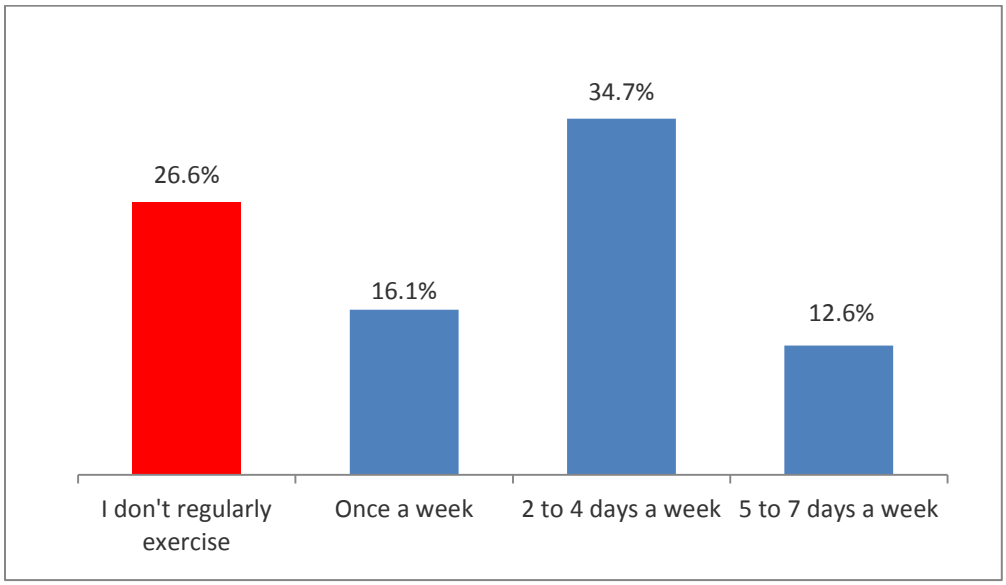
Healthy Lifestyle

According to Healthy People 2020 daily physical activity, maintaining a healthy body weight and good nutrition are essential components of good health and well-being. Maintaining a healthy lifestyle can help to decrease an individual's risk of developing serious health conditions such as high blood pressure, diabetes, heart disease, stroke or cancer.[11]

Physical activity

An important health indicator is level of daily physical activity. The CDC 2018 guidelines recommend that adults ages 18 - 64 need at least 2 ½ hours of moderate intensity physical activity (brisk walking) each week.[12] However, 26.6% of survey respondents indicate that they do not regularly exercise and another 16.1% exercise only "*once a week*", as seen in **Figure 24.**

Figure 24. Question 26. In a typical week, how many days do you exercise?

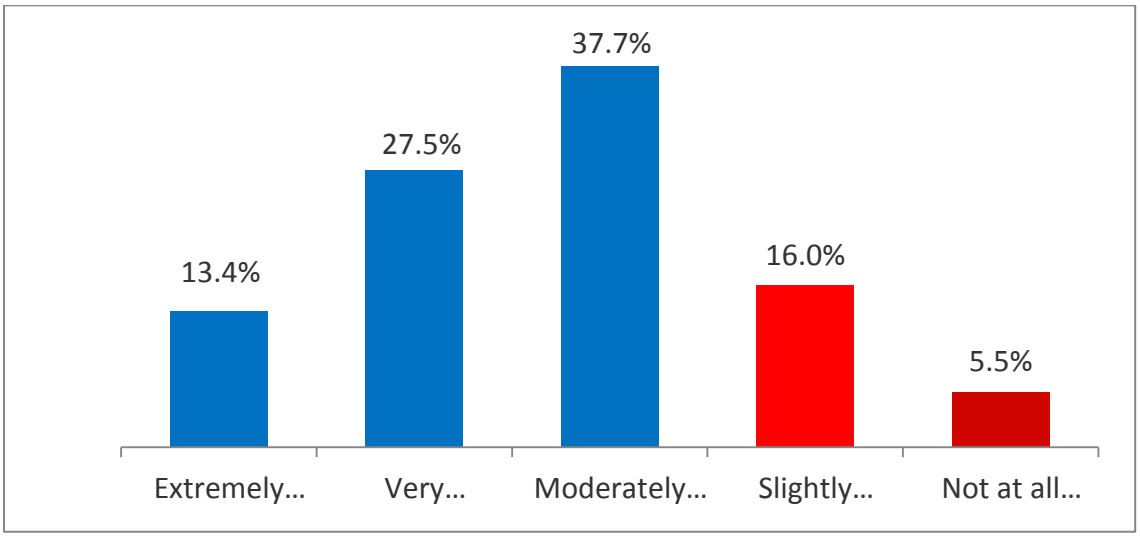


[11] Healthy People 2020, www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Nutrition-Physical-Activity-and-Obesity accessed 08/12/2018

[12] Centers for Disease Control and Prevention, https://health.gov/paguidelines/second-edition/10things/ accessed 09/26/18

The survey identified that *exercise* was only "*slightly*" or "*not at all important"* among 21.5% of respondents.

Figure 25. Question 25. How important is exercise to you?



Those who do exercise walking was the far most popular exercise (84.4%) followed by lifting weights (16.6%), running (12.8%), and swimming (12.7%). Other forms of exercise gaining popularity are cycling (10.4%), and yoga (10.2%).

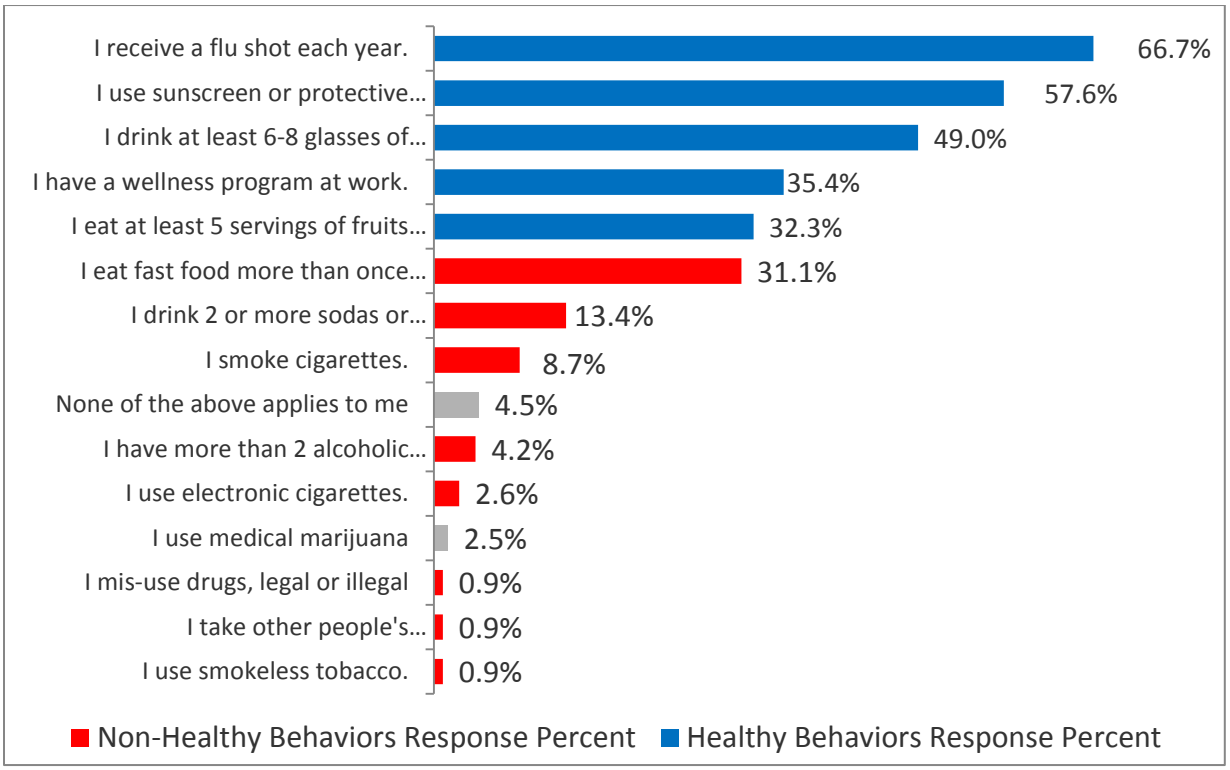
Table 15. Q27. What do you most often do for exercise?

Answer Options	Response Percent	Response Count
Walk	84.4%	969
Lift weights	16.6%	191
Run	12.8%	147
Swim	12.7%	146
Other	11.7%	134
Biking/Cycling	10.4%	119
Yoga	10.2%	115
Hike	9.6%	110
Aerobics	5.9%	68
Dance	5.8%	67
Pilates	2.2%	25
Play a team sport	1.5%	17

The CHNA community survey identified behaviors associated with preventative care and wellness. Adult persons reported having received a flu shot at a rate of 66.7%, an increase of exactly 10% from the FY2016 survey. Over 57% of respondents identified using sunscreen or protection from prolonged sun exposure, the same percentage as three years ago.

The average, healthy adult living in a temperate climate needs about 13 cups of water for men and 9 cups for women on a daily basis according to the Institute of Medicine.[13] The popular advice to drink eight glasses of water daily is not evidenced-based, but is a rough equivalent for adequate intake. Nearly half of respondents (49%) reported drinking six to eight glasses of water daily (no change) and about one third of respondents (32.3%) also reported eating *at least* five servings of fruit and vegetables daily , a slight decrease from the last survey (34.8%).

Figure 26. Question 23. All statements that apply to you (healthy vs. health risk behaviors)



A workplace health program is a health promotion activity or organization-wide policy designed to support healthy behaviors and improve health outcomes while at work. With rising costs in health care coverage, employers have a vested interest in the health of their employees. The RAND Employer Survey (2013) suggests that, nationally, about 50% of all employers with 50 or more employees offer a wellness program.[14] In the current survey 35.4% of respondents identified having a wellness program offered in their workplace currently, up 9% from the FY2016 survey (26.7%).

[13] The Mayo Clinic, www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/water/art-20044256?pg=1 , accessed 09/08/2015.

[14] DOL Workplace Wellness http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf, accessed 09/08/2015.

The CHNA community survey identified behaviors associated with an increased risk to health and wellness. According to the CDC, fast food is a part of the American diet associated with high caloric intake, and poor diet quality.[15] Time, financial resources, price, and availability influence fast food consumption. Between 2016 – 2018 a CINT consumer poll determined that 29.4% of Americans reported eating fast food more than once per week[16], compared to the Washington County survey rate of 31.1% which is 3.8% higher than three years ago.

Smoking, electronic cigarettes and smokeless tobacco use was reported at a combined total of 12.2% of the survey, a decrease of 3.6% from FY2016. The most recent CDC surveillance data reports the Maryland value as 13.7% adult smokers and 2.2% adult e-cigarette users.[17] E-cigarettes and "vaping" are electronic nicotine delivery systems that are gaining in popularity especially among youth, but these forms of nicotine have still largely unknown long-term health effects.

13.4% of surveyed adults report drinking more than two soda or energy drinks daily. These drinks include high caloric values derived from sugar, ranging from 39g to 110g. The U.S. Food and Drug Administration (FDA) limits the amount of caffeine in soda to no more than 71 milligrams per 12-ounce serving. Unregulated energy drinks are advertised as "energy boosting" and include not only high levels of caffeine and sugars but also other stimulants such as guarana, green tea, yohimbine, vinpocetine, 5-hydroxyl trypophan methylphenylethylamine (5-HTP) and ginseng. When multiple stimulants are mixed into a single beverage, research suggests that the additive effects of all of these stimulants pose additional health risks, including an increase in blood pressure and cardiac dysrhythmia.[18]

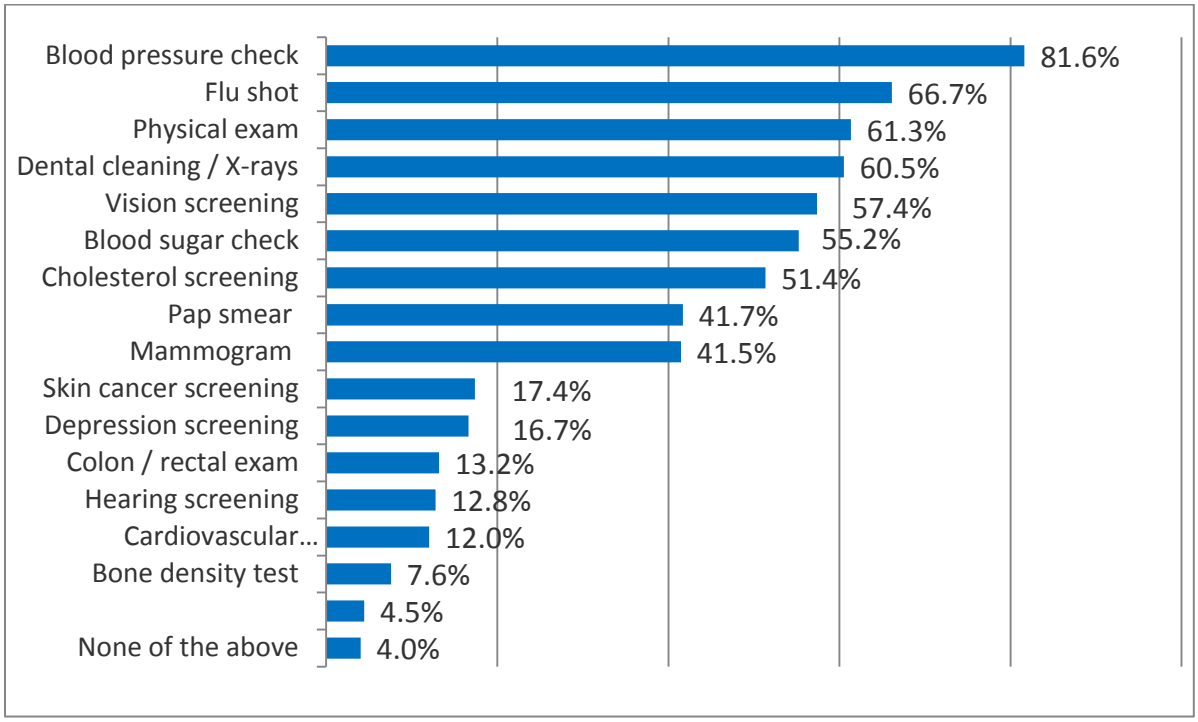
The Maryland legislature has approved the use of medical cannabis in Maryland for persons with specific health conditions as regulated by the Maryland Medical Cannabis Commission. Our survey included 2.5% persons reporting use of medical cannabis. It is noted that the Food and Drug Administration has not approved any product containing or derived from cannabis and prescribing cannabis remains illegal under federal law.

Figure 27 summarizes responses regarding preventative health procedures and screenings over the past 12 months. Survey participants reported receiving blood pressure checks (81.6%), flu shots (66.7%), annual physical exam or wellness visit (61.3%), dental cleaning and X-rays (60.5%), and vision screening (57.4%), all at a slightly higher rate than screenings reported three years ago. There is evidence for moderate compliance for blood sugar check (55.2%),

[15] https://www.cdc.gov/nchs/products/databriefs/db322.htm
[16] https://www.statista.com/statistics/561297/us-average-fast-food-consumption-per-week/
[17] CDC, Behavioral Risk Factor Surveillance System, 2016
[18] American Heart Association, 2013; http://newsroom.heart.org/news/energy-drinks-may-increase-blood-pressure-disturb-heart-rhythm accessed 09/12/2015.

cholesterol screening (51.4%), and among women pap smear (41.7%), and mammograms (41.5%).

Figure 27. Question 24. Which of the following preventive procedures have you had in the past 12 months?



Areas of opportunity include skin cancer screening (17.4%), colon rectal exam (13.2%), and prostate screening for men (4.5%). The U.S. Preventative Services Task Force has recommended depression screening for all adults. Our survey reports only 16.7% of adult respondents participated in a depression screening in the past 12 months, although this is up 4.4% from 2015. Also, 4% of survey respondents reported having no preventative or wellness care in the past year.

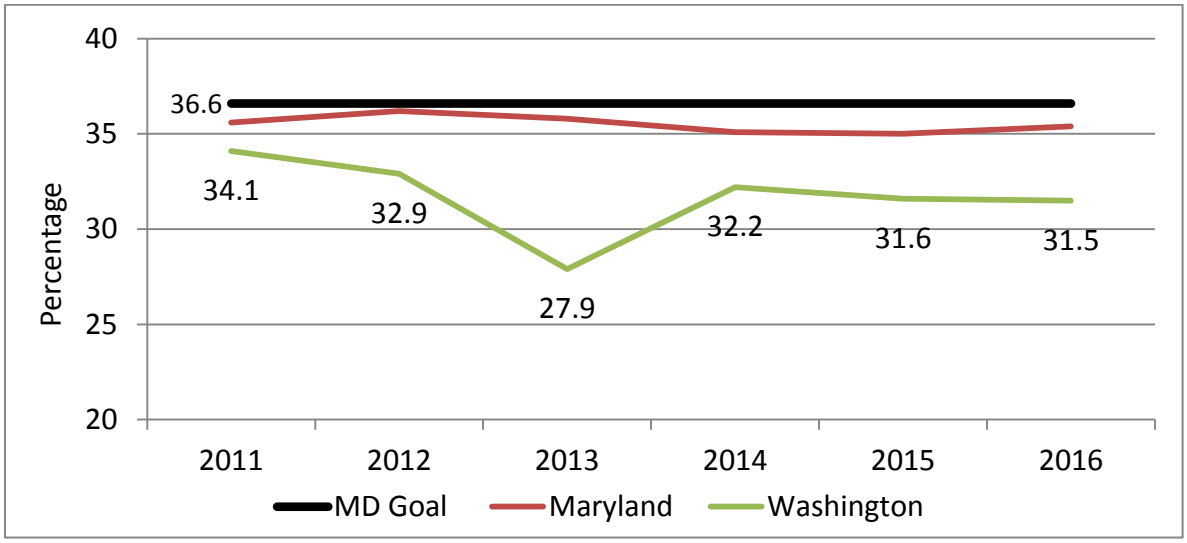
Weight Status

According to the CDC the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016.[19] Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death. The estimated annual medical cost of obesity in the United States was $147 billion in 2008 US dollars; the medical cost for people who have obesity was $1,429 higher than those of normal weight.[20]

Obese people are between 1.5 to 2.5 times more likely to die of heart disease than people with normal body mass indices (BMIs). This means that obesity related death is linked to approximately 18% of deaths among Americans ages 40 to 85 and is comparable to cigarette smoking as a health hazard.[21]

Higher rates of physical inactivity and a lack of exercise result in a higher frequency of adults who are overweight and obese in our community. There is observed to be a 2.6% ***decrease*** in the percentage of adults who are determined to be at a ***healthy weight*** (BMI ≤ 25) from 2011 to 2016, meaning that 31.5% of our local residents are maintaining the status of a healthy weight.

Figure 28. Adults at Healthy Weight

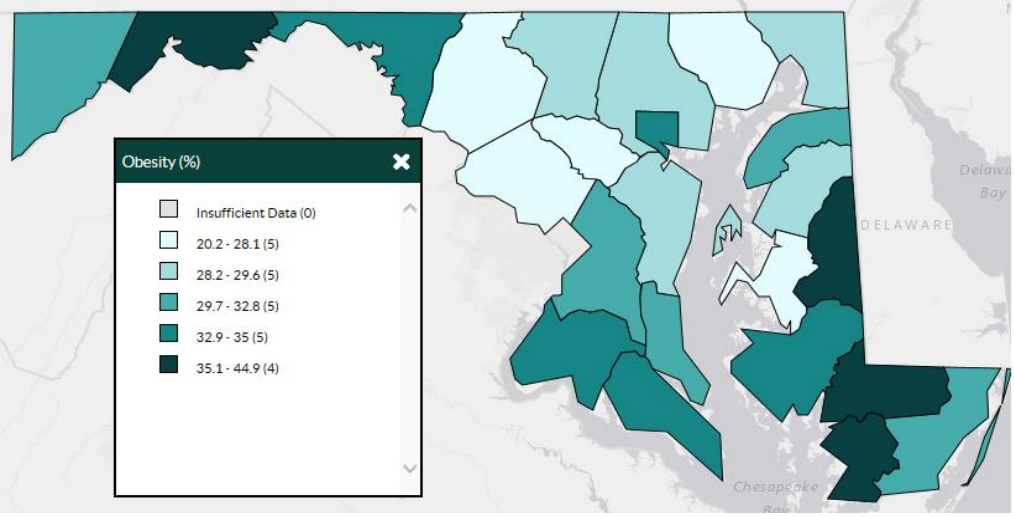


Source: SHIP 2018

[19] https://www.cdc.gov/obesity/data/adult.html accessed November 19, 2018
[20] Ibid
[21] D. Blumenthal and S. Seervai, "Rising Obesity in the United States Is a Public Health Crisis," Apr. 23, 2018.

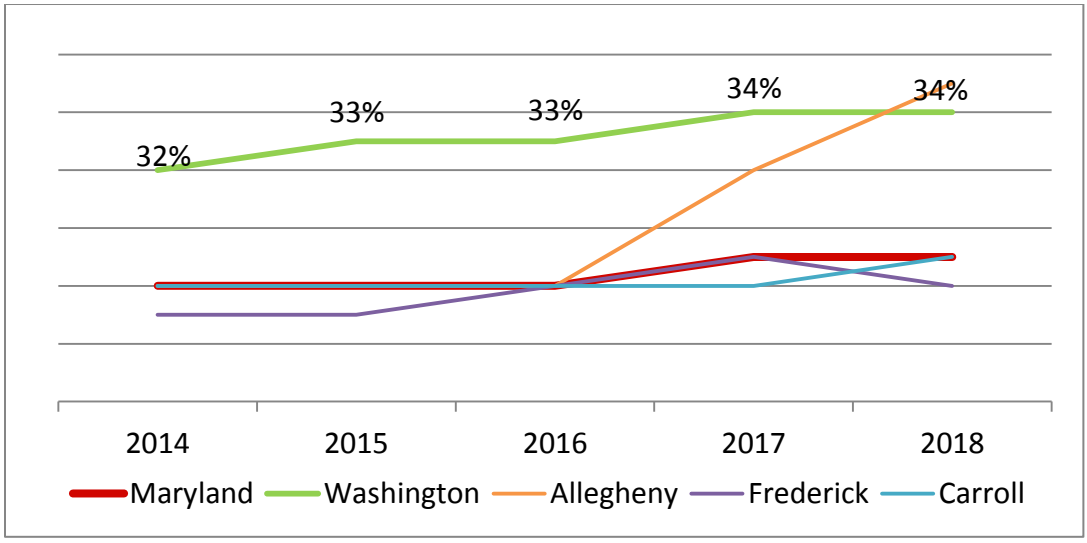
While the trend nationwide is adults becoming more overweight and obese, the decline in adults who maintain a healthy weight in our community continues a downward trend and is well below the Healthy People 2020 goal of 33.9%. As fewer adults maintain a healthy weight, we continue to see an increase in the rate of obesity, as determined by body mass index (BMI).

Figure 29. Obesity Rate



The data indicator marks the obesity rate at 33.75% for Washington County, ranked as the 8th highest rate among Maryland counties. [22] This rate slightly increased 2% over the past five years for people who have a BMI ≥ 30.

Figure 30. Western Maryland Adult Obese BMI > 30



Source: RWJ County Health Rankings 2018

[22] CDC https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=MD accessed Oct. 23, 2018

Focus group input regarding why overweight and obesity issues are a challenge in our community included:

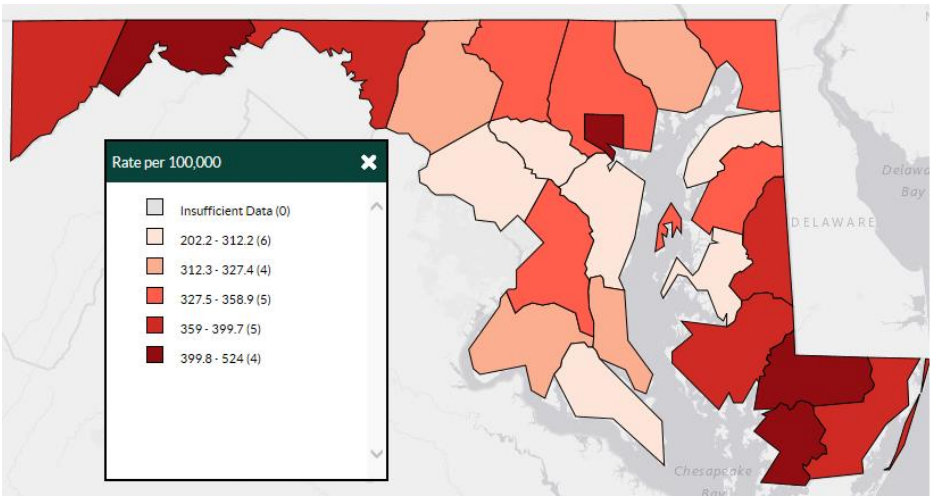
- “Fast food doesn’t cost much and is generally unhealthy”
- Not enough time to cook healthy meals
- Not enough time to exercise
- Too much screen time with electronic devices
- Lack of knowledge
- A lack of motivation to make changes
- Healthy food costs more
- “Dietary counseling is not a benefit that is covered by most insurances”
- “Why don’t we have medical weight loss services?”
- “We have an obesity problem because of poor nutrition, a lack of physical activity and over-eating.”

Chronic Disease

Heart disease and hypertension

According to the CDC heart disease is the leading cause of death in the United States.[23] Heart disease is the leading cause of death in Washington County and the state of Maryland accounting 24% of all deaths.[24] A rate of 372 deaths per 100,000 adults ranks heart disease mortality in Washington County as the 6th highest rate in Maryland (see **Figure 31**). Approximately 19.3% of adults in the county have heart disease.

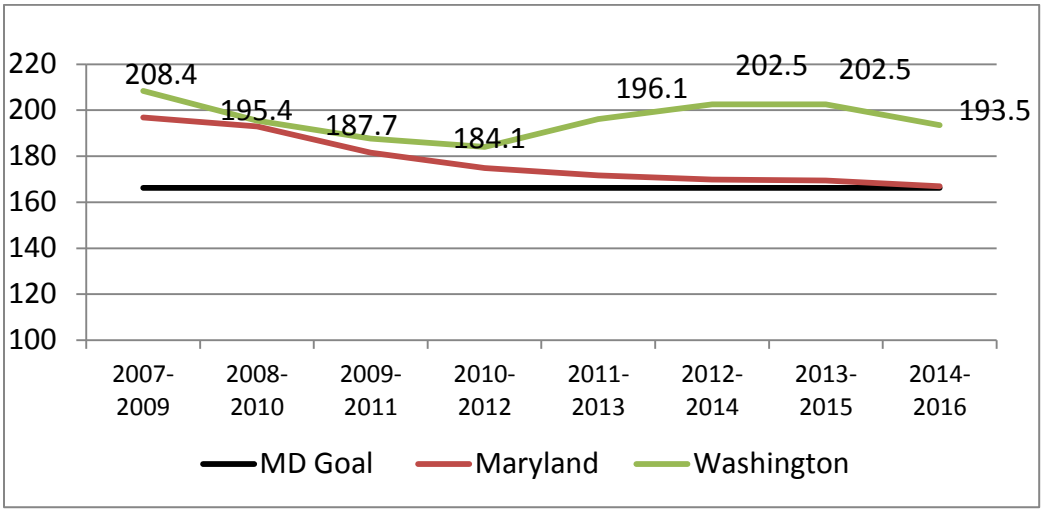
Figure 31. Heart Disease Mortality



In 2007 - 2009, the overall rate of Washington County heart disease mortality was measured at 208.4 per 100,000. The current rate of 193.5 per 100,000 demonstrates a ***significant decline*** of 14.9%. While the downward trend remains positive, it is noted that the state of Maryland is also decreasing the overall rate of heart disease mortality at a faster rate than Washington County (see **Figure 32**). The state goal of 166.3 will not be obtained in 2020 but remains a target to work towards.

[23] Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2014.
[24] CDC https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=MD accessed Oct. 23, 2018

Figure 32. Age-adjusted Heart Disease Mortality per 100,000 lives



Source: Maryland SHIP 2018

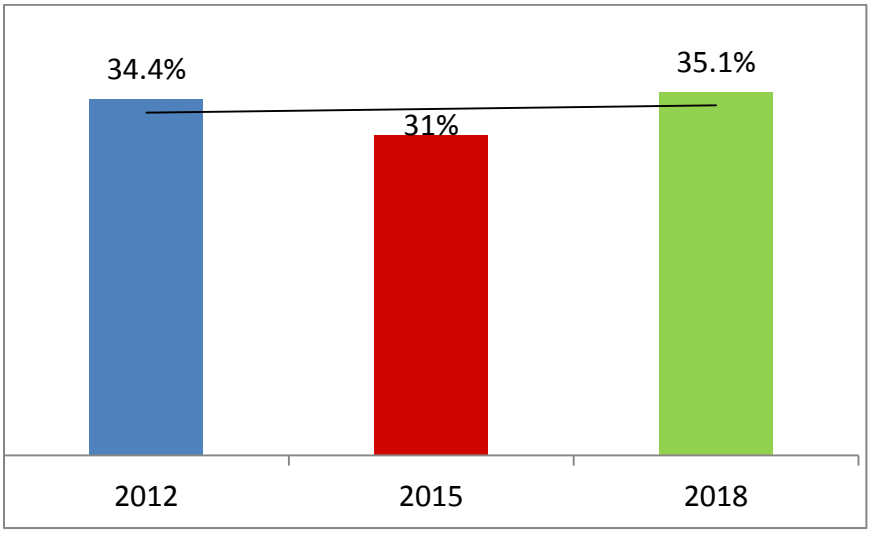
According to the CDC having hypertension or "high blood pressure" is a primary risk factor for heart disease and stroke.[25] About 75 million Americans have hypertension (about 32%), or about 1 in 3 adults.[26] Hypertension usually has no symptoms, so many people don't realize they have it, so having blood pressure checked frequently is important as we age. Having certain medical conditions such as diabetes can increase the chance of developing hypertension. Unhealthy behaviors such as smoking tobacco, eating a diet high in sodium, not getting enough physical activity, being overweight and drinking too much alcohol can contribute to the risk of developing prehypertension or hypertension.

Survey responses for people who had been told that they have hypertension have fluctuated between a high of 35.1% reported in 2018 to a low of 31% in 2015 (see **Figure 33**). Overall, the report of hypertension remains relatively flat over the seven years. Survey responses indicated that 81.6% of respondents had their blood pressure checked within the past 12 months. Also 61.3% reported having a physical exam in the past year.

[25] https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_bloodpressure.htm accessed Oct. 24, 2018

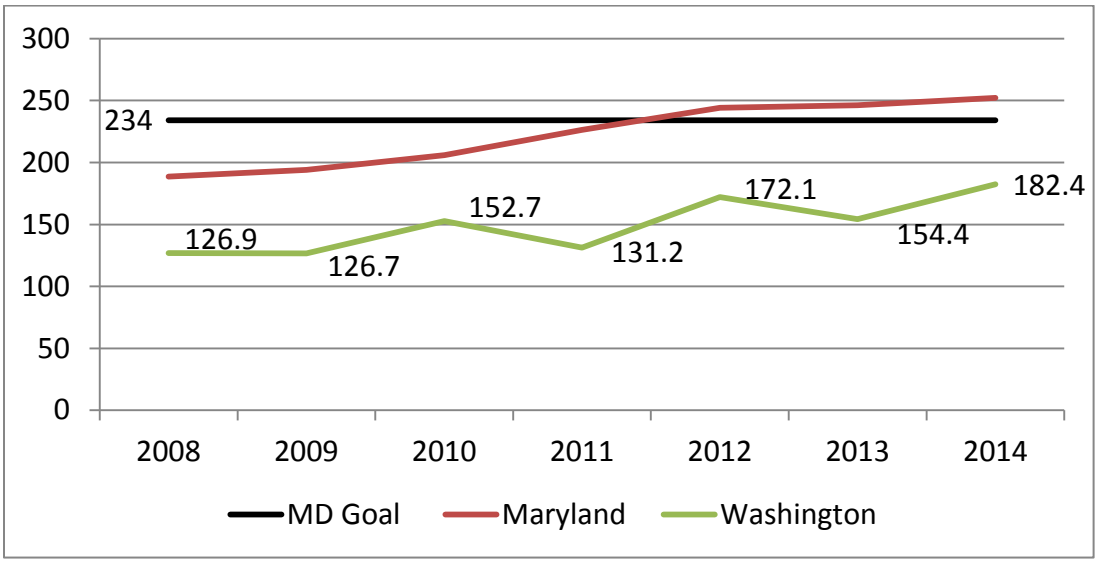
[26] Ibid.

Figure 33. Have you ever been told that you have hypertension?



The Washington County rate of Emergency Department visits for hypertension is 182.4 per 100,000, an *increase* of over 9% from the 2012 SHIP data (172.1 per 100,000). While the prevalence of hypertension is unchanged, the number of ED visits for unmanaged hypertension has trended upward over time (see **Figure 34**).

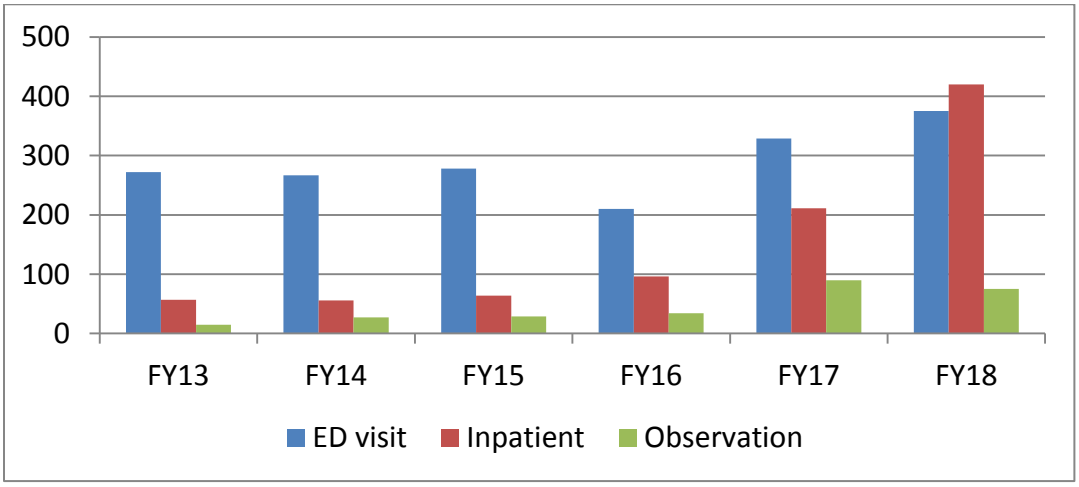
Figure 34. Emergency Department Visit Rate Due to Hypertension



Source: Maryland SHIP 2018

While a gradual up-trend is noted in the State of MD data through 2014, internal Meritus Medical Center data demonstrates a significant increase in the number of ED visits for hypertension between 2016 – 2018 (see **Figure 35**).

Figure 35. Emergency Department Visit Data and Admission Status



Raw data

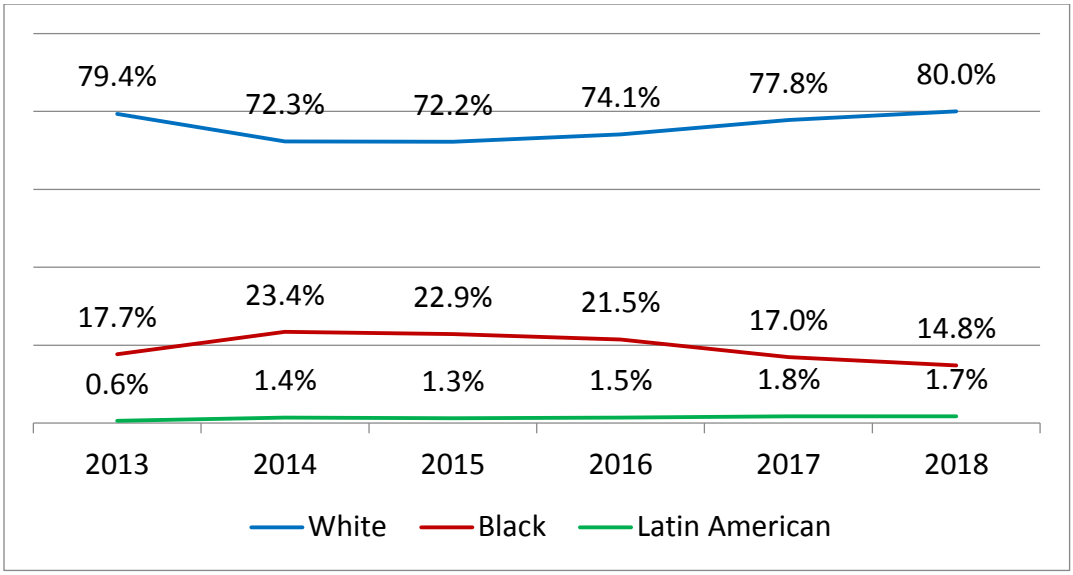
	FY13	FY14	FY15	FY16	FY17	FY18
ED visits	272	267	278	210	329	375
Inpatient	57	56	64	96	211	220
Observation	15	27	29	34	90	75
% of inpatient admissions	21%	21%	23%	46%	64%	59%

Source: Meritus Medical Center data 2012 - 2018

In addition to an increase in Emergency Department visits, the number of visits resulting in hospital admission for hypertension has also increased more than 34% when comparing the immediate past three year period with the prior three years.

The increased trend in ED visits was previously explained by a higher rate among the Black population. However, over the past four years the percentage of ED visits for hypertension among Blacks has decreased by 8.6% suggesting improved management of hypertension through improved screening and management efforts. There is an observed 7.8% increase in ED visits among the White population over the past three years. The rate among the Latino / Hispanic population has remained flat (see **Figure 36**).

Figure 36. Hypertension in the Emergency Department



Source: Meritus Medical Center Emergency Department 2018

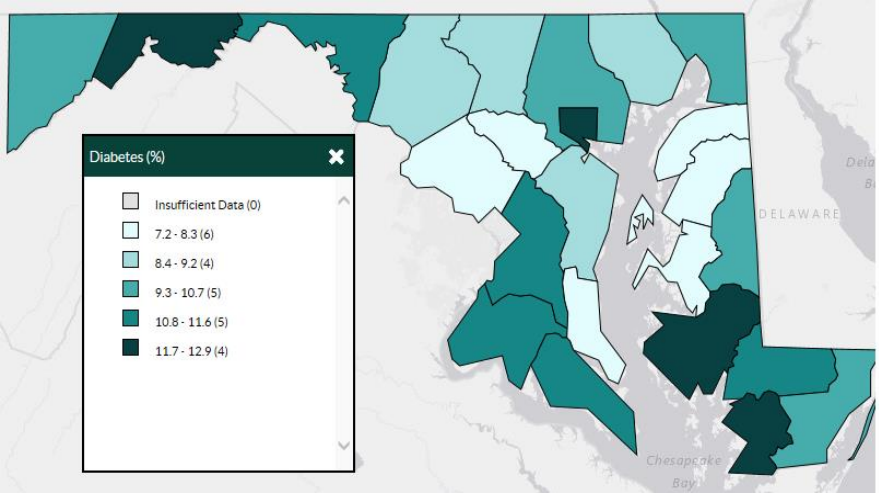
Keeping blood pressure levels in a healthy range can be accomplished by eating a low sodium diet, daily physical activity, not smoking and taking blood pressure medication as prescribed if diagnosed with hypertension. People living in Washington County take blood pressure medication as prescribed about 78% of the time according to the Centers for Disease Control's Behavioral Risk Factor Surveillance System.[27]

[27] CDC https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=MD accessed October 23, 2018.

Diabetes

According to the 2017 National Diabetes Statistics Report an estimated 9.4% of the U.S. population had diabetes in 2015.[28] The most recent BRFSS data available identifies prevalence of diabetes among adults in Washington County as 11.3%, ranking the county as the 7th highest in the state of Maryland (see **Figure 37**). The rate of diabetes prevalence has ***decreased*** 3.53% in Washington County since 2010 when the area was ranked as the 4th highest rate in the State of Maryland.

Figure 37. Diabetes Prevalence



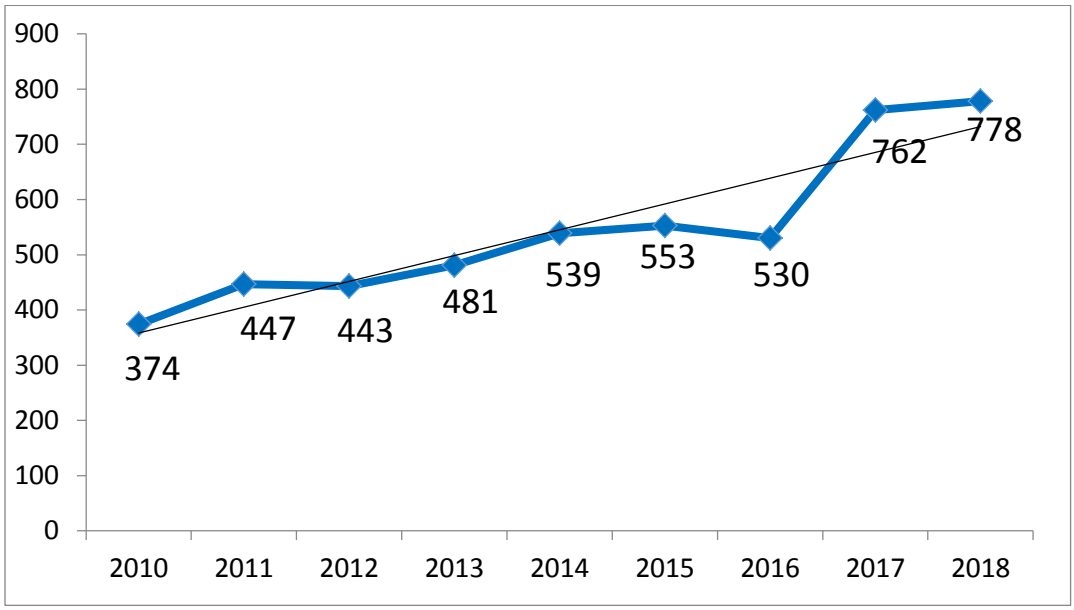
Diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, nerve damage, pregnancy complications and birth defects. Emergency department visits for diabetes-related complications may signify that the condition is not well managed or is uncontrolled.

According to the most recent rate of Emergency Department visits for diabetes in Washington County is reported as having ***increased*** to 297.1 per 100,000 population by the MD State Health Improvement surveillance. The rate of change has ***increased*** over 109 since measured in 2014, an increase of 36%. There is no readily identifiable explanation for this increase in ED visits for diabetes as the number of community providers and availability of education services for diabetes has remained stable or increased. In addition, the prevalence rate for diabetes has improved and the percentage of uninsured persons has ***decreased***.

[28] National Diabetes Statistics Report, 2017

Internal Meritus Medical Center raw data for primary diabetic ED visits validate that rates have increased significantly over the past two years.

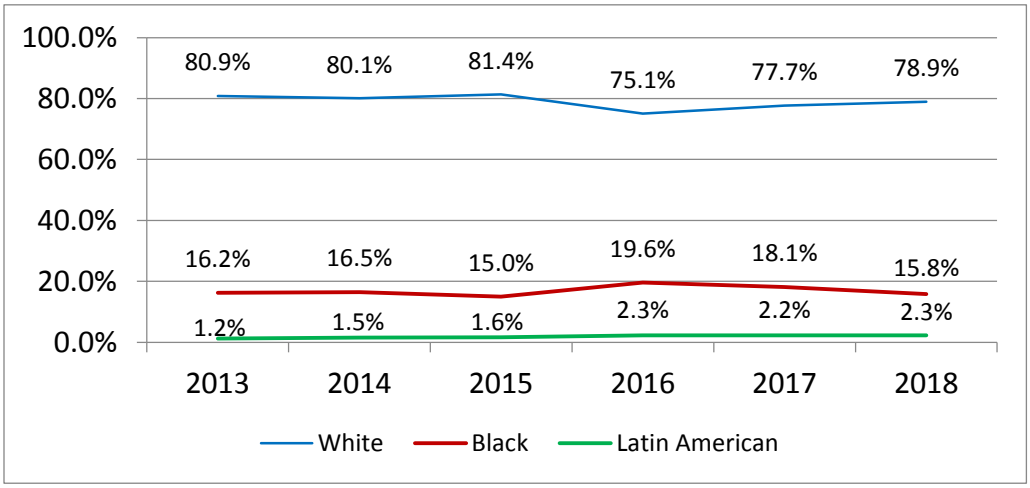
Figure 38. Diabetes Visits in the ED – raw data



Source: Meritus Medical Center data 2010 - 2018

A review of ED visits based on population indicate that there is a higher rate among the Black population presenting at a rate of 1.49 times higher per capita calculated based on census data.

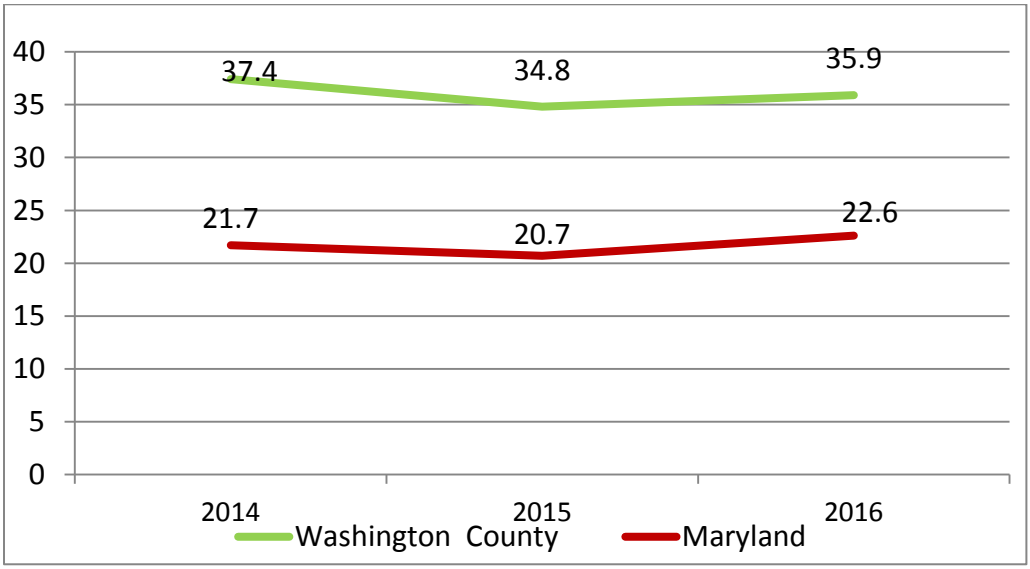
Figure 39. Diabetes in the Emergency Department



Source: Meritus Medical Center Emergency Room data 2013 - 2018

Additional concern continues to be the rate of diabetes mortality in Washington County at 35.9 per 100,000 persons, the second highest mortality rate in the state of Maryland followed only by Baltimore City (see **Figure 40**).

Figure 40. Diabetes Mortality



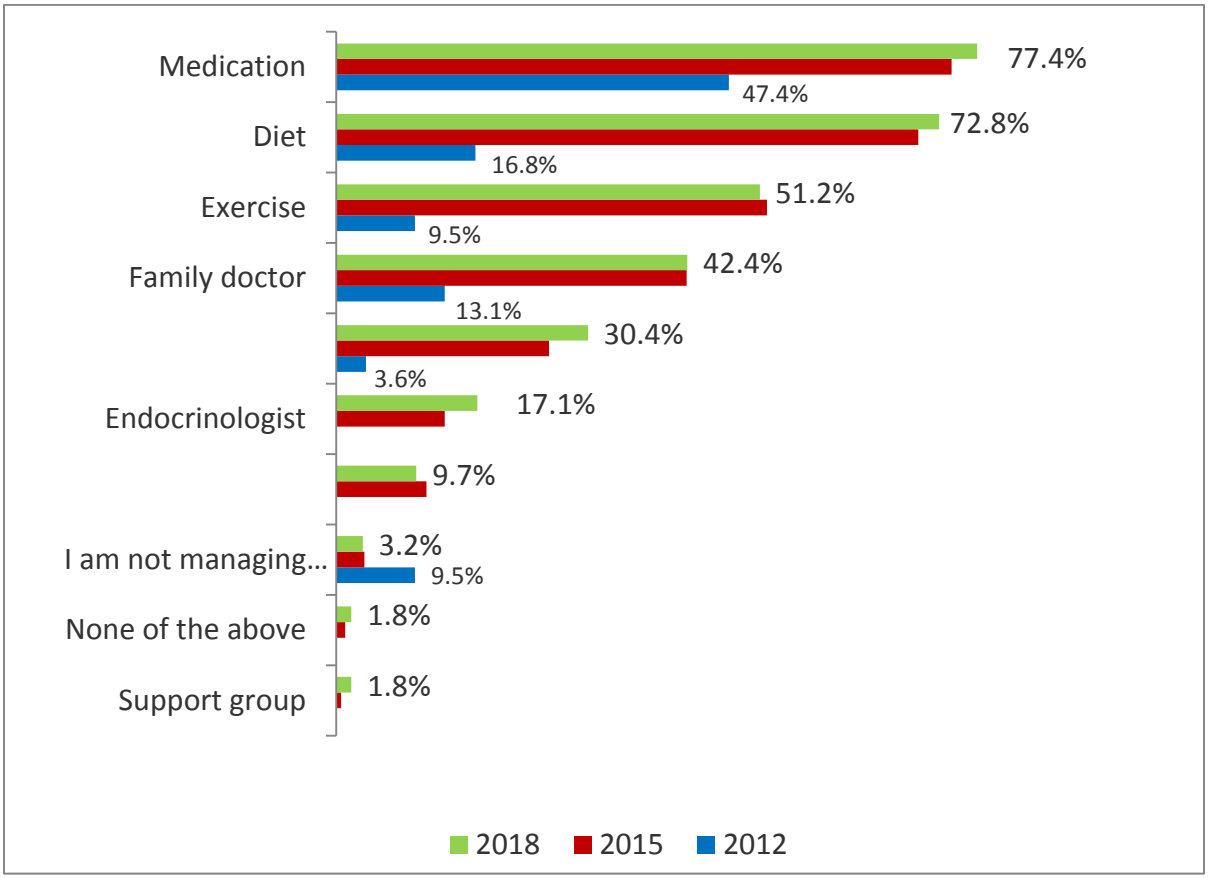
Source: Maryland Vital Statistics 2016

When asked "have you ever been told by a health professional that you have diabetes?" the 2018 survey respondents answered in the affirmative 17% of the time, higher than the state's projected prevalence rate of 11.3% for Washington County. The 17% response was 3.3% higher than the community survey response of 13.7% from 2015. The conclusion is that sampling error from 2015 is a more likely explanation than the actual prevalence increasing by more than 3% over the subsequent three years.

Most respondents who indicated having diabetes diagnosis reported managing diabetes with medication (77.4%), diet (72.8%) and exercise (51.2%). Also, 30.4% reported receiving diabetes education, a rate that has steadily increased since first measured in 2012 (6%) (see **Figure 41**). In addition 5% indicated that they are either not managing their diabetes or chose "none of the above" as measures for helping manage diabetes.

Diabetes Monitoring measures the percentage of fee-for-service Medicare patients between the ages of 65 and 75 with diabetes who had their blood sugar control monitored using a test of their glycated hemoglobin (HbA1c) is then divided by the total number of Medicare patients in the same age group who are diagnosed with diabetes. For Washington County the measure was last reported as 87% compliant.

Figure 41. Question 12. If yes for diabetes, how are you managing your symptoms?



The response "I am not managing my diabetes" was reduced from a high of 9.5% in 2012 to 3.2% in 2018. Given the higher rates for being overweight and obese in our community, residents are at higher risk for pre-diabetes and developing Type II diabetes in the future. The survey asked for interest in learning how to prevent diabetes of which only 29% responded "yes" they would be interested.

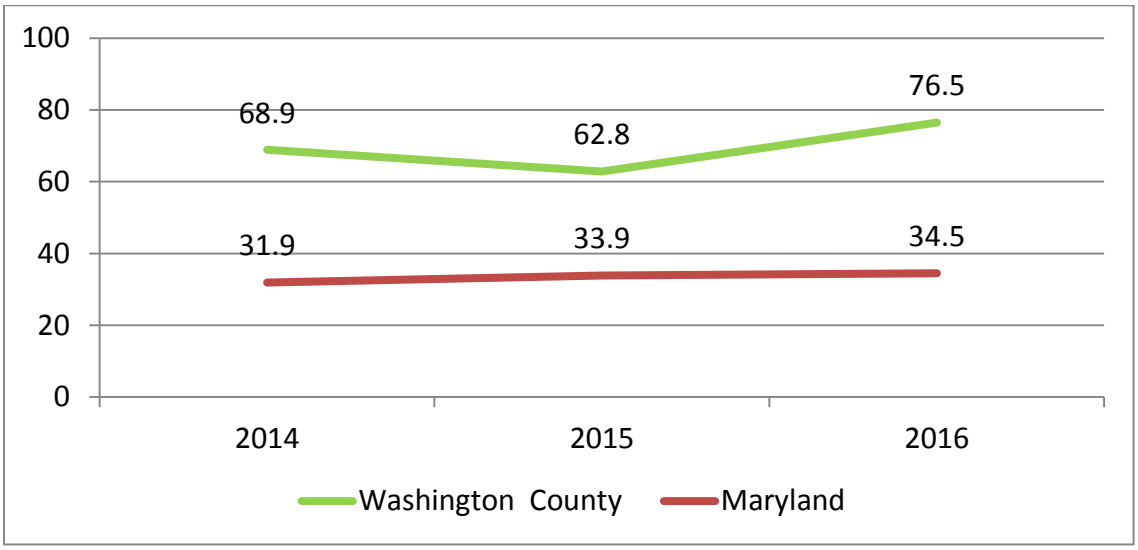
Focus group input regarding why diabetes is challenge in our community includes:

- "fast food is cheap and easy"
- There is a socioeconomic factor
- people lack knowledge of the diabetic resources available
- there is a lack of motivation to make changes when not in a "crisis"
- the location of health and education services are not always convenient
- the cost of care especially for treatment, medication and education

Respiratory

Chronic obstructive pulmonary disease (COPD) and asthma are significant public health burdens.[29] Mortality from chronic lower respiratory disease has increased in Maryland with a higher rate noted in Washington County. Specific methods of detection, intervention, and treatment exist that may reduce these disease burdens and improve the quality of life.

Figure 42. Chronic Lower Respiratory Disease Mortality (per 100,000 lives)



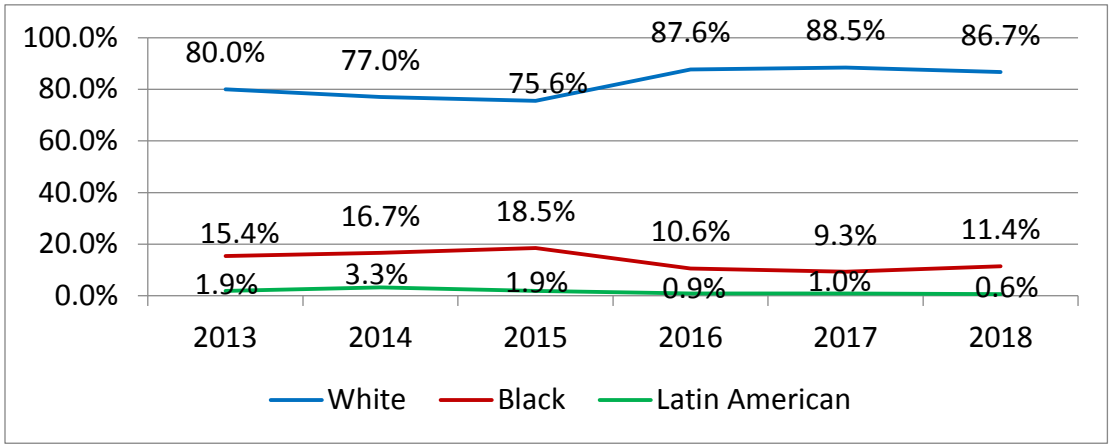
Source: Maryland Vital Statistics 2016

Chronic Obstructive Pulmonary Disease (COPD) is the main contributor to this group of diseases. Currently, COPD is the fourth leading cause of death worldwide. It is projected to move to third place by 2020. COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases.

While there are many new and effective medications available to treat COPD, cost remains the biggest barrier to those with the disease. Failure to keep exacerbations in check results in more frequent trips to the emergency room. When ED rates for COPD diagnosis are compared between the years 2013 – 2015 and 2016 – 2018, and are categorized by race, we find an increased rate of 10% among Whites, a decrease among Blacks 6.4%, and no significant change for Latinos (<0.015 variation) (see **Figure 43**). Between the years 2016 – 2018, COPD was identified as the second leading cause of hospital readmission.

[29] Centers for Disease Control and Prevention. National surveillance – United States. MMWR 2007.

Figure 43. COPD in Emergency Department



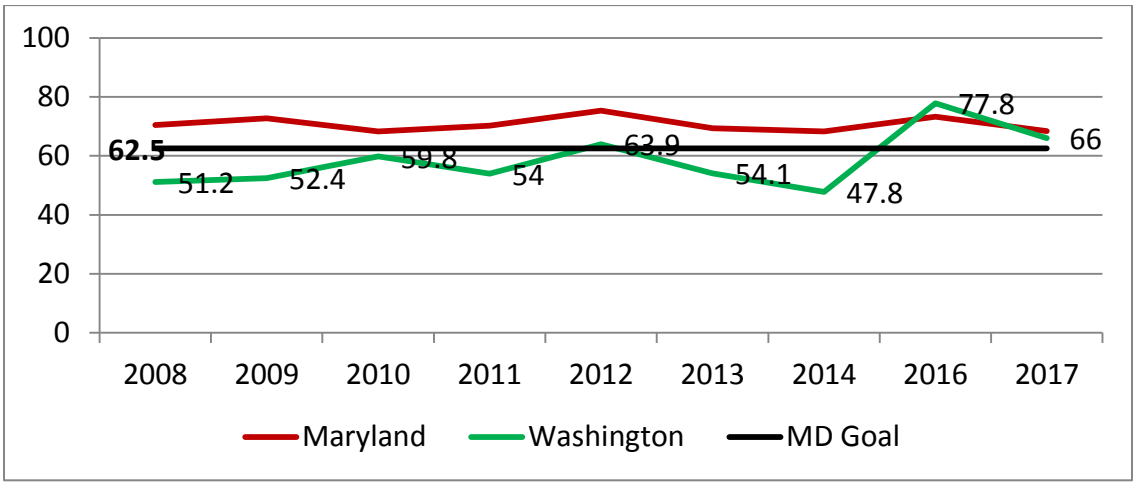
Source: Meritus Medical Center Emergency Department data 2013 - 2018

Treatment can lessen symptoms and improve quality of life for those with COPD. Smoking remains the leading risk factor for COPD. Prevention through nonsmoking or smoking cessation programs will impact the rate of COPD the most. People with advanced COPD have, on average, four comorbid conditions such as heart failure, hypertension, diabetes, obesity and mental health issues, all factors that contribute to poor outcomes.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. This disease affects 26 million Americans including 7 million children. Though asthma has some genetic risk factors, environmental factors play a large part in the development of the disease. Indoor factors such as mold, animal dander, insect droppings, smoke and vapors are controllable. Outdoor factors such as pollen, air pollution, temperature and humidity are more difficult to control. As with COPD, controller medications are often expensive and difficult to access, which contributes to higher emergency room visits.

Washington County Emergency Department visits for asthma have been historically below the state average and near or at target goal. The trend for Washington County was downward until 2016. However, the methodology used to select emergency department visits in the HSCRC data files changed in 2016. Therefore, data reports in 2016 and beyond are not be comparable to data reports released in earlier years.

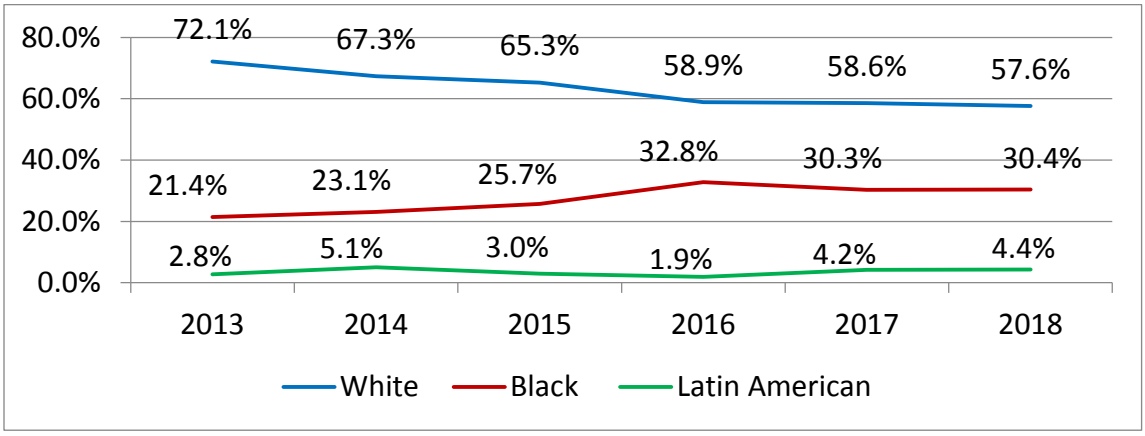
Figure 44. Emergency Department Asthma Visit Rates (per 100,000 population)



Source: Maryland SHIP 2019

When specific Meritus Medical Center Emergency Department (ED) visits for asthma symptoms are categorized by race (see **Figure 45**), a three year trend demonstrates an average decline of 9.9% annually among white persons and a 7.8% increase among black persons. The rate among the Latino persons is relatively flat during the three year time intervals with a change of less than 1%.

Figure 45. Asthma Rates by Race in Emergency Department



Source: Meritus Medical Center Emergency Department data 2013 – 2018

The national rates of hospitalization and death due to asthma have been three times higher among blacks than among whites.[30] According to the National Heart, Lung and Blood Institute Asthma is more common and more severe among children, women, low-income, inner-city residents, and African American and Puerto Rican communities. In general, these at-risk populations experience above-average rates of emergency department visits, hospitalizations, and death.[31] In addition to genetic risk, explanation for greater disparity includes economic, social and cultural determinants of health. "Individuals within disadvantaged populations also may face substandard housing and work conditions that place them at greater risk for frequent and prolonged exposure to environmental allergens and irritants that worsen asthma." [32] Research demonstrates that culturally competent clinical and educational approaches are most effective when tailored to the individual needs of the patient. Disparities in the burden and care of asthma suggest that such approaches are needed in Washington County.

[30] Centers for Disease Control and Prevention. Asthma prevalence, health care use and mortality: United States, 2003-05

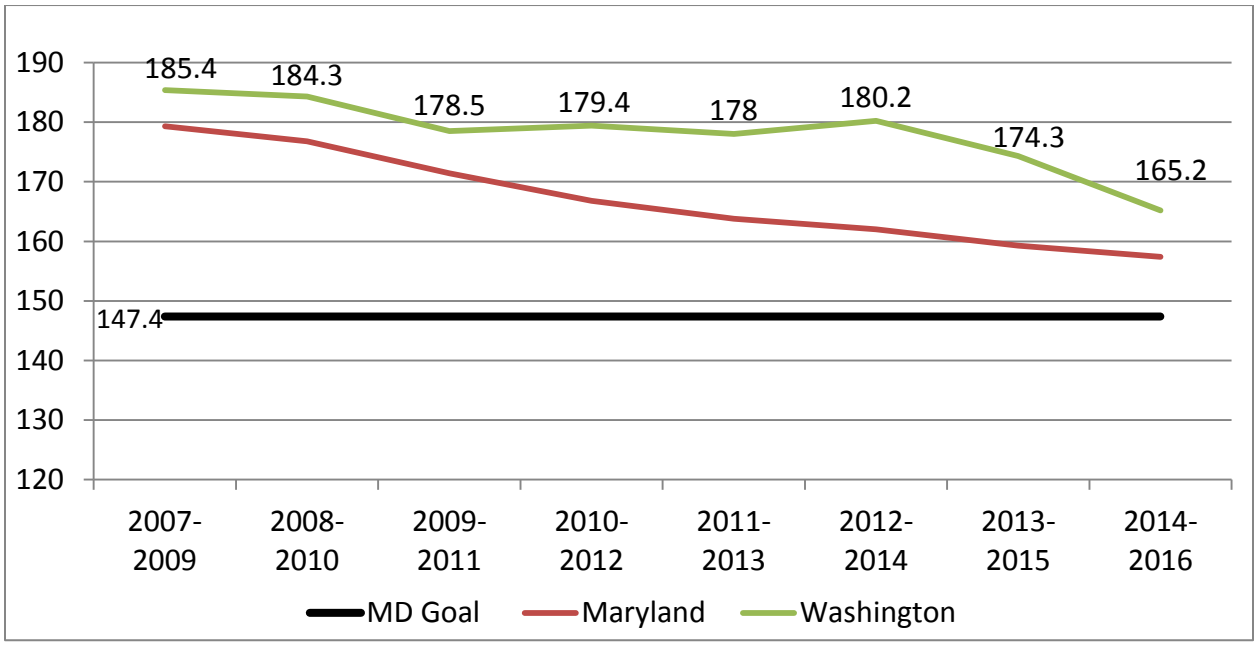
[31] https://www.nhlbi.nih.gov/health-pro/resources/lung/naci/discover/disparities.htm accessed 3/22/2019

[32] Ibid.

Cancer

Cancer continues to be the second leading cause of death for Washington County residents (21%).[33] The cancer mortality rate in **Figure 46** indicator shows the age-adjusted mortality rate from cancer (per 100,000 population) in Washington County compared to the state of Maryland. The Washington County rate has consistently been higher than the state average but is showing a positive decreasing trend over the past nine years. Maryland's age adjusted cancer mortality rate remains higher than the U.S. but is also decreasing and edging closer to the goal of 147.4 per 100,000 persons.

Figure 46. Cancer Mortality (per 1,000 lives)

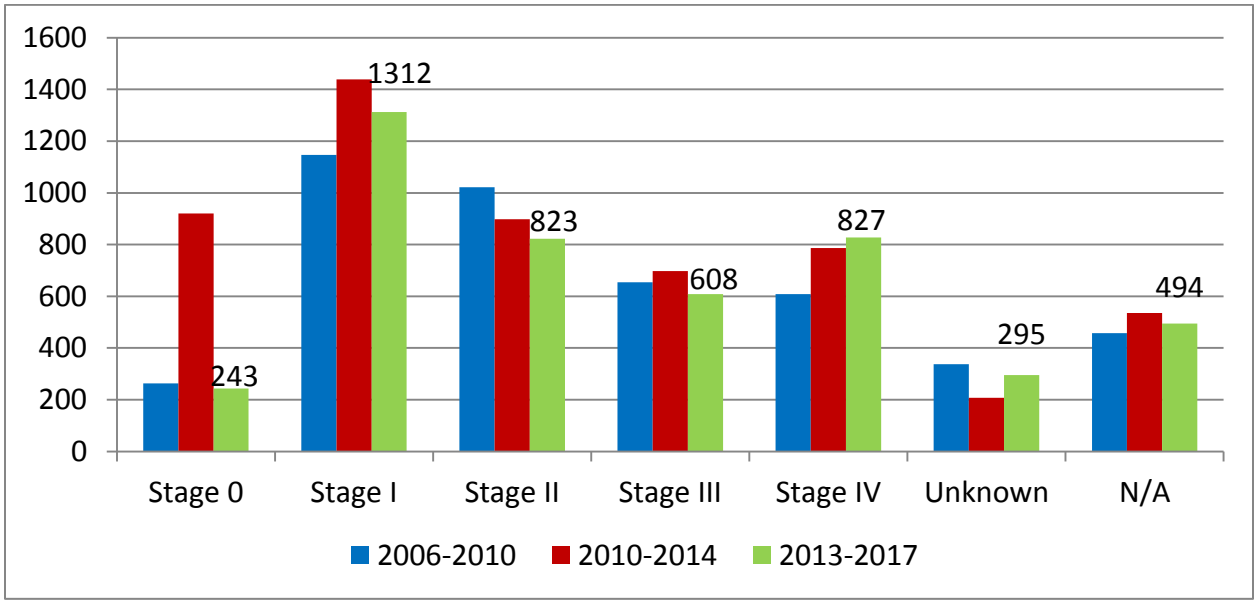


Source: Maryland Vital Statistics 2007 - 2016

Cancer impacts people across all racial and socio-economic groups. The graph below details the malignant neoplasms, or "cancer" diagnosis to include the stage of disease progression (I, 2, 3 or 4), grouped in four year intervals using data from the cancer registry at Meritus Medical Center (see **Figure 47**). With the exception of some stage 4 diagnosis, cancer cases are being diagnosed earlier. It is a positive trend that the majority of new diagnoses occur in earlier stages, allowing for timely intervention and in many cases improved prognosis and survivability.

[33] Maryland Vital Statistics 2016

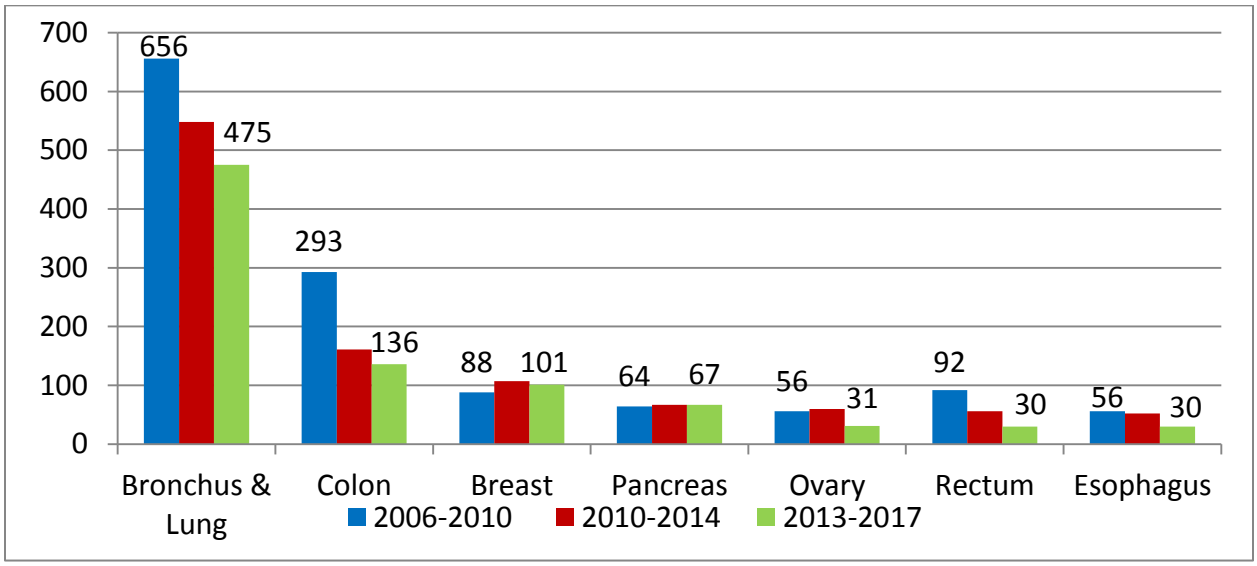
Figure 47. Meritus Medical Center Cancer Cases



Source: Meritus Medical Center, John R. Marsh Cancer Registry 2018

Disease sites with a larger volume of Stage III and IV cancers demonstrate significant reductions in bronchus & lung, colon, ovarian, rectal and esophageal cancers for years 2013-2017 compared to the prior four year period, 2010-2014. The John R Marsh Cancer Center has been using a low-dose CT screening protocol for earlier detection of lung cancer. The stage 3 and 4 diagnoses of breast and pancreatic cancer were similar for the prior periods (see **Figure 48**).

Figure 48. Meritus Medical Center Cancer Disease Sites with Larger Volume of Stage 3 or 4



Source: Meritus Medical Center, John R. Marsh Cancer Registry 2018

Meritus Medical Center continues to demonstrate commitment to the quality of care that cancer patients receive. Over the past three years the Comprehensive Community Cancer Program was reaccredited by the American College of Surgeons, the Center for Breast Health was reaccredited by the National Accreditation Program of Breast Centers, and Radiation Oncology services were reaccredited through the American College of Radiology.

Additionally Meritus continues to invest in the cancer service programs, including the development of the Meritus Hematology Oncology Specialists practice, providing four Registered Nurse Clinical Navigators, adding registered dietitian services, and initiating the Hope Soars Survivorship Program as a support to patients in recovery.

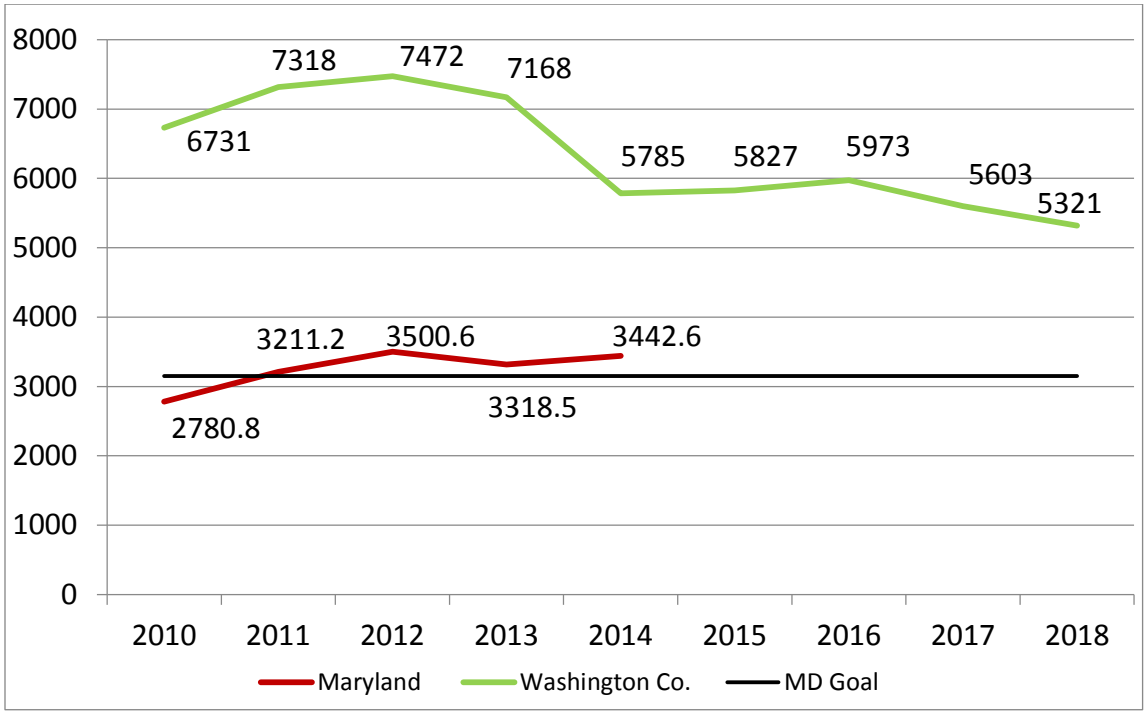
The leadership from the Cancer Committee and the Hematology Oncology Service Line dyad at Meritus Medical Center has identified the following needs for the patients in our community:

- Earlier diagnosis of lung cancer: Conducting quarterly low dose CT screenings and providing education to providers and the community
- Reducing head and neck cancer mortality by developing clinical pathways and earlier access to an RN clinical navigator to reduce barriers and improve compliance
- Reducing colon cancer mortality by developing a colon cancer pathway and providing earlier access to RN clinical navigator to reduce barriers and increase compliance
- Earlier diagnosis of colon cancer through providing education to the providers and community on colon cancer screening and use of electronic health record reminders

Mental Health

Mental illness is a critical health problem in the U.S. Mental illnesses are common with one in five adults or approximately 46.6 million Americans will experience a diagnosable mental illness in a given year, but less than half (42.6%) receive any form of treatment.[34] About 4.5% of adults live with a serious mental illness (SMI).[35] Annually, Washington County continues to experience a significantly higher number of Emergency Department (ED) visits for behavioral health and crisis services (5,785) than the state of Maryland average (3,443).

Figure 49. Mental Health Emergency Department Visits



	2008	2009	2010	2011	2012	2013	2014
MD Goal	3152.6	3152.6	3152.6	3152.6	3152.6	3152.6	3152.6
Maryland	2393	2550.9	2780.8	3211.2	3500.6	3318.5	3442.6
Washington	5171.8	4968.9	6730.6	7318.2	7472.1	7168.4	5785.3
Allegany	3363.4	3523.1	2320.6	2797.5	3107.8	4318.2	4722.9
Frederick	1229.8	1371.1	1448.1	3126.6	5282.6	3788.9	3892
Carroll	1336.5	1642.4	2755.9	3812.2	3087.7	3368.5	3140.8

Source: Maryland SHIP 2018 and Meritus Medical Center 2018

[34] National Institutes of Health, National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml accesses

[35] Center for Behavioral Health Statistics and Quality. (2018). National-level comparisons of mental health estimates from the National Survey on Drug Use and Health (NSDUH) and other data sources: NSDUH methodological report. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Following a disruption and end of funding to our Intermediate Mental Disorders (IMD) the net result is fewer inpatient beds are currently funded in Maryland specialty facilities, decreasing access to inpatient acute care beds for persons with mental illness. In Maryland, the state psychiatric hospitals have transitioned to provide care primarily for the forensic patient population. As a result of these changes general community hospitals become the default safety net to provide care to persons with chronic, serious mental illness.

> **"Mental health treatment isn't always available when the person is ready for help."**
>
> Focus group participant

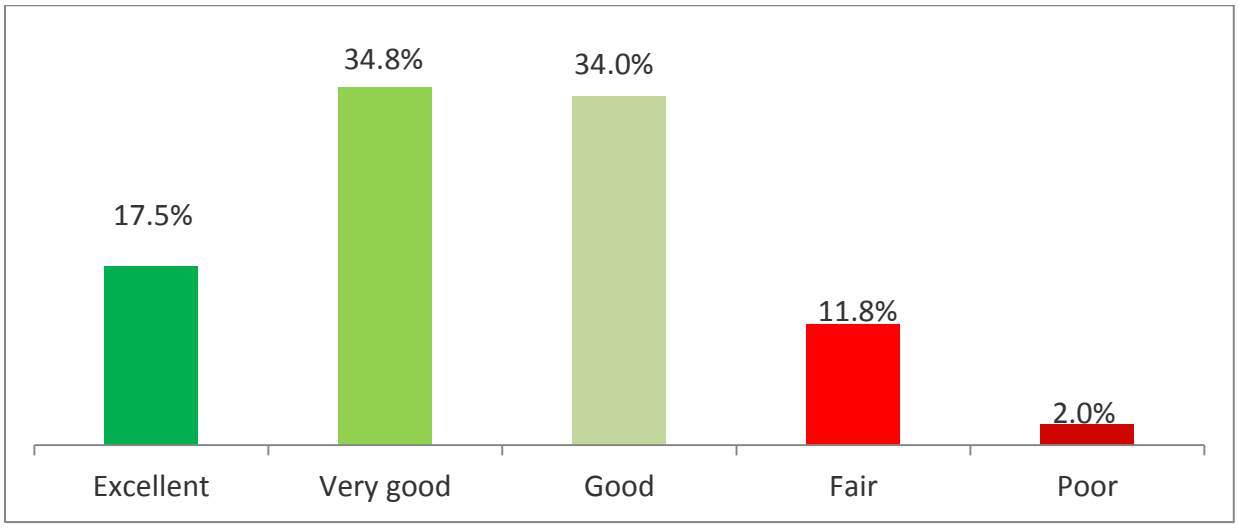
Increased ED utilization is associated with an inability to receive mental health treatment on an outpatient basis. At the time of this report the wait time for a new patient to see a psychiatrist averaged five weeks. The Physician Needs Assessment from 2016 identified a shortage in psychiatric providers for the primary service area. The recruitment of new psychiatrists to the area has been challenging and is an identified need by some outpatient services. Outpatient programs have begun hiring Nurse Practitioners and Physician Assistants to help meet increased demand for medication evaluation and management.

There is evidence that patients in crisis seek out treatment intervention in local Emergency Departments when an outpatient appointment is not readily available. The primary diagnoses for behavioral health ED visits include mood, anxiety, psychosis and substance-related disorders. It is noted that Washington County has no licensed crisis beds within the community. Crisis beds in other counties are used as a "step-up" service providing 24 hour monitoring without the need for inpatient hospitalization, or as a "step-down" as a transition from acute level of care back into the community setting. Crisis beds are useful for persons with chronic mental illness who are evaluated as "low risk" for self-harm and could benefit from increased structure and monitoring for short time periods to help stabilize mood and behavior.

The self-reported mental health status is a widely used measure of people's health-related quality of life. The average number of mentally unhealthy days reported in past 30 days (age-adjusted) for Washington County is higher at 3.9 days compared to an overall score of 3.5 for Maryland.

Survey participants demonstrated a range of responses when rating their overall mental and emotional health. While the majority of respondents indicated that it was good to excellent (86.3%), 11.8% rated their mental health as "fair" and 2% rated it "poor" (see **Figure 50**).

Figure 50. Question 16. In general, how would you rate your overall mental or emotional health?



Two subsequent survey questions were asked, based on the PH-Q2 depression screening tool (see **Figures 51** and **52**).

Figure 51. Question 17. Based on PHQ-2 depression rating scale

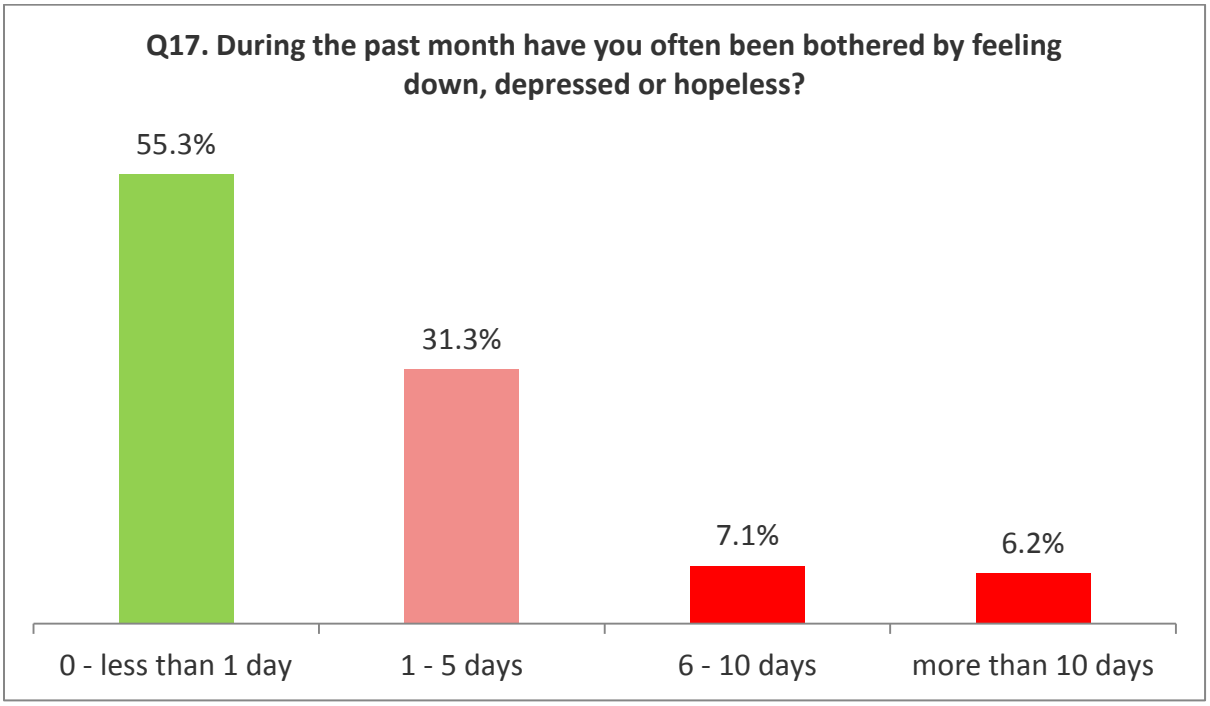
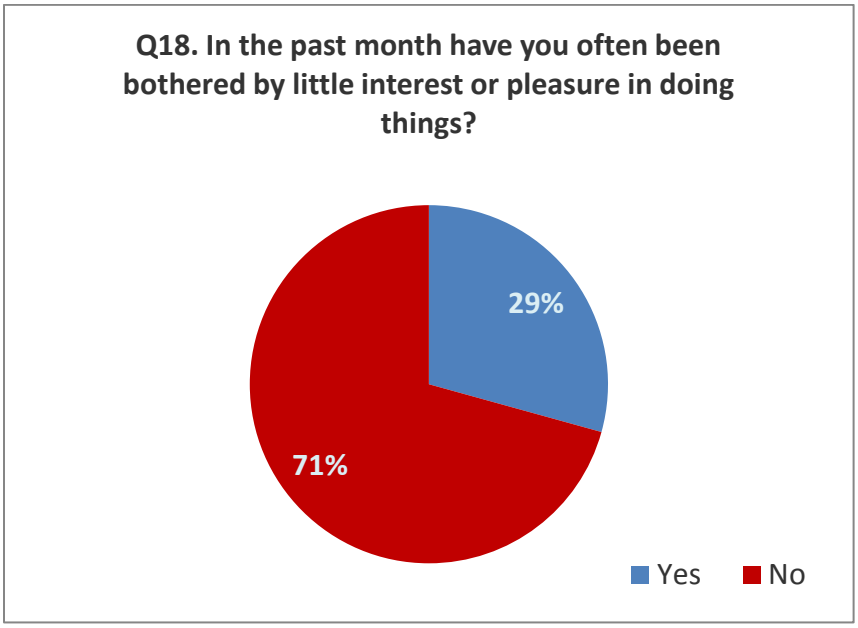


Figure 52. Question 18. Based on PHQ-2 depression rating scale



The questions were stated as:

1. During the past month how often have you been bothered by feeling down, depressed or hopeless? 44.6% answered "yes", with 13.3% having a positive screen.

2. During the past month have you often been bothered by little interest or pleasure in doing things? 29% answered "yes".

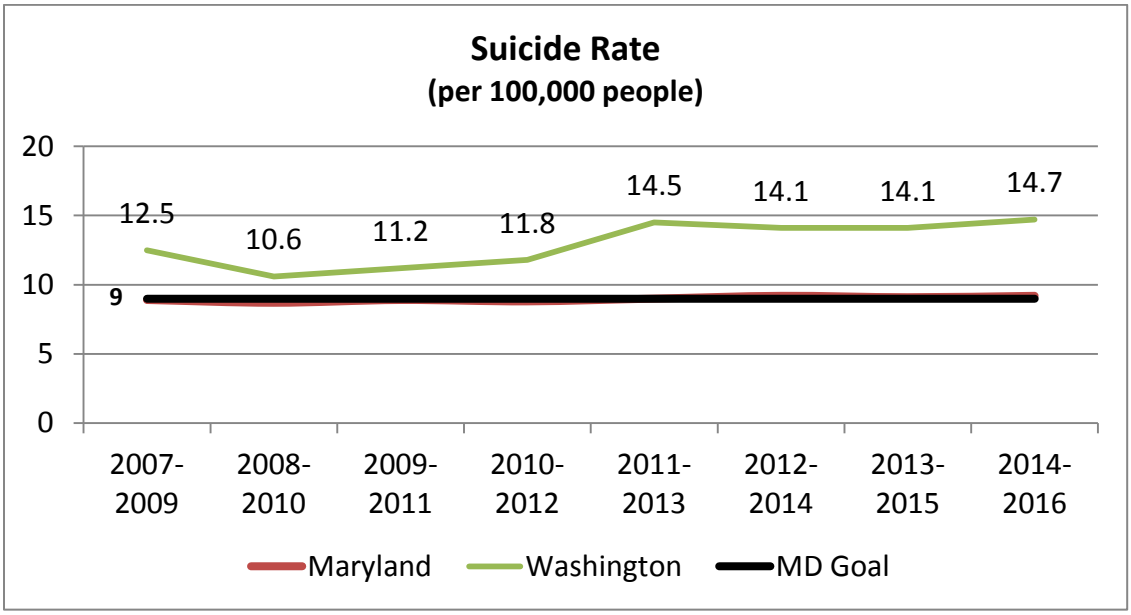
The respondents who answered both questions "yes" totaled 27.3%, five percent ***higher*** than the same result in 2015. Affirmative answers to these screening questions suggest the need for further evaluation of depressive symptoms (not designed as a diagnostic instrument).

Suicide

The rate of suicide per 100,000 persons in Washington County increased to 14.7 in the most recent vital statistics report, years 2014 – 2016. According to a CDC report released in January 2019, rates of death by suicide in the country have increased by 25% over the two decades ending in 2016 with rates rising by more than 8% in Maryland.[36] The CDC reports that more than half (54%) of successful suicides are by people who did not have a known mental health diagnosis. Since 2008, the suicide rate in Washington County has experienced an increased suicide rate trend that is higher than both the state of Maryland average and the MD2020 goal of 9 per 100,000 (see **Figure 53**).

[36] Suicide rising across the US. (2019). https://www.cdc.gov/vitalsigns/suicide/

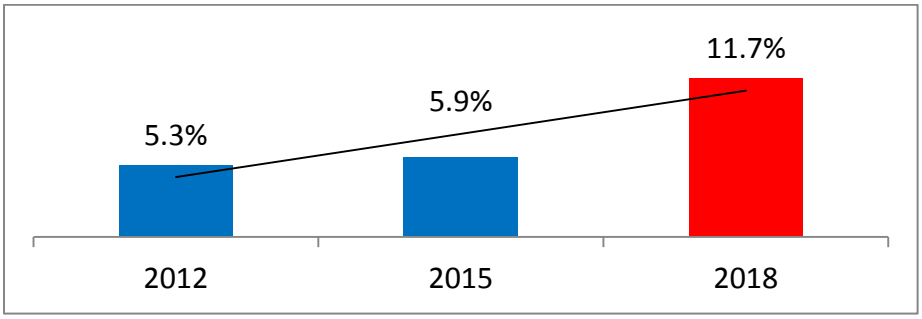
Figure 53. Suicide Rate



Source: Maryland Vital Statistics 2016

Survey respondents indicated that they were unable to obtain mental health or substance abuse treatment when they needed it, 11.7%. This is a significant increase from the 2012 and 2015 survey years (see **Figure 54**).

Figure 54. Question 19. Have you ever needed mental health and couldn't get it?



Despite more Washington County residents being insured between 2012 – 2018, the surveyed rate of persons who couldn't get mental health treatment when needed increased significantly by more than 6% (5.3% vs. 11.7%). An additional 3.8% selected "prefer not to answer" this question instead of skipping the question entirely.

A barrier identified by the mental health focus group was the inability to access treatment on demand when the person is ready, or in crisis. Higher percentages of persons who could not access mental health treatment when needed is partially attributed to the shortage of

psychiatric treatment providers and their capacity to schedule new patient appointments promptly. At the time of the survey a sample of community provider appointment wait times for a "new patient" to see a psychiatric provider for medication evaluation ranged from 4 to 6 weeks. An additional barrier is the uninsured or "underinsured" population with limited behavioral health benefits coverage, and high co-pays or insurance deductibles for persons with behavioral health needs. A sample of outpatient programs report 15-20% no show and cancellation rate demonstrating some unused capacity.

Regarding why mental health is a challenge in our community the summary points from focus group members input include:

- stigma and denial of the problem
- depression symptoms are minimized
- cost for uninsured
- high deductibles co-pays and co-insurance
- limited mental health benefits
- "I don't want my employer to know I'm getting treatment"
- federal rules around confidentiality
- long waits for new psychiatry patient intake
- shortage of psychiatry providers
- few options for medication management other than psychiatry

Substance Use Disorder

According to the 2017 National Survey on Drug Use and Health (see **Appendix L**), 19.7 million adults had a substance use disorder during 2017.[37] From this report, the most used substance was identified as alcohol, 74%. Nearly 38% of adults' drug of choice was an illicit drug including heroin, cocaine, and methamphetamines, and marijuana. Drug abuse and addiction is estimated to cost society more than $740 billion annually in lost workplace productivity, healthcare expenses, and crime.[38]

The use of alcohol, illicit substances, heroin, opioids and other prescription drugs has increased in Washington County over the past ten years. When compared with the state of Maryland averages, Washington County's drug and alcohol use trends are consistent with the rest of the state.

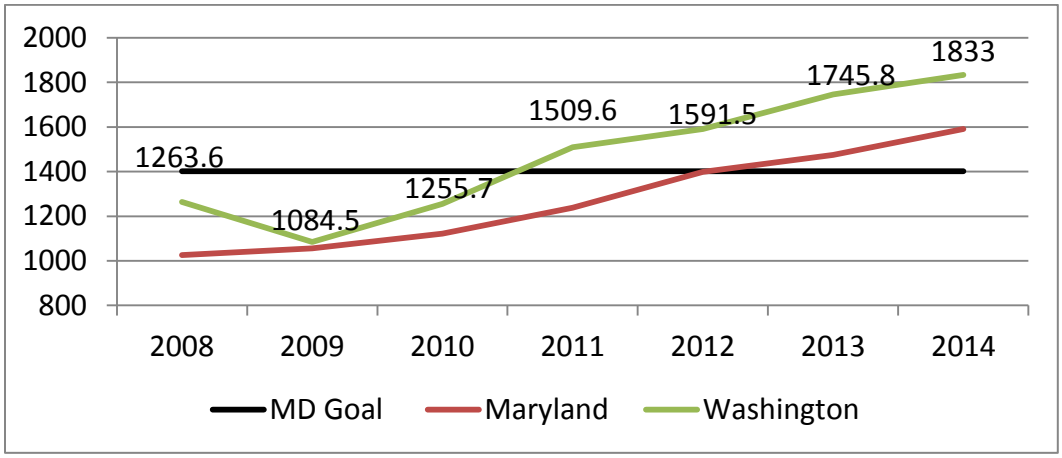
Alcohol related disorders are 24% in Washington County compared to 23.8% for the state of Maryland.[39] Excessive Drinking measures the percentage of a county's adult population that reports binge or heavy drinking in the past 30 days. The Washington County rate for excessive drinking is 16% compared to the Maryland rate of 17%.[40] Excessive drinking is a risk factor for a number of adverse health outcomes that may include alcohol poisoning, hypertension, heart attack, sexually transmitted infections, unintended pregnancy, suicide, and motor vehicle crashes among others.

> ***"I wasn't able to get into treatment when I needed it the most."***
>
> Focus group participant

Despite alcohol and illicit drug disorder rates being very similar between Washington County and the state of Maryland, locally we have experienced a steady annual increase in Emergency Department addictions related visits that include alcohol and drug-related disorders from 2009 to 2014 (see **Figure 55**). Substance abuse problems and drug overdoses place a heavy burden on the healthcare system, particularly when persons who need treatment resort to help through emergency departments.

[37] Substance Abuse and Mental Health Services Administration. (2018). Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health.
[38] National Institute on Drug Abuse. (2017). Trends & Statistics. https://www.drugabuse.gov/related-topics/trends-statistics accessed Nov. 19, 2018.
[39] National Institute on Alcohol Abuse and Alcoholism. Alcohol Facts and Statistics. Last reviewed June 2017. Accessed February 21, 2018
[40] Behavioral Risk Factor Surveillance System (BRFSS), Maryland as conducted by the CDC. www.cdc.gov

Figure 55. Meritus Addictions Emergency Department Visits



Source: Maryland Vital Statistics 2016

The state of Maryland Department of Health maintains counts of unintentional drug- and alcohol-related intoxication deaths occurring throughout the state by county. **Table 16** shows data by drug classification for 2007-2017. Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.

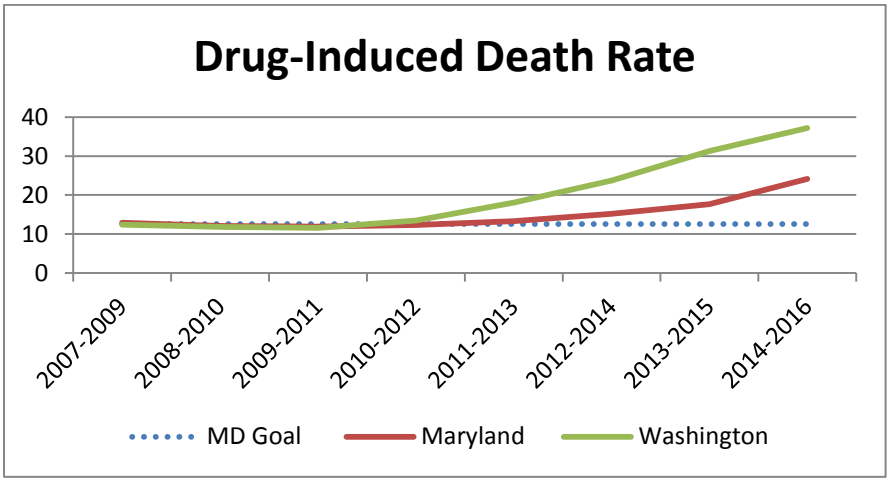
Table 16. Unintentional Drug and Alcohol-related Intoxication Deaths, Maryland

Substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018*
Alcohol	3	10	4	5	4	3	6	11	10	17	14	11
Cocaine	3	1	0	3	3	5	6	6	10	9	10	21
Heroin	5	13	11	6	8	11	14	21	38	39	22	23
Fentanyl	0	0	0	2	1	1	4	1	14	31	39	52
Prescription	7	10	4	7	11	9	11	16	20	23	8	14

Source: Maryland Depart of Health, 2018

A key driver in fatal overdoses has been the increase in opioid-related overdose since 2011. Between 2010 and 2012, drug induced rates of death increased significantly in Washington County which in prior years had remained equal to or lower than the state of Maryland average (see **Figure 56**). Through 2016 the current trend has increased at a rate higher than the state average for the past eight years. In 2017 there were 309 overdoses and 39 deaths. In 2018, there were 347 overdoses and 62 deaths at the time of this assessment. In 2018 there was a 55% increase in opioid related deaths and the overall opioid related death rate increased by 5%.

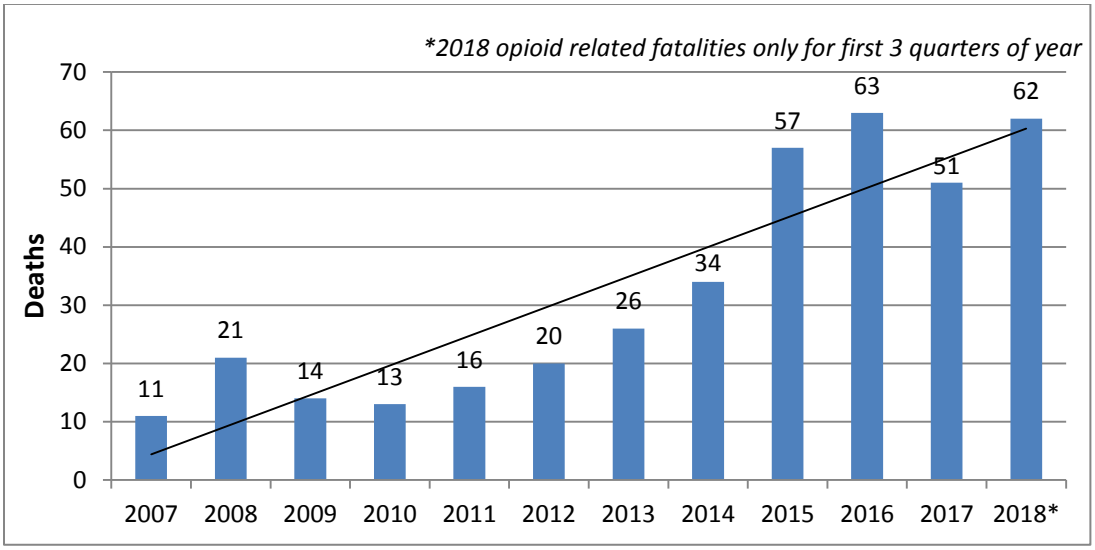
Figure 56. Drug Induced Death Rate



Source: Maryland Vital Statistics 2016

An increase in opioid use, misuse and abuse has resulted in more overdose deaths, a national trend that is seen in both the state of Maryland and Washington County. Opioid related intoxication is the leading cause of drug overdose fatality in Washington County and have increased every year but one since 2010 (see **Figure 57**). The drug mortality review process finds that most opioid deaths in Washington County over the past two years are attributed to the drug Fentanyl, which is much more powerful than heroin and other prescription opioids. The 2018 data in the figure below only includes data from the first nine months of the year which will result in the most opioid overdose deaths in one year ever for our community.

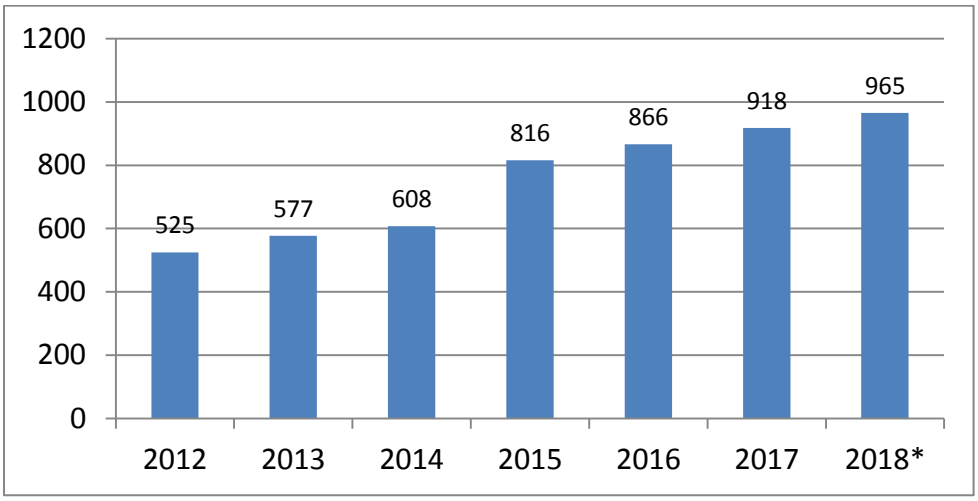
Figure 57. Opioid Related Intoxication Deaths – Washington County



Source: Maryland Department of Health March 2019

Since 2010 there is an increased trend for people presenting for emergency treatment in the ED related to opioid overdose. In 2017 there was a 27% increase in visits and in 2018 another 11% increase. More women are treated in the ED for opioid overdose than men. The administration of naloxone (Narcan®) can be effective for the treatment of opioid-induced respiratory depression in adults. The need to administer naloxone during an ED visit in attempt to reverse an opioid overdose has also increased annually (see **Figure 58**). The 2018 data is preliminary based on the first nine months of the year. During FY2018 approximately 5% of babies born at Meritus Medical Center were diagnosed with Neonatal Abstinence Syndrome (NAS).

Figure 58. Meritus Medical Center Health ED Visits with Administration of Naloxone HCl 2mg/2mL syringe



Source: Meritus Medical Center Emergency Department pharmacy data 2011 - 2018

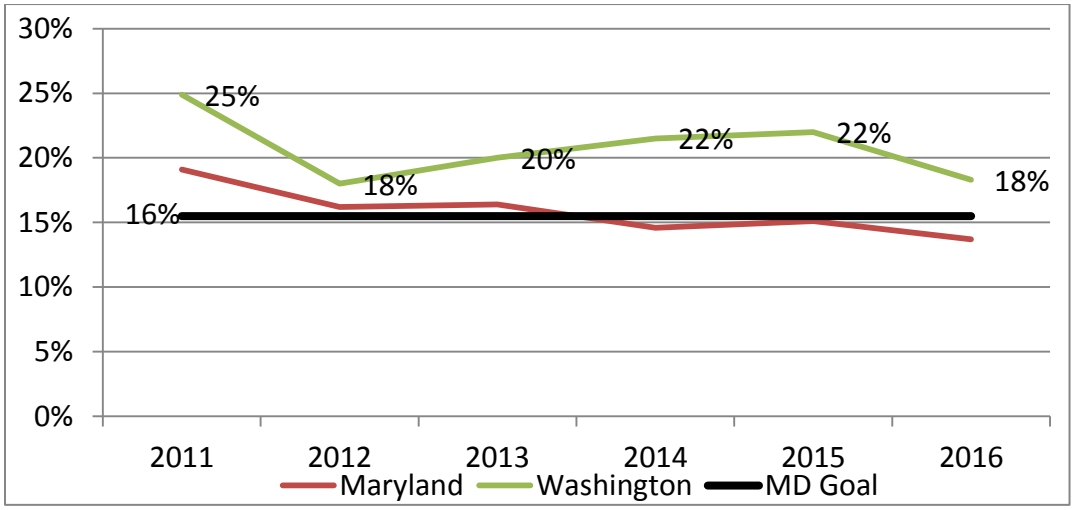
Focus group input regarding why substance abuse and addiction issues are a challenge in our community included:

- drugs are readily available
- timely treatment is not readily available
- there are a lack of inpatient beds
- no “detox” or crisis services
- pain management by doctors is part of the problem
- stigma
- sometimes viewed as a moral problem or “weakness”
- can have association with crime
- socioeconomic factors contribute to using
- a lack of transportation to outpatient treatment

Tobacco Use

Smoking, electronic cigarettes and smokeless tobacco use was reported in the survey at a combined total of 15.8%. The most recent Maryland SHIP surveillance data reports the value as 20% among adults, slightly higher than the survey's margin of error. Adult tobacco use is declining in Washington County but remains well above the state average and is far short of the Maryland 2017 goal of 15.5% (see **Figure 59**). Unregulated E-cigarettes and "vaping" are electronic nicotine delivery systems that are gaining in popularity, but have still largely unknown public and individual health effects.

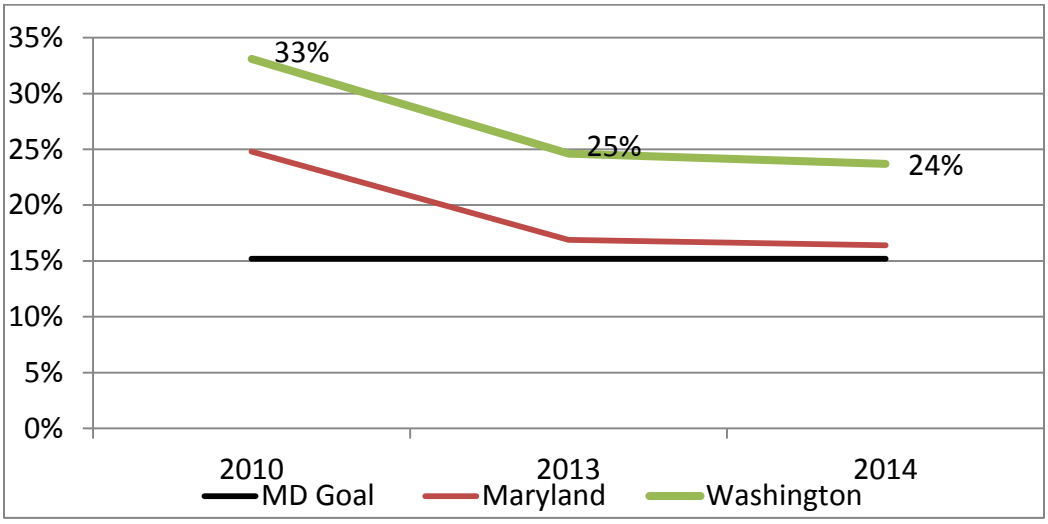
Figure 59. Adult Tobacco Use



Source: Maryland Vital Statistics 2016

There is a decreased rate of tobacco use among adolescents in Washington County from 2010 - 2014 (-8.5%), however the rate of 24.6% remains much higher than the overall state average of 16.9% and far short of the Maryland state goal to reduce to 15.2% by 2017 (see **Figure 60**). The decrease in rate of tobacco use amongst adolescents corresponds to the increased surveillance and monitoring of retailers to prevent sales of tobacco to minors. Additional detail on tobacco and drug use trends among youth can be reviewed in the Child Health section of this report (see page 89).

Figure 60. Adolescent Tobacco Use



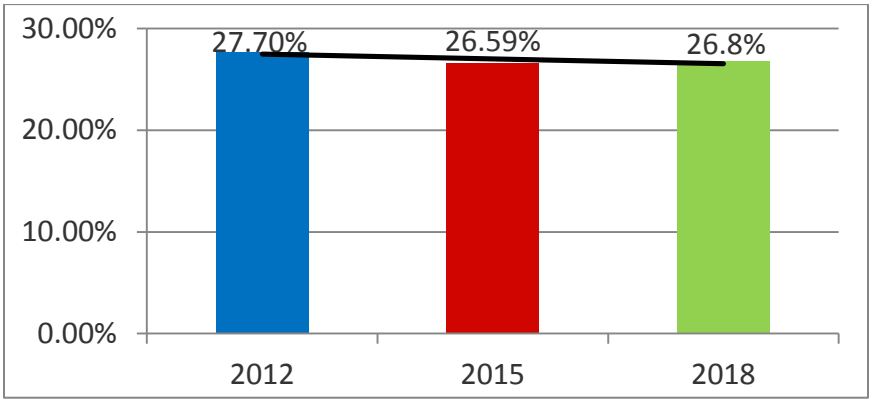
Source: Maryland Vital Statistics 2016

Additional findings for youth tobacco use rates from the 2016 Maryland Youth Risk Behavior and Youth Tobacco Survey (YRBS/YTS) are summarized in the Child Health section (see **page 88**).

Dental

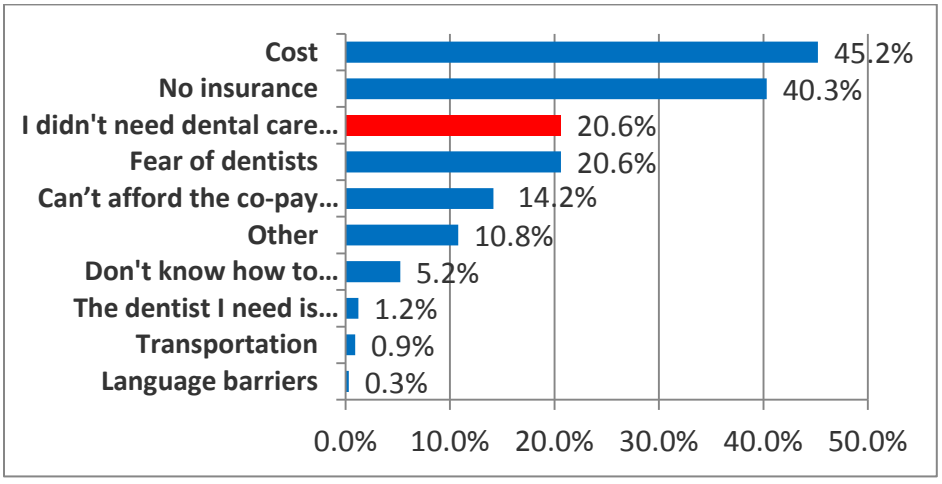
Good oral and dental health is a worthy goal in and of itself as it presents someone with a healthy smile, good breath and keeps teeth healthier over the lifespan. Recent research suggests that there may be an association between oral gum infections and poorly controlled diabetes, cardiovascular disease and preterm birth[41]. Preventative care that includes cleaning every six months helps to maintain good dental hygiene. More than 26% of survey respondents report having not received any dental care over the past year, a trend that is unchanged.

Figure 61. Question 21. In the past 12 months did you receive dental care? Answered "NO"



Economic considerations including cost (45.2%), no insurance (40.3%) and unaffordable co-pays (14.2%) are again identified as the primary barriers among persons having not received dental care in the past 12 months (see **Figure 62**).

Figure 62. Question 22. If no, why have you not received dental care?

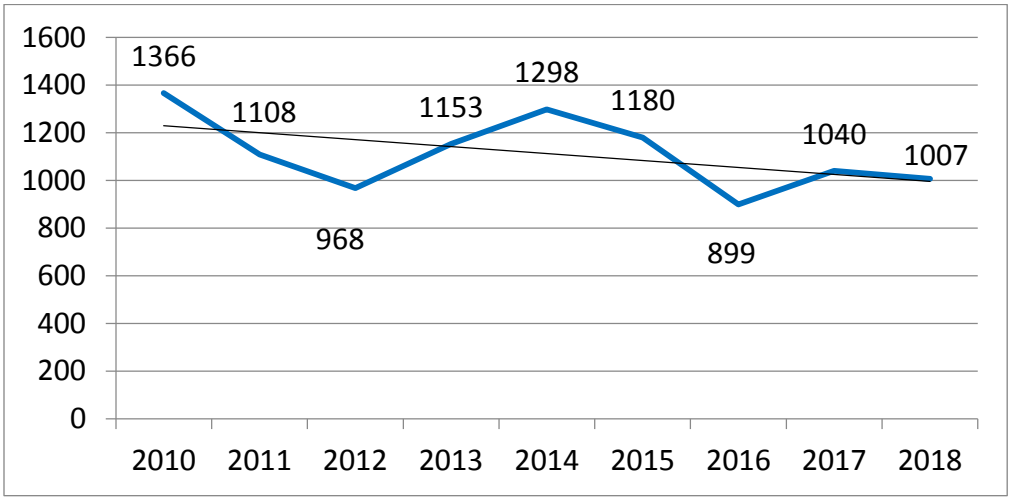


[41] Oral health: A window to your overall health; http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475

Maryland BRFSS data indicates that 12.7% of Washington County did not access dental care specifically because of cost. Of note, 20.6% of respondents reported "didn't need dental care" in the past 12 months suggesting a lack of knowledge regarding the recommended routine cleaning every six months for good dental hygiene and preventative health.

All of Washington County is designated as a Health Professional Shortage Area (HPSA) for Medical Assistance patients who need dental care. When people are experiencing dental pain and cannot obtain immediate help through an outpatient office or cannot afford to see a dentist they most often resort to visiting the ED. The trend indicates use of the ED for emergency dental care has decreased over the past nine years (see **Figure 63**).

Figure 63. ED Avoidable Condition: Dental



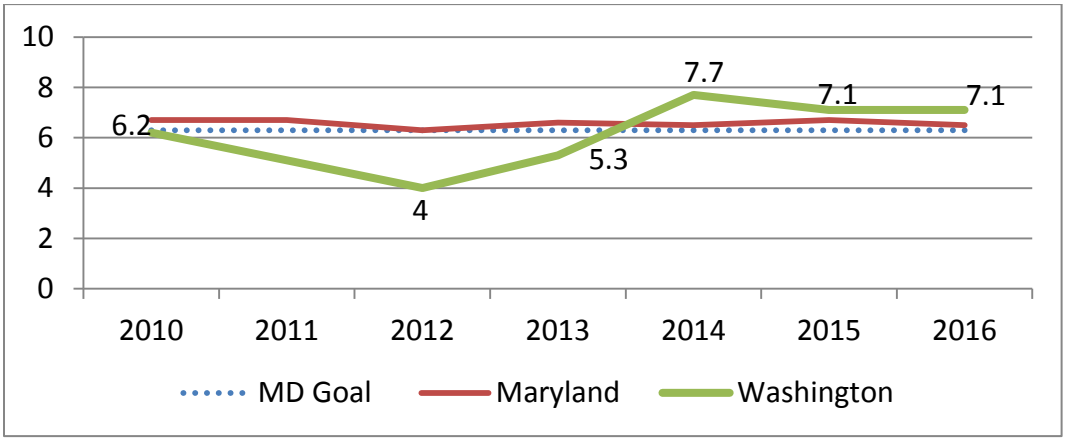
Source: Meritus Medical Center Emergency Department Data 2010 - 2018

Family Healthcare of Hagerstown (FQHC) provides adult and child dental services that include an office practice and mobile dental services that target Washington County Public Schools and Hagerstown neighborhoods. A sliding-scale fee program is available. Expanding dental services for county residents are dependent on the receipt of additional grant funds.

Child Health

One strategy to help prevent chronic disease is early intervention and promotion of healthy lifestyles with children. Infant mortality has long been considered the most sensitive indicator of the overall health of a population. While there have been several decades of improvement in infant mortality, Maryland's rate of 6.5 per 1,000 births remains higher than the national average. The Washington County rate is measured at 7.1 for years 2015 – 2016 as noted by the Maryland Vital Statistics, 2016.

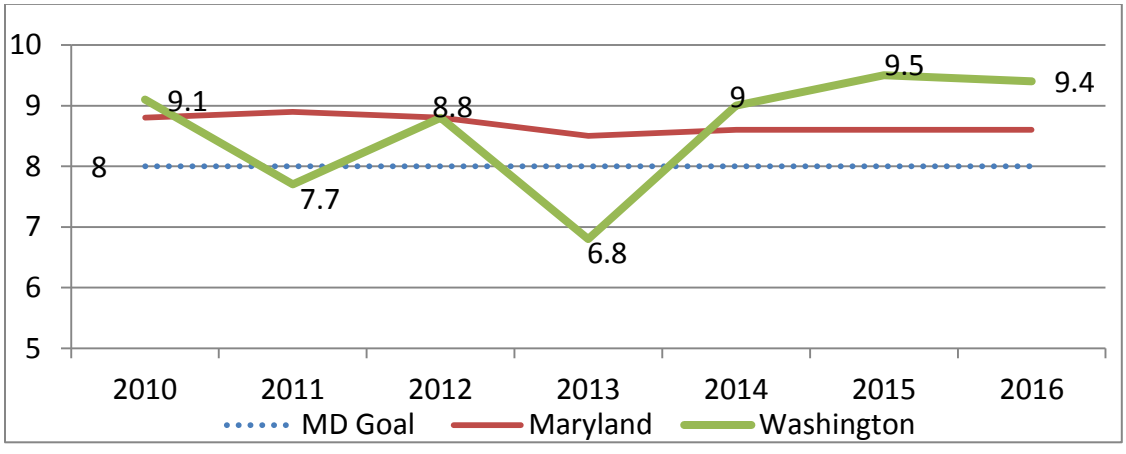
Figure 64. Infant Death Rate (per 1,000 lives)



Source: Maryland Vital Statistics 2014- 2016

Healthy children start with good pre-natal care of the mother as measured by the outcome of infants born with low birth weight. This indicator shows the percentage of live births that are a low birth weight defined as 5.5 pounds or less (**Figure 65**). Babies born with a low birth weight are at increased risk for serious health consequences including disabilities and death. Both Maryland and Washington County's low birth weight percentage is higher than the national average.

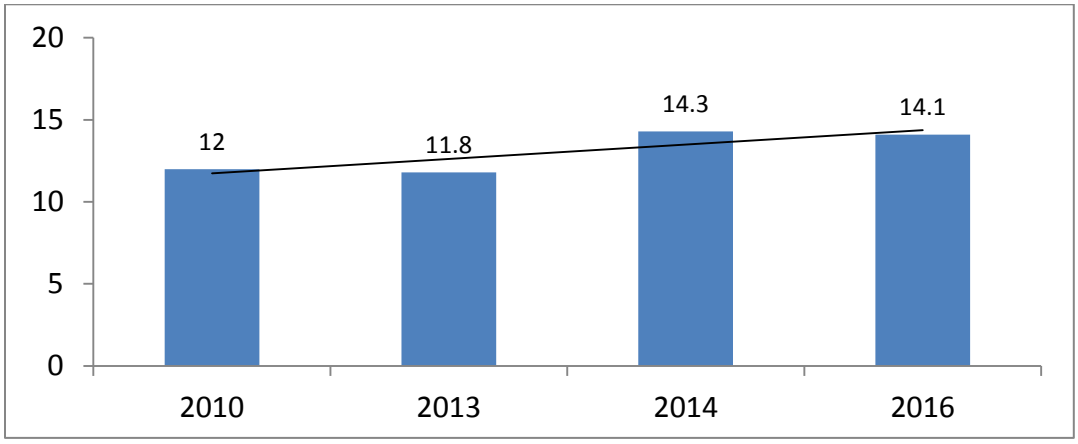
Figure 65. Infants at Low Birth Weight (per 1,000 lives)



Source: Maryland SHIP 2018

The Obesity Rate in Children indicator shows the percentage of children and adolescents who are obese. In the last 20 years, the percentage of overweight/obese children has more than doubled and, for adolescents, it has tripled. Obesity is a risk factor in the development of life-threatening chronic disease including hypertension, Type II diabetes, heart disease and some cancers. Decreasing the rate of obesity in children and teens continues to be a leading State Health Improvement Plan indicator. The rate of obesity for Washington County children has trended higher than the state during the past surveillance period, 2010 – 2016 (see **Figure 66**).

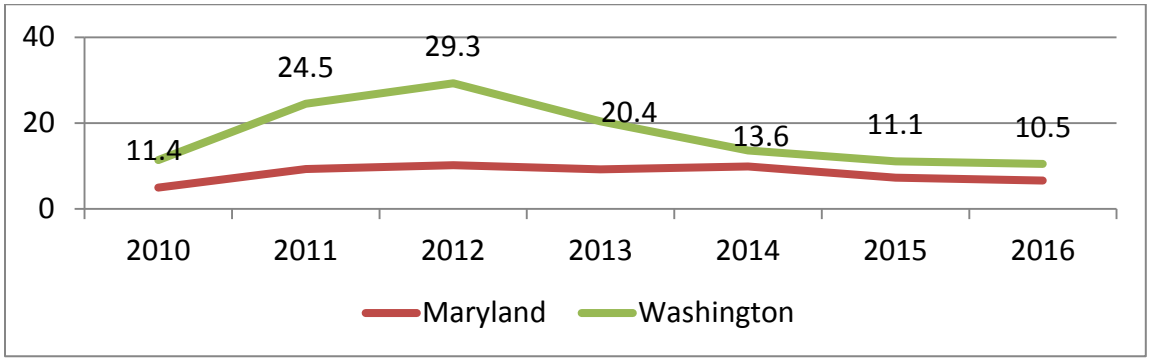
Figure 66. Percentage of Children who are Obese



Source: Maryland SHIP 2018

The child maltreatment indicator shows the rate of children who are maltreated per 1,000 population under the age of 18 (**Figure 67**). Child abuse or neglect can result in physical harm, developmental delays, behavioral problems, or death. Abused and neglected children are at greater risk than other children for delinquency and mistreatment of their own children. The child maltreatment rate in Washington County continues to decline, but remains slightly higher than the state average. Family intervention and prevention efforts continue.

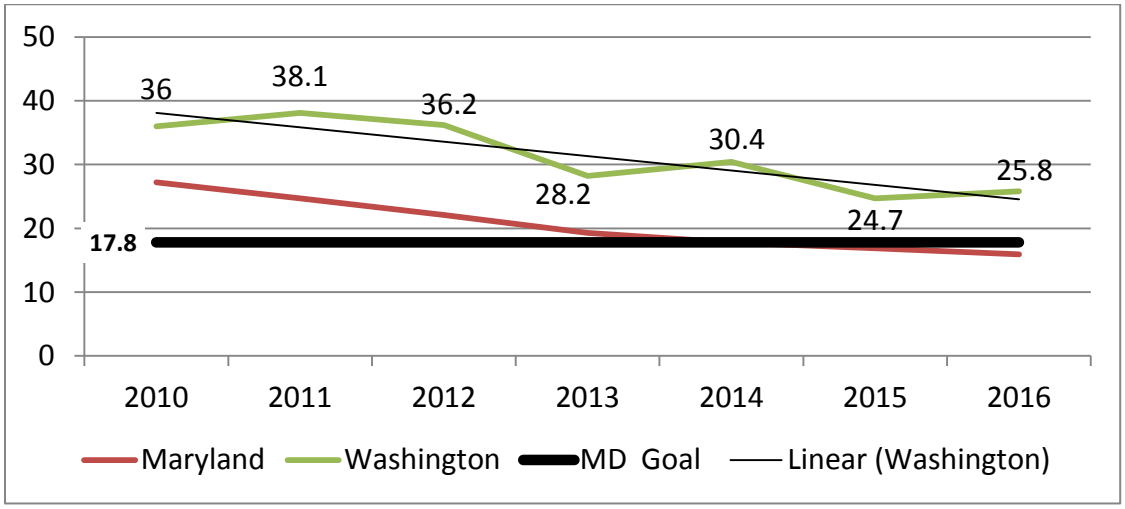
Figure 67. Child Maltreatment Rate (per 1,000 population)



Source: Maryland SHIP 2018

During the FY2013 CHNA the teen birth rate in Washington County was identified as one of the top five health priorities. Since that time the teen birth rate has declined, although it remains higher than both the state average rate of 15.9 and Maryland goal of 17.8.

Figure 68. Teen Birth Rate (per 1,000 population)



Source: Maryland Vital Statistics 2016

The teen birth indicator that is calculated using the rate of births to teens ages 15-19 years (per 1,000 population) demonstrates Washington County's most recent rate at 25.8 (2016 data), accounting for 112 births.[42] Teenage pregnancy is linked to a host of social problems such as poverty, lack of overall child well-being, out-of-wedlock births, lack of responsible fatherhood, health issues, school failure, child abuse and neglect and at-risk behaviors. Although the teen birth rate has been improving overall, Washington County rate continues to rank as the second highest geographic location in the state following only Baltimore City (32.6).[43]

Maryland Youth Risk Behavior and Tobacco Survey

The Maryland Youth Risk Behavior and Youth Tobacco Survey (YRBS/YTS) is an on-site survey of students in Maryland middle and high schools, focusing on tobacco-use prevalence and other health-related behaviors among Maryland youth. The survey started in 2000 and is conducted every two years. The results are publically reported.[44] Below, is a summary of ***significant*** positive and negative behavior trends for Washington County middle and high school students between the years 2014 to 2016.

[42] Maryland Vital Statistics , 2016. http://dhmh.maryland.gov/ship/Pages/home.aspx, accessed November 5, 2018.
[43] Ibid.
[44] Maryland Youth Risk Behavior Survey https://phpa.health.maryland.gov/ccdpc/Reports/Pages/YRBS-Main.aspx

Maryland Youth Risk Behavior and Youth Tobacco Survey (YRBS/YTS) 2014 - 2016

Middle School

Positive trends

- Smoked cigarettes in past 30 days 1.9% (-3.3)
- Ever smoked whole cigarette before age 11 2.2% (-1.6)
- Used a vape product in past 30 days 5.5% (-3.4)
- Smokes cigars in past 30 days 2.2% (- 2.7)
- Used marijuana in past 30 days 5% (-2.4)
- Tried marijuana before age 11 1.7% (-2.3)

Negative trends

- Carried a weapon to school past 30 days 37.1% (+ 6.3)
- Played video / computer games > 3 hrs / day 42.5% (+7)
- Attended physical education 1 or more days / week 84.2% (-7.3)
- Attended physical education all 5 days / week 10.2% (-5.6)
- Students receiving 8+ hours sleep per night 50.6% (-6.1)
- Ever rode in car with someone who texted while driving 62.8% (+7.6)
- Felt sad or hopeless nearly every day > 2 weeks 26.6% (+6.6)

High School

Positive trends

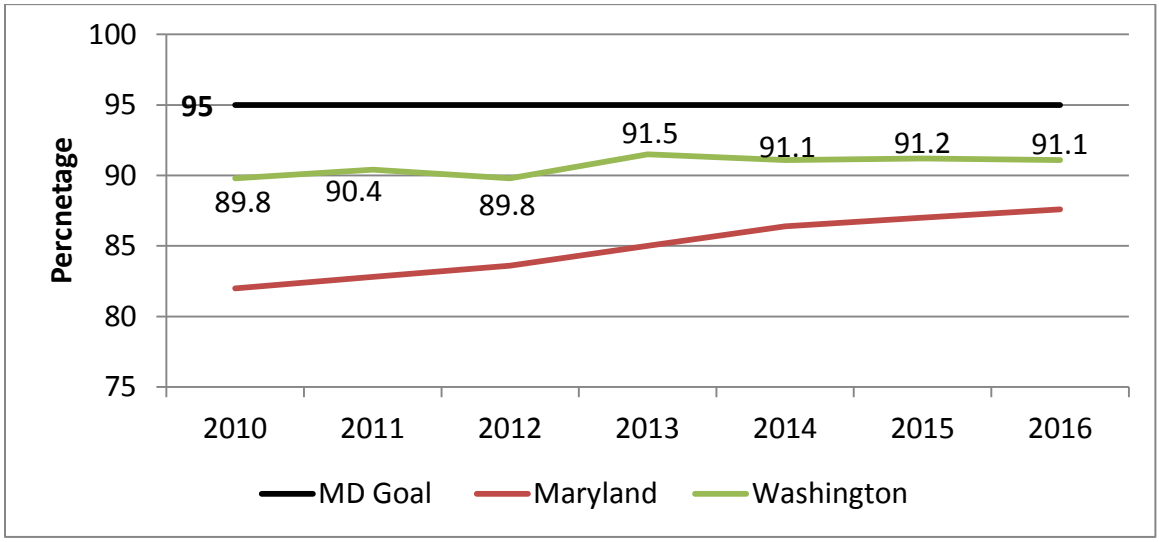
- Rode with a driver drinking alcohol, one or more times past 30 days 13.7% (-4.3)
- Experienced sexual violence within past 12 months 6.5% (-4.4)
- Currently drink alcohol, at least 1 drink in past 30 days 28% (-2.7)
- Had sexual intercourse with 4 or more persons in life 6.8% (-2.1)
- Describes themselves as overweight 28.6% (-2.8)
- Watched more than 3 hours television per day 21.1% (-3.5)
- Drank at least 1 sugar soda in the past week 17.9% (-5.5)

Negative trends

- Carried a weapon to school past 30 days 7.4% (+ 2.3)
- Felt sad or hopeless nearly every day > 2 weeks 30.2% (+3.4)
- Sexually active students who used a condom during last sexual intercourse 51.2% (-8.4)
- Students who ate fruit or drank 100% fruit juices 1 or more times per day 48.1% (-6.1)
- Students who ate vegetables three or more times per day in past week 10.8% (-2)

The High School Graduation Rate indicator shows the percentage of students who graduate high school in four years (**Figure 69**). Completion of high school is one of the strongest predictors of health in later life. People who graduate from high school are more likely to have better health outcomes, regularly visit doctors, and live longer than those without high school diplomas. Washington County students consistently graduate at a higher rate (91%) than the average for the state of Maryland (86.4%). The current rate of graduation exceeds the Healthy People 2020 national goal rate of 82.4% and is an identified strength in our community.

Figure 69. High School Graduation Rate



Source: Maryland SHIP 2018

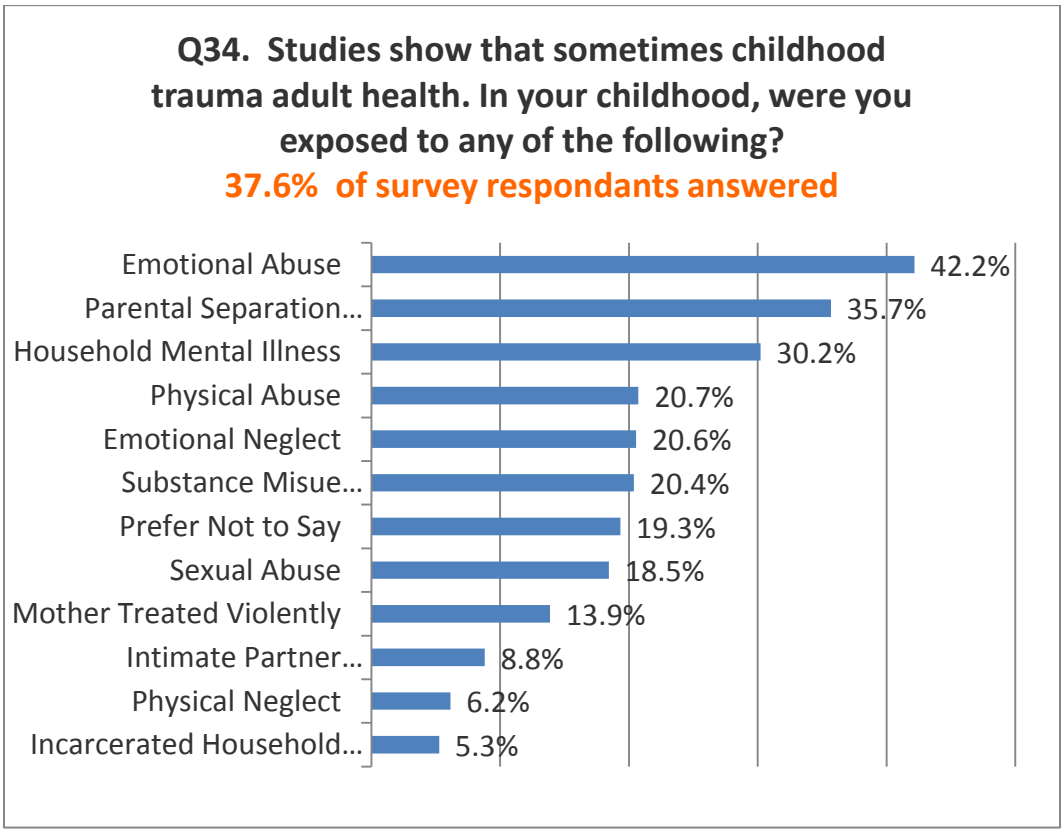
Adverse Childhood Experiences (ACE)

Adverse Childhood Experiences, known as ACEs, are traumatic events or "toxic stress" that happen in childhood from birth through age 18 and can include various forms of abuse, neglect and household dysfunction. ACEs are now known to be high risk factors for numerous health, learning, social and behavioral problems throughout a person's lifespan.

The FY2019 Community Health Needs Assessment for Washington County included a question about ACEs for the first time. Respondents were not required to answer the question, so our data for this section is limited, but it does give us some insight into how ACEs are effecting our local population.

37.6% of survey respondents answered the question that you see at the top of the slide, indicating whether they were exposed to various adverse childhood experiences. 19% of those who responded checked "prefer not to say." For those who responded, the percent of each ACE category here in Washington County is indicated in blue.

Figure 70. Question 34. Studies show that sometimes childhood trauma affects adult health. In your childhood, were you exposed to any of the following?



Standout points for our community include:

- Nearly half of respondents experienced emotional abuse, higher than the Maryland results and significantly higher than the original study
- More than 1/3 experienced parental separation or divorce, also higher than Maryland and the original study
- 1/3 experienced household mental illness, a significantly higher number than in our state surveys or the original study
- Physical abuse and emotional neglect were also slightly higher than for Maryland and the original study
- Substance abuse in the household was actually slightly lower
- And while we may think of ourselves as a prison community, the percentage having an incarcerated household member was also slightly less.

Figure 71. Number of People Reporting 1 or More A.C.E.

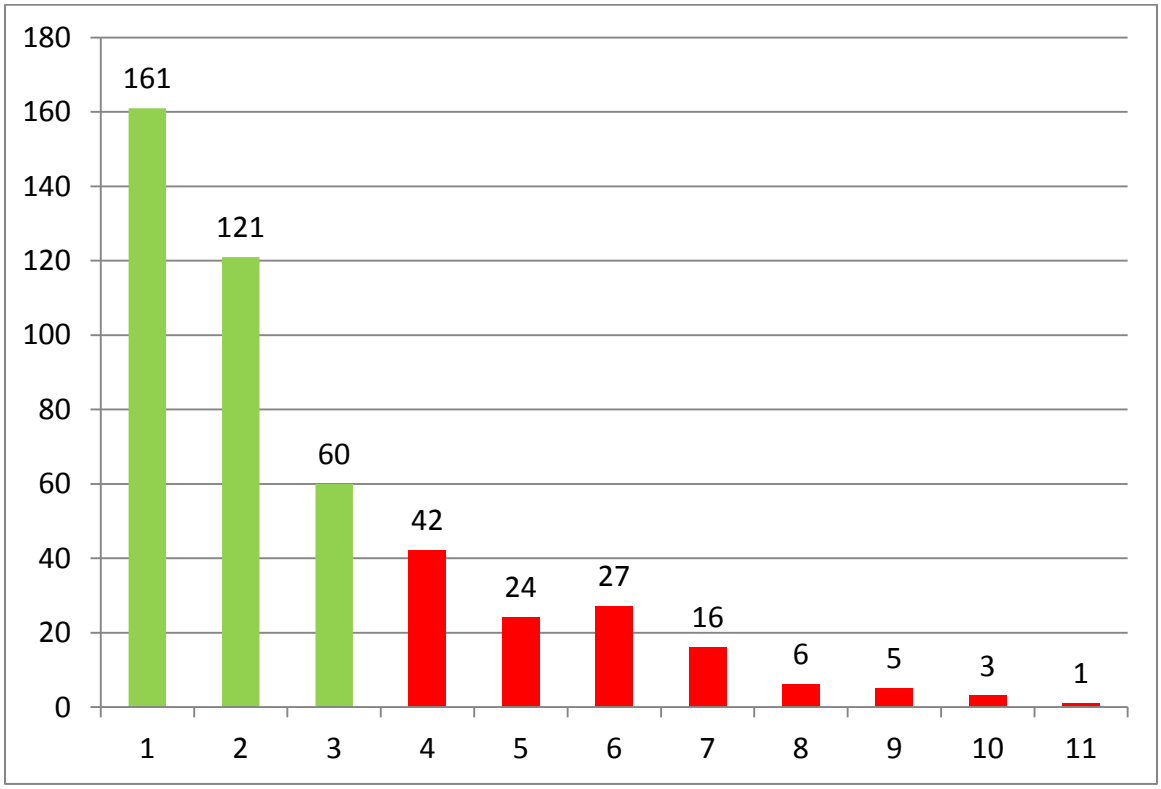


Figure 71 provides raw data for the number of people who reported 1, 2, 3 and 4 or more ACEs. We know that having 4 or more ACEs increases risk factors dramatically. Here we see that 124 people, or 27% of those who answered this question indicated having 4 or more ACEs. In the original study, 16% had 4 or more ACEs. Maryland's study stopped at 3 or more ACEs with 24%. For comparison, 40% of our study respondents had 3 or more ACEs. Having multiple ACEs

appear to be more prevalent in our community than the work conducted at a state level or in the original study.

Further data analysis of the respondent group with 4 or more ACEs revealed:

- More than 90% reported at least one health issue (from Q2)
- 63%, reported 3 or more health issues (from Q2)
- 39.5% reported 4 or more health issues (from Q2)
- 42.7%, reported mental health issues vs. 15.6% of all survey respondents
- 31.5%, reported being down or depressed at least 6 days in the prior month; 18%, reported 10+ days down or depressed. These were also significantly higher than the general survey respondents.
- 51%, reported they have been bothered with little interest or pleasure in doing things in the past month (double the rate of all survey respondents)
- 9%, reported alcohol or drug abuse, which seemed low, until realizing that only 2.6% of all survey respondents reported substance abuse (more than 3 times higher)
- 36% reported an income between $0-$49,000 / year
- 12% respondents with 4+ ACEs were male vs. 88% female. (Overall survey responses were 16.7% male and 82.4% female). This may reflect that more men skipped this question, rather than showing a disparity between men and women with ACEs.

Of all people who responded with 1 or more ACE:

- 53% marked “no exercise or once in past week” (significantly higher than general response)

Limitations of ACEs data

Question #34 gave no option for "none of the above" or "no trauma," so 1) we do not have any respondents who responded with zero ACEs and 2) we do not know if those who skipped this question did so because they did not want to answer it or because none of the answers applied to them.

In the original ACEs study, the childhood trauma questions were worded differently, giving more of an explanation for each of the questions. Since the questions aren't as clear, a direct comparison of numbers may not be valid.

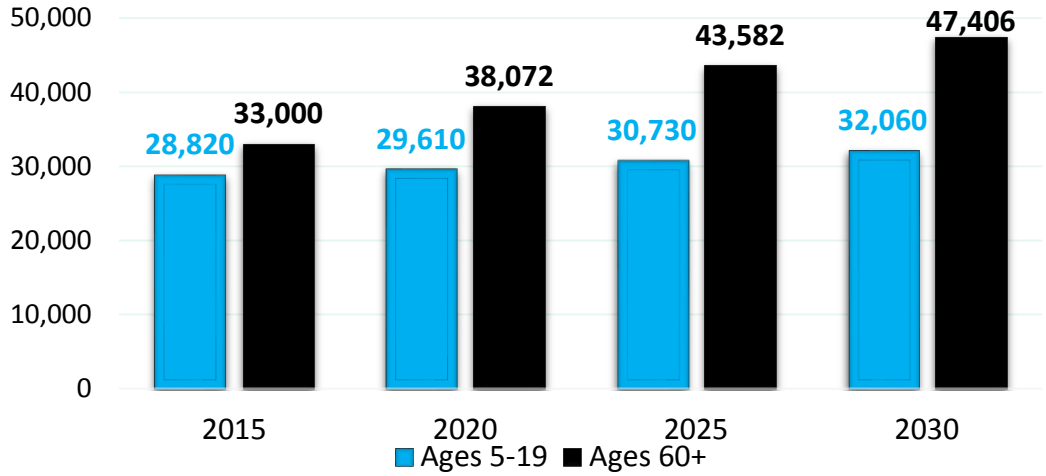
In the original ACEs study, two thirds of those surveyed had at least one ACE; 16% had four or more ACEs. In the CHNA survey 27% of those who responded to the childhood trauma question had four or more ACEs. Either our population has a higher rate of ACEs OR with the issue noted above the numbers do not reflect overall respondents (as in those who would have marked zero ACEs factoring into the numbers).

It would be helpful to have the baseline, or general population rates, of the above health issues in order to more effectively compare disparities in health between the general population and those with 4 or more ACEs. The data chosen to include above reflected rates that were high or likely to be distinctly higher than the general public.

Senior Health

Seniors are the fastest growing segment of our Washington County community population.

Figure 72. Age Cohort Projection



Source: Maryland Department of Planning Assessment, 2018

Many seniors have multiple health issues that require greater levels of support and services. The Washington County Commission on Aging is a not-for-profit organization which serves our community by helping seniors, with programs such as nutrition and wellness services, congregate nutrition sites, a senior center, guardianship, small-group home housing subsidies, a senior health insurance program, benefits screening, ombudsman services, among other services.

The Commission on Aging (COA) has identified many needs of local seniors including:

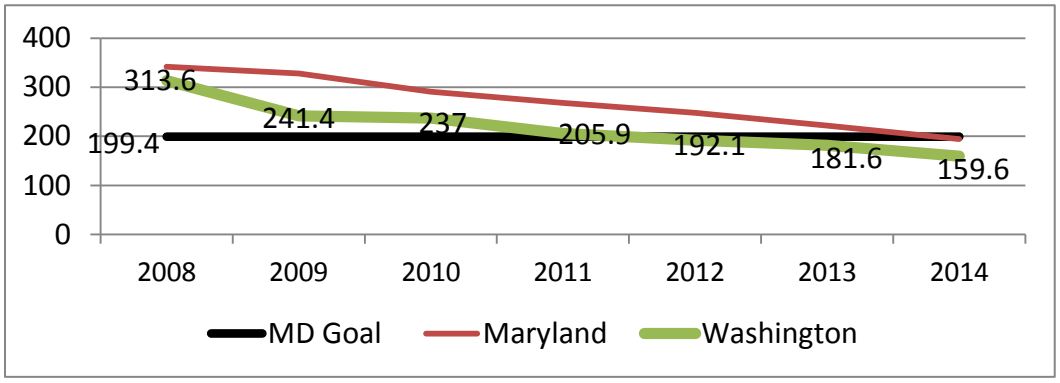
- medical treatment and medications
- food security and nutrition
- safe housing
- supports services such as personal care, homemaker, chore and respite
- increased isolation

As health declines and mobility issues increase, decreased independence and increased isolation become concerns. The COA offer social connections through congregate sites, the senior center, Meals on Wheels program and other evidence based education programs to help address needs. The majority of the seniors who are reached through a COA program are low income.

Alzheimer's disease and dementia are the 6the leading cause of death in the U.S.[45] In 2018 about 10% of Americans age 65 and older are living with Alzheimer's dementia, and among people aged 75 and older, 14.3% have reported at least one symptom of subjective cognitive decline.[46] The median survival time for people with dementia is six years, and 6.2 years for those with dementia due to Alzheimer's disease. Prevalence estimates project increased rates of Alzheimer's disease as the population ages.

While local prevalence rates for Alzheimer's dementia are not easily determined the hospitalization rate due to dementia diagnosis in Washington County has steady decreased over seven years and has surpassed the MD goal (see **Figure 73**).

Figure 73. Hospitalization Rate Related to Alzheimer's or Other Dementias



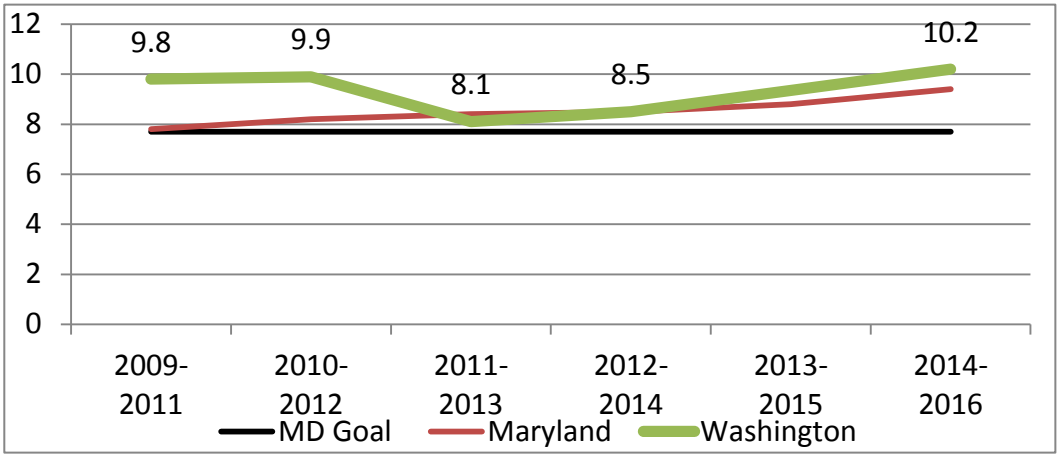
Source: Maryland State Health Improvement Plan 2018

The 2016 rate of death attributed to Alzheimer's and dementia for Washington County MD is 27.4 per 100,000 persons.[47] There is a slight increase trend since 2010. The death rate is not significantly different from the state of Maryland or U.S. for persons age 65-84. However, persons age 85 and older in Washington County have a higher rate of death attributed to Alzheimer's dementia than both Maryland and the U.S.

Another age-related indicator is the rate of deaths from falls. As seniors age, mobility issues become an increasing concern. The fall-related death rate has increased in Washington County since 2011 and remains slightly higher than the state of Maryland since 2014 (see **Figure 74**).Good nutrition has been shown to help support a healthy and active lifestyle, reduce frailty and disability, improve health outcomes, and reduce health disparities and health care costs.

[45] https://www.alz.org/alzheimers-dementia/facts-figures
[46] https://www.cdc.gov/chronicdisease/resources/publications/aag/alzheimers.htm
[47] Maryland Vital Statistics, 2016. https://health.maryland.gov/talbotcounty/Documents/2016%20Maryland%20Vital%20Statistics%20Annual%20Report.pdf

Figure 74. Fall-Related Death Rate



Source: Maryland State Health Improvement Plan 2018

Malnutrition is leading cause of morbidity & mortality among older adults. Older adults experiencing food insecurity suffer from higher rates of chronic disease, including diabetes, heart disease and depression. Food insecurity is associated with an increased risk for obesity as "eating less or skipping meals to stretch food budgets may result in overeating when food does become available."[48] In 2016, approximately 16,150 (10.8%) seniors in Washington County were identified as being "food insecure."[49]

Needs are going unmet in our senior population due to limited funding and resources. The primary food security program, Meals on Wheels, by the Commission on Aging provides a freshly prepared noontime meal delivered throughout the county to medically homebound individuals or couples age 60 and older. The Meals on Wheels also provides education, socialization and a safety check for the client. Currently there is a waiting list of more than 50 seniors for the Meals on Wheels program which would cost more than $88,000 per year for food costs alone.

At this time there is greater demand for COA services than can be met. As of March 5, 2019 there are 174 individuals on waiting lists for services. Capacity to provide services is limited by funding and staffing. Demand is projected to only increase as the Baby Boomer generation ages.

[48] Food Research and Action Center, 2018. http://frac.org/research/resource-library?type=resource&filter_resource_category=11&filter_topics=53&search=

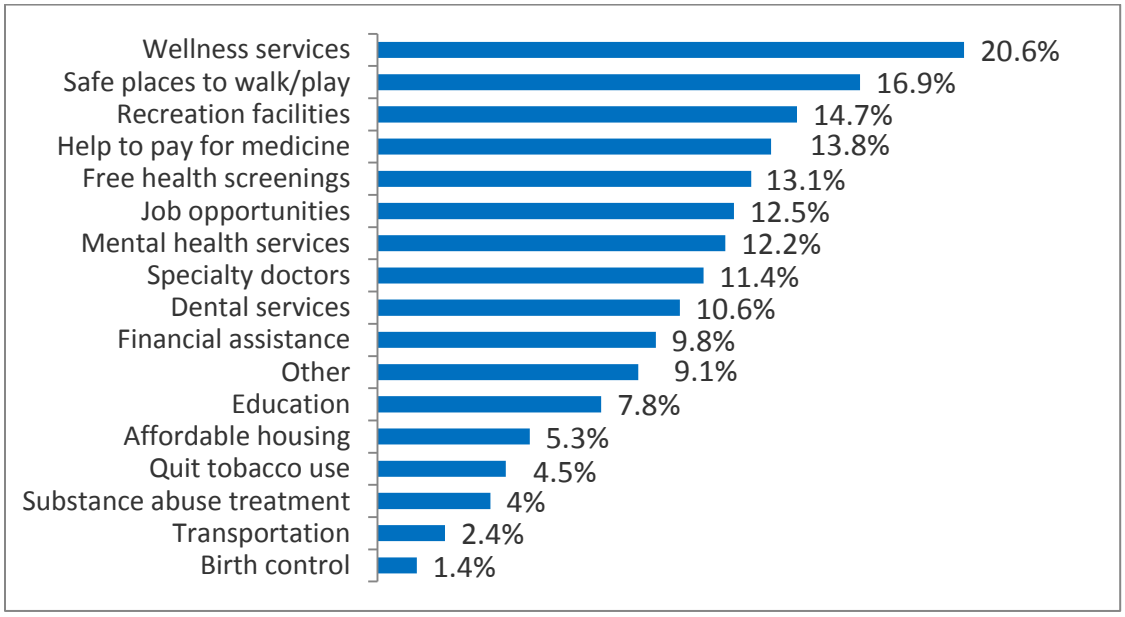
[49] Feeding America, 2016. https://www.feedingamerica.org/sites/default/files/research/map-the-meal gap/2016/overall/MD_AllCounties_CDs_MMG_2016.pdf

Community Health Needs

As the burden of chronic disease and complex care consumes the majority of healthcare resources, we often do not give adequate time or attention to the wellness and preventative health measures available in helping prevent chronic illness. Survey participants were asked to identify the top three needs that would help to improve the health of their family (**Figure 75**).

The top priority to improve health was again identified as wellness services (20.6%), the same as in 2015. Our participants are looking for opportunities and activities that promote health and well-being and look to health professionals to provide the expertise and guidance that will help fill this knowledge deficit. Safe places to walk and play (16.9%) and Recreational facilities (14.7%) were the 2nd and 3rd most popular choices, once again this year as they were in 2015.

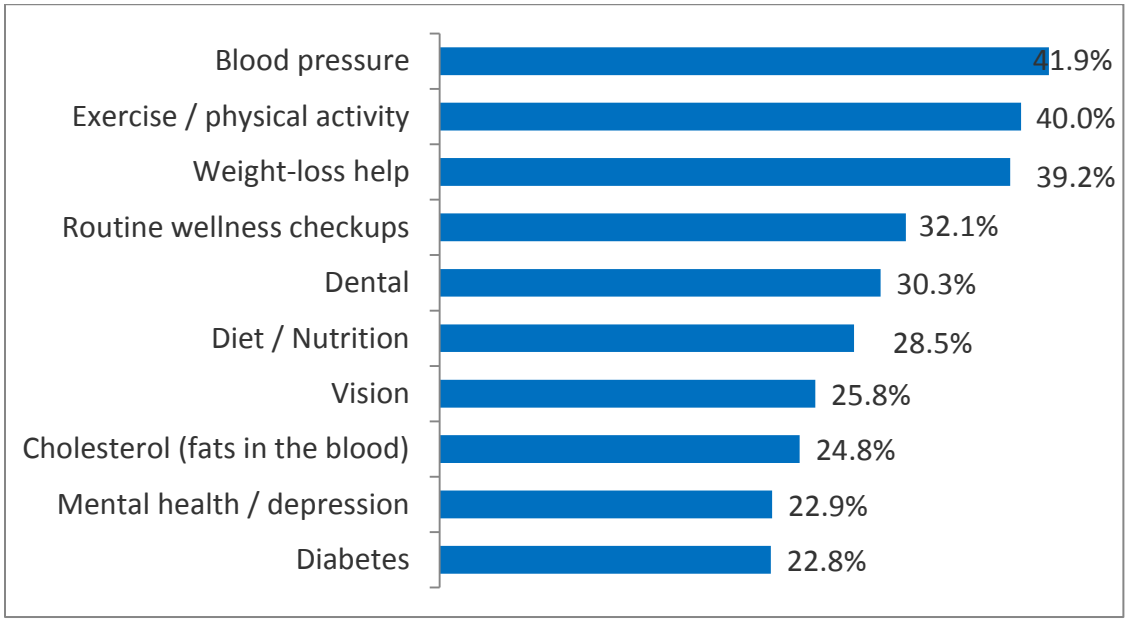
Figure 75. Question 9. What is the MOST needed to improve the health of your family? (Check up to 3)



Socio-economic factors are highlighted in the next three most popular responses: help to pay for medicine (13.8%), free health screenings (13.1%) and job opportunities (12.5%). Financial assistance to help cover medication costs is a consistent need demonstrated in both our survey and secondary data. When medication costs become too much the person will choose to go without the medication. This need continues even though Medicaid coverage has been expanded and a greater percentage of Washington County residents have health coverage. The request for free health screenings has also continued despite greater health coverage and access. High co-pays and a lack of preventative coverage may be contributing factors to this need.

Along with needs for good family health, the next survey question asked what type of health screenings or services were needed to promote good health (**Figure 76**). Nearly 42% of respondents answered that blood pressure checks were the most needed health screening to stay healthy. We believe that the significant community campaign focus on hypertension and participation in the Million Hearts initiative have helped increase the awareness of checking blood pressure as a necessary test.

Figure 76. Question 10. What types of health screenings and/or services are needed to keep you and your family health? (Check up to six)



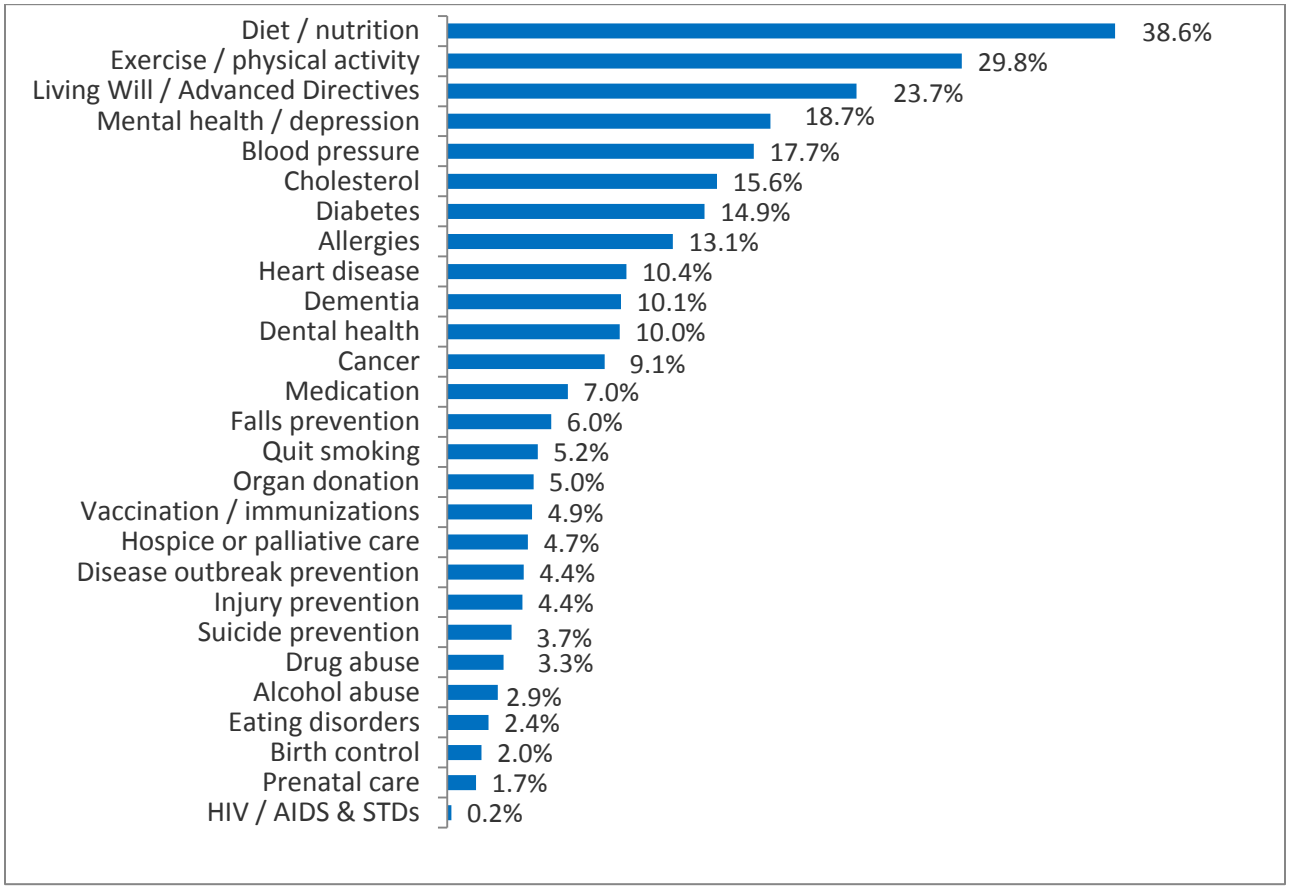
Forty percent (40%) of respondents readily identified the need for exercise and or physical activity. The question was not specific as to the type of exercise. The need for weight loss help (39%) increased in rank from the 5th place in 2015 to 3rd place for this survey. Routine wellness checkups (32%), dental needs (30%) and diet and nutrition services (29%) were all ranked similarly. As previously discussed the lack of dental insurance or the ability to pay for services was identified as a primary barrier to accessing dental care. The need for education and understanding about diet and nutrition is also greatly desired.

Making healthy lifestyle changes are a process that takes time. Having the necessary information can help people who are contemplating the need for change to become engaged. It is important to understand what health issues people in our community are interested in and need more information about.

When asked "What health issues do you need more information about?" the top three survey responses remain unchanged from 2015 survey; the need for more information about diet and

nutrition 38.6%, exercise and physical activity 29.8% and a greater understanding of advance directives and living wills, 23.7%. As our community is aging the need to better understand how decisions are made to live well and make end of life care desires known earlier, is paramount. All of the responses are included below (see **Figure 77**).

Figure 77. Question 14. What health issues do you need more information about? (check up to six)



One challenge for health providers and knowledge experts is to better understand how people in our community desire to receive and learn about health information. The majority of survey respondents reported that they receive health information from their physician or health professional (81.8%), that they do research using the internet (55.7%) and that other sources for health information is most frequently sought from family or friends (21.4%), the pharmacy (13.4%), newspapers and magazines (12.4%) and the hospital (12.1%).

All participants were asked “What is the biggest unmet health need in Washington County?” as an open-ended question with the opportunity for free text response. Answers were summarized and grouped into like categories. Survey responses identified the top five health needs in Washington County as:

1. Substance use (34.6%)

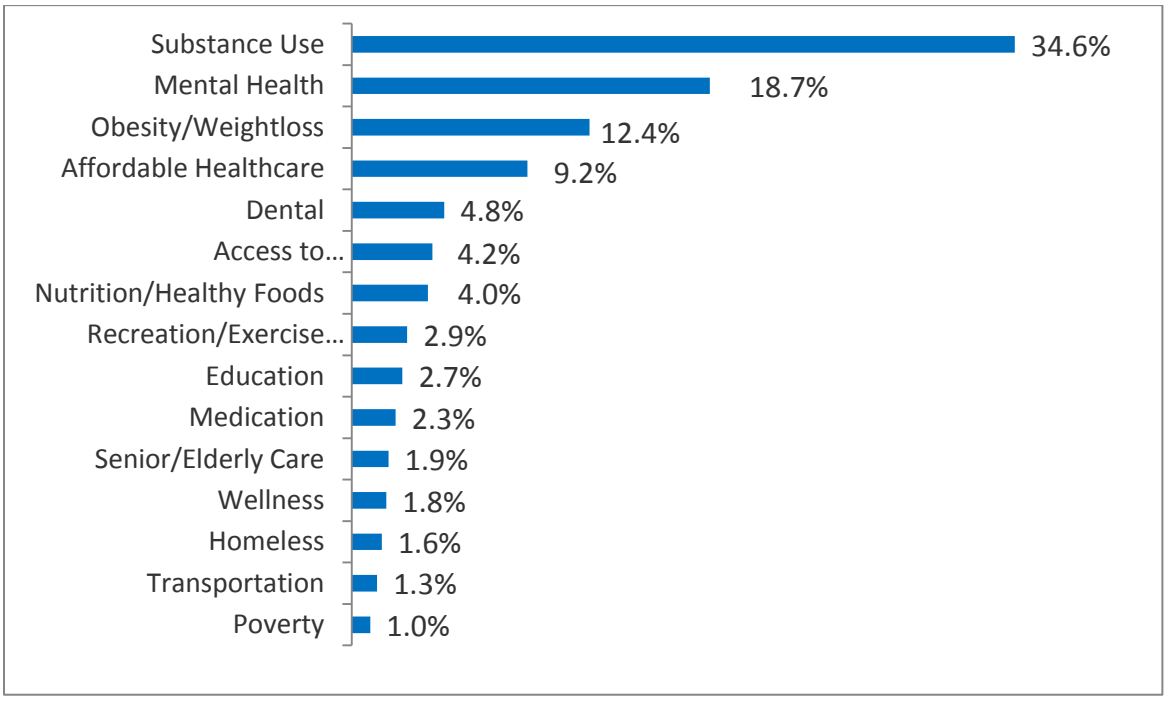
2. Mental health (18.7%)

3. Obesity and weight loss (12.4%)

4. Affordable healthcare (9.2%)

5. Dental care (4.8%)

Figure 78. Question 32. What is the biggest unmet health need in Washington County?



Social Determinants Summary

The Social Determinants of Health are the conditions where people live, learn, work, and play. Social determinants include some of the underlying factors that contribute to or detract from overall health. These determinants are often key-drivers in health disparities and need to be better understood. Examples include: socio-economic factors, access to clinical care, and the physical environment. Social and economic factors can be measured by indicators such as income, employment, education, and housing conditions. The new Maryland State Health Improvement Plan website provides access to meaningful data layers that allow thorough exploration of a local community by county, with links to best and promising practices that help point to improvements and solutions.[50] Below is a list of Washington County's significant social determinants arranged by Strengths and Opportunities.

Strengths

- 100% of 10th graders passed the exit exam for math, the rest of Maryland was 81.1%
- 100% of 10th graders passed the exit exam for English, the rest of Maryland was 87.7%
- 4.6% unemployed workers in the civilian labor force, U.S. value is 4.4%
- 39.6% renters who spend 30% or more of household income on rent, Maryland is 46.3%
- 4.6% residents could not see a doctor due to cost, compared to Maryland rate 9.3%

Opportunities

- 18.4% of children under age 18 in Washington County live below the Federal Poverty Level (FPL) compared to Maryland 12.7%
- 14% of the Washington County population lives below the Federal Poverty Level compared to Maryland 9.7%
- 42.9% of students are eligible for the Free Lunch program in public schools
- 6.4% of residents are low income and live greater than 1 mile from a grocery store
- 20.2% of residents over age 25 who have earned a Bachelor's degree or higher, Maryland is 39.3%

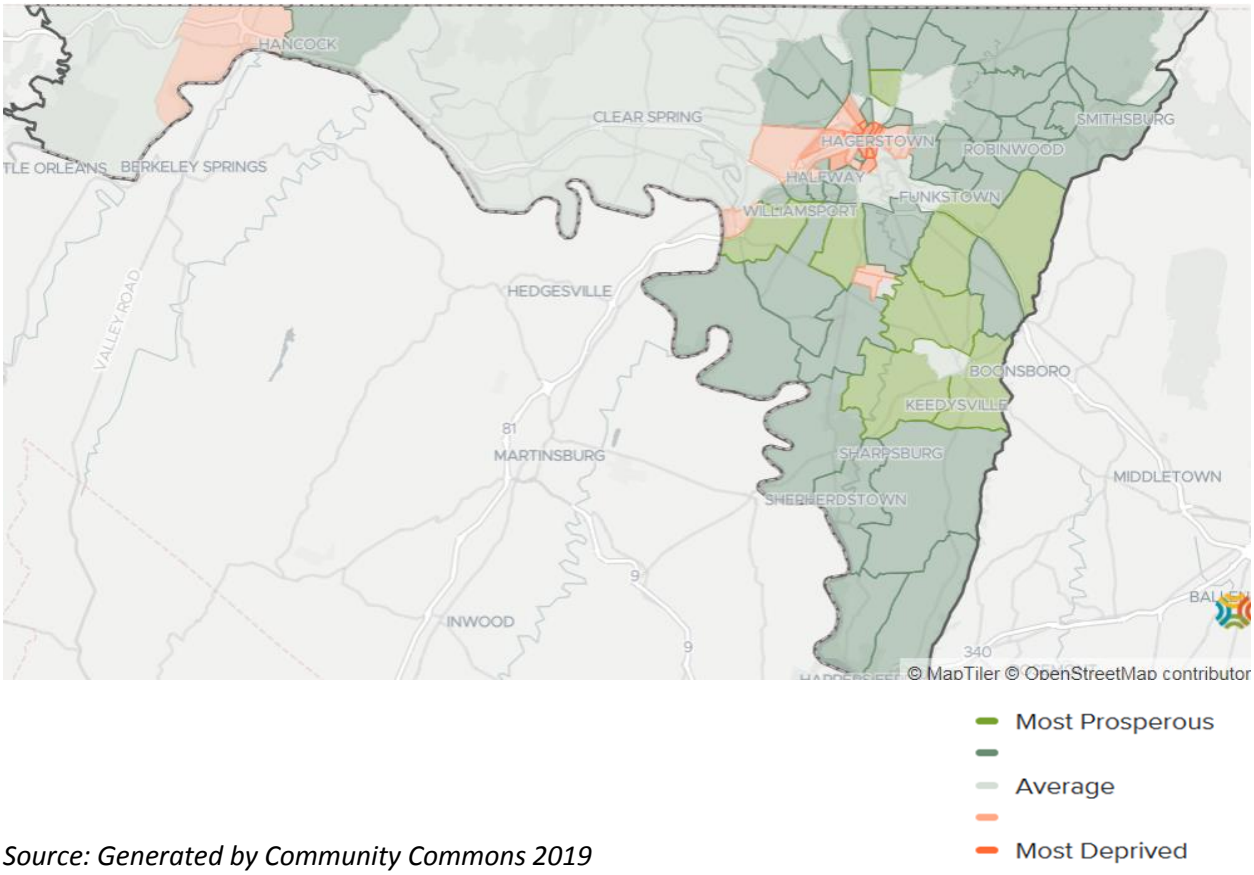
Other areas of social determinants are not easily measured, requiring individualized assessment for changes such as individual loss, changes in income, functioning and lifestyle.

[50] Maryland State Health Improvement Plan, Other Health Indicators: Social Determinants http://ship.md.networkofcare.org/ph/HealthIndicatorsList.aspx?cid=19

Area Deprivation Index

The Centers for Medicare & Medicaid Services have previously mapped geographic locations to target improvement with underserved Medicare populations based on residence.[51] The Area Deprivation Index (ADI) is a measure of social vulnerability developed by Community Commons.[52] The ADI combines 17 indicators of socioeconomic status (e.g. income, employment, education, housing conditions) and has been linked to health outcomes such as 30-day re-hospitalization rates, cardiovascular disease death, cervical cancer incidence, cancer deaths, and all-cause mortality.[53] Within the Washington County community, there are regional and racial disparities in deprivation that may contribute to unique health challenges for those living in the highlighted areas seen in **Figure 79**. Consistent with these findings the Bester Community of Hope completed an in-depth survey of Hagerstown neighborhoods in the fall of 2016 to help identify strengths, challenges and potential of each at risk neighborhood (see **Appendix M**).

Figure 79. Washington County Area Deprivation Map.



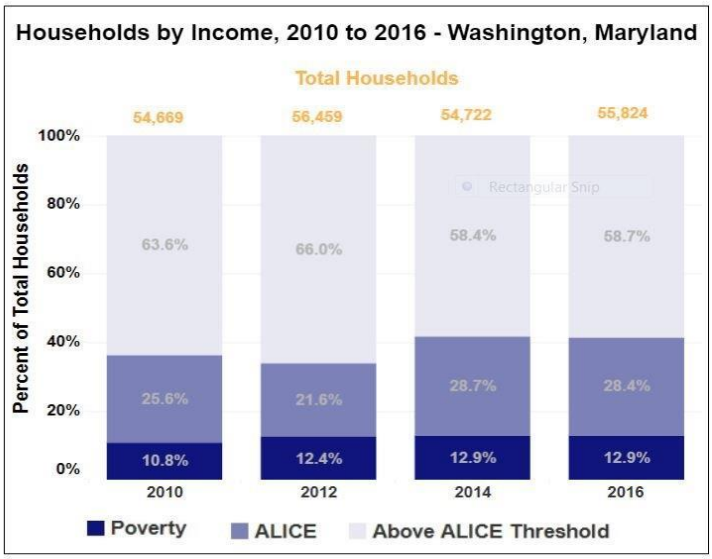
Source: Generated by Community Commons 2019

[51] https://www.nimhd.nih.gov/news-events/features/community-health/disadvantaged-neighborhoods.html
[52] https://www.communitycommons.org/
[53] Ibid.

ALICE Project (Asset Limited, Income Constrained, Employed)

With the cost of living higher than what most people earn, ALICE families – an acronym for Asset Limited, Income Constrained, Employed – have income above the Federal Poverty Level (FPL), but not high enough to afford a basic household budget that includes housing, child care, food, transportation, and health care. The United Way's "United for ALICE" project provides a framework, language, and tools to measure and understand the challenges faced by the growing number of ALICE households in our community.

Figure 80. ALICE Households by Income, 2010 to 2016



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

How has the number of struggling households changed over time?

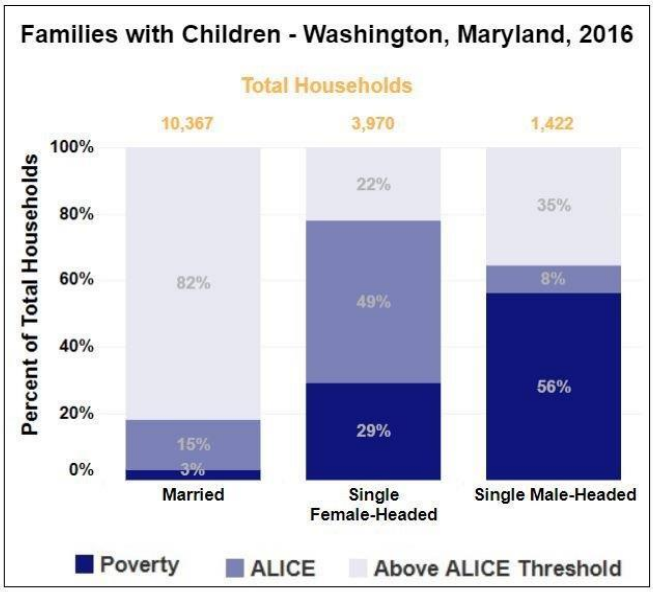
The number of households below the ALICE Threshold fluctuates throughout the year. Households move in and out of poverty and ALICE as their circumstances worsen or improve. The general trend has been a flat recovery since 2010, the end of the Great Recession. In many locations, the cost of basics has increased more than wages, leading to an increase in the number of ALICE households.

In 2016 there were 22,888 households (41%) in Washington County identified as "ALICE" households that struggled to afford basic household necessities like housing, food, health care, child care, and transportation despite many being employed. Despite the combination of ALICE's wages and some public assistance, ALICE households still face an average 15% unfilled income gap to reach financial stability. Because government assistance expenditure is increasingly composed of health care spending, which cannot be transferred to meet other needs, there are larger gaps in the areas of housing (45%) and child care (54%).

Figure 81. ALICE Families with Children

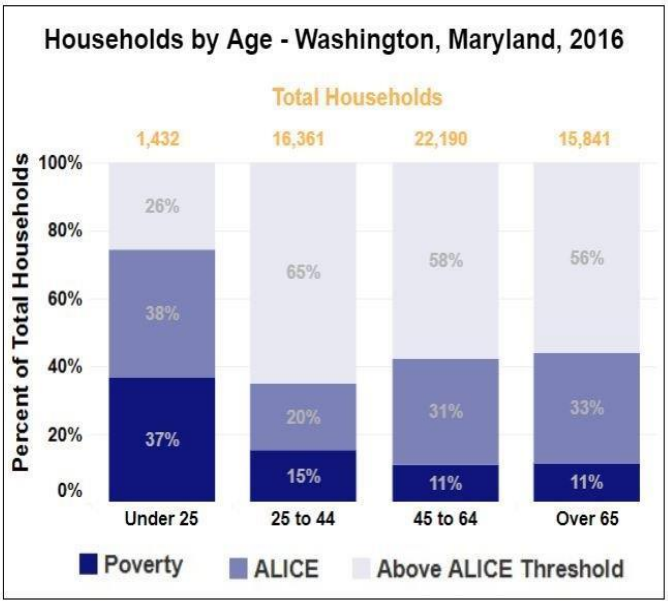
How many families with children are struggling?

Children add significant expense to a family budget, so it is not surprising that many families with children live below the ALICE Threshold. Though more families are headed by married parents, those families with a single parent are more likely to have income below the ALICE Threshold.



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

Figure 82. ALICE Households by Age



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

What are the differences in ALICE households by age?

There are ALICE households in every age bracket. The youngest group (people under 25) is more likely to be in poverty, and both the youngest and the oldest (people 65 and older) are more likely to be ALICE.

ALICE is a research-based model to better understand the causes of socio-economic needs and problems faced by people living in our community. The collection and review of this objective, standardized data over time can be used for policy planning and future outreach.

Physician Needs

Specific benchmarking was completed by an outside vendor in the form of a Physician Needs Assessment completed in May, 2016. The assessment documented physician demand, physician assets and defined the gaps and needs for medical providers in this community. The document helps forms the basis to identify and support physician recruitment plans.

As required under HG§19-303, Meritus Medical Center provided a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital. Washington County has very limited Health Professional Shortage Areas (HPSAs) status for Primary Care and Mental Health. These designations are specifically assigned to the two Federally Qualified Health Center facilities, one located in downtown Hagerstown and the other in Hancock. The entire county is designated as a HPSA for Medical Assistance patients requiring dental care.

The defined Centers for Medicare (CMS) Service Area for the 2016 Physician Needs Assessment included the same zip codes as the CHNA identified Primary Service Area (see page 20) plus an additional 8 zip codes in Pennsylvania and 6 zip codes in West Virginia whose residents access health care services in Washington County. Based on the methodology and analysis the vendor calculated that there is a demonstrated community need for 27 of the 30 specialties analyzed within the designated geographic CMS Service Area. A demonstrated community need for physician services is defined as a current deficit equal to or greater than (0.5) FTEs within the CMS Service Area (see **Tables 17** and **18**).

Table 17. General Provider Surplus / Deficit Results for CMS Service Area

Specialty	Current FTEs			DCN
	Supply	Demand	Surplus / (Deficit)	
Primary Care				
General Primary Care	71.0	201.2	(130.2)	✓
Obstetrics & Gynecology	17.7	31.2	(13.5)	✓
Pediatrics	22.7	40.2	(17.5)	✓
Total Primary Care	**111.4**	**272.6**	**(161.2)**	
Medical Sub-Specialties				
Allergy & Immunology	1.2	5.4	(4.2)	✓
Cardiology	17.9	21.9	(4.1)	✓
Dermatology	3.0	12.1	(9.1)	✓
Endocrinology	2.0	4.9	(2.9)	✓
Gastroenterology	6.0	16.3	(10.3)	✓
Hematology/Oncology	6.7	11.1	(4.4)	✓
Infectious Disease	2.0	3.8	(1.8)	✓
Nephrology	3.0	8.0	(5.0)	✓
Neurology	5.1	13.6	(8.5)	✓
Pain Management	2.0	4.4	(2.4)	✓
Physical Medicine & Rehab	5.6	9.7	(4.1)	✓
Psychiatry	9.0	14.5	(5.5)	✓
Pulmonary	1.1	10.0	(8.9)	✓
Reproductive Endocrinology	-	0.4	(0.4)	
Rheumatology	1.6	4.6	(3.0)	✓
Sleep Medicine	1.1	0.7	0.3	
Sports Medicine	-	2.3	(2.3)	✓
Total Medical Specialties	**67.2**	**143.6**	**(76.5)**	

The largest assessment gaps were identified in general primary care (130.2), pediatricians (17.5), and OB/GYN (13.5). Other significant gaps are noted for gastroenterology 10.3), dermatology (9.1), pulmonology (8.9), neurology (8.5), psychiatry (5.5) and nephrology (5.0).

Similarly, there is a provider deficit for nine of the ten surgical sub-specialties. The greatest need is general surgery (17.6) followed by orthopedic surgery (13.4), ophthalmology (8.9), cardio/thoracic surgery (5.9) and urology (5.9).

Table 18. Surgical Provider Surplus / Deficit Results for CMS Service Area

Specialty	Current FTEs			DCN
	Supply	Demand	Surplus / (Deficit)	
Surgical Sub-Specialties				
Cardio/Thoracic Surgery	1.0	6.9	(5.9)	✓
General Surgery	10.7	28.3	(17.6)	✓
Gynecology Oncology	-	0.7	(0.7)	✓
Neurosurgery	1.3	3.8	(2.4)	✓
Ophthalmology	9.9	18.8	(8.9)	✓
Orthopedic Surgery	11.5	24.9	(13.4)	✓
Otolaryngology	5.3	12.3	(7.0)	✓
Plastic Surgery	3.0	2.2	0.8	
Podiatry	9.5	10.7	(1.2)	✓
Urology	5.3	11.2	(5.9)	✓
Total Surgical Sub-Specialties	**57.6**	**120.0**	**(62.4)**	
Total All Specialties	**236.2**	**536.2**	**(300.0)**	

Adequately supplied physician specialties include plastic surgery, reproductive endocrinology and sleep medicine.

In FY 2018, the following new primary care providers were added as employees of Meritus Medical Center:
Internal Medicine: 4 FTE
Family Medicine: 9 FTE
Obstetrics / Gynecology: 1 FTE
Oncology: 1 FTE
General Surgery: 5 FTE
Endocrinology: 1 FTE
Nursing Home: 1 FTE
Wound Care: 1 FTE

Between FY 2016 - 2018 nine (9) psychiatric providers were added as employees of Brook Lane Health Services. In the past year The Mental Health Center has also added one (1) FTE psychiatrist.

According to the County Health Ratings published by Robert Wood Johnson Foundation, the ratio for Primary Care Physicians to patients is 1:1,810 in Washington County, compared to a Maryland state average of 1:1,140. There is no significant change in the ratio trend since 2010.

Referral staff reported no difficulties in obtaining appointments for uninsured or Medicaid patients who are seeking care in a Meritus Medical Center owned specialty practice such as gastroenterology, endocrinology or OB/GYN due to the Meritus Medical Center Financial Aid Policy. Access to psychiatry services is available through Brook Lane, Meritus Behavioral Health, The Mental Health Center and other local mental health provider practices and resources. One private cardiology practice accepts uninsured/Medicaid patients with minimal down payment and a payment plan.

The most difficult specialty for patient access is orthopedics where high down payments are required. Other specialty services with limited access, reported by the FQHCs include Dermatology, Allergy/Asthma, Neurology, Neuro-surgery, Urology, Pulmonology and Otolaryngology.

As a sole community hospital provider, Meritus Medical Center provides around the clock care in the Emergency Department including specialist coverage: Cardiology, Critical Care, ENT, Eye, GI, General Surgery, Interventional Cardiologist, Neurology, Neurosurgery, Ortho, Pediatrics, Plastics, and Urology.

In addition, Meritus Medical Center subsidizes the Hospitalist program in response to a community need for this service. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured population necessitated the need for a Hospitalist program subsidized by the Hospital.

Focus Groups and Interviews

While the community survey process obtained an excellent representative sample of the Washington County, we wanted to ensure that input was obtained directly from members of the community who were not well represented in the survey sample. We focused on the under-represented percentages in the survey that included men, African Americans and Hispanic communities. In an effort to obtain in-depth feedback related to the biggest health challenges and assets in the community are, we interviewed physicians and hospital care managers. Finally, we focused on populations with specific health challenges to include seniors and behavioral health (mental health and substance abuse). The series of focus groups and interviews were conducted from August 28, 2018, to November 2, 2018 (see **Table 19**)**.**

Table 19. Community Health Focus Groups & Interviews

Focus Group Topic	Location	Date	Number of Participants
Senior health focus group	Williamsport Fire Hall	August 28, 2018	65
Men's health focus group	The Greens at Hamilton Run	September 6, 2018	11
Hispanic focused interviews	Hagerstown Fairgrounds Park	September 23, 2018	10
Physician focused interviews	Meritus Medical Center	October 2-19, 2018	5
African-American focus group	Zion Baptist Church	October 9, 2018	9
Behavioral health focus group	American Red Cross	October 29, 2018	7
Care management focused interviews	Meritus Medical Center	October 18 – November 2, 2018	12

Members of the focus groups and volunteers who agreed to individual interviews provided invaluable insight into how health issues are perceived by persons living in the community. Relevant input and feedback has been incorporated throughout this needs assessment by topic. A summary of the focus groups and interviews is included in **Appendix N.**

Conclusions

Findings

- Life expectancy has declined in over five years in Washington County, largely attributed to opioid fatalities and an increased rate of suicide.
- The leading causes of death among adults in Washington County are heart disease 24% (-1%) and cancer 21% (-3%).
- The most frequent health concerns reported include being overweight 48.2% (+8.3%), high blood pressure 35.1% (+4.1%), joint or back pain 31.6% (+0.6%), high cholesterol 25.4% (+1.2%), sleep problems 21.4% (+1.7%), diabetes 19.7% (+2.5%), and mental health 18.6% (+4.3%).
- Other areas of concern include dental, smoking, heart disease, cancer, and Chronic Obstructive Pulmonary Disease (COPD).
- Only 20% of health outcomes are attributed to the quality of clinical care provided.
- When combined, health behaviors (30%), social, and economic determinants (40%) account for 70% of the community's health ranking.
- A majority of residents view the health status of people living in Washington County as "fair" or "poor" 59.7% (+7%).
- The primary barriers to accessing health care include the cost of care 27%, including inability to afford co-pays and health insurance deductibles 13.3%, and convenience 14.5%.
- The majority of Washington County residents have health insurance 93% (+5.2%), largely subsidized by their employer 59.6% (-12.6%), or government 19.1% (+1.4%).
- Approximately 7% of Washington County residents do not have health insurance.
- About 12% of residents report being unable to afford prescription medications.
- More than 68% of the adult population is overweight or obese (BMI > 25).
- There was a 2.6% decrease in the percentage of persons who maintained a healthy weight 31.5% over the past three years (BMI < 25).
- More than 26% of adults received no dental care in the past 12 months due to cost or the lack of insurance coverage.
- The report of high blood pressure 31.5% has increased +4.1% from three years ago.
- While diabetes prevalence at 11.3% is similar to the rest of the state, Washington County has the second highest rate of diabetes mortality 35.9.
- Emergency Department visits for diabetes have increased 29% over the past three years.

- Given the higher than average rates for physical inactivity, and being overweight and obese in our community, residents are at higher risk for pre-diabetes and developing diabetes in the future.
- There are higher rates of readmission to the hospital for Congestive Heart Failure (CHF) and COPD than other chronic health disorders.
- There is a health disparity among the Black population observed in a higher rate of Emergency Department visits for chronic health issues including diabetes and respiratory illness, however ED visits for hypertension declined by 8.6% over past three years.
- The mortality rate for cancer decreased 3% since last measurement period in 2016.
- While a higher number of cancer cases are being diagnosed, they are being identified earlier in stages I and II which often result in improved prognosis and survivability.
- Washington County experiences 40% more Emergency Department visits for mental health and crisis services than the state of Maryland average.
- Mental health Emergency Crisis visits decreased 6.6% in 2018 from the past five year average.
- 27.3% of survey respondents had a positive response to the depression screening questions, a 5% increase compared to survey data from three years ago.
- Over four years the rate of suicide at 14.7 per 100,000 lives has increased significantly in Washington County while the state average has remained flat.
- 11.7% of survey respondents reported an inability to access mental health treatment when they needed it, an increase of 6% from last survey.
- Alcohol related disorders prevalence of 24% and binge drinking rates of 16% are similar to the state of Maryland averages.
- There is a five year increased trend in the number of addictions related visits to the Emergency Room for drugs and alcohol.
- There is a steady increase of drug overdoses attributed to heroin and opioids over the past eight years, at a rate that is slightly higher than the state of Maryland average.
- The trend for opioid-related intoxication deaths has increased significantly since 2014 and will be the most ever for 2018 (more than 63 deaths).
- In 2018 there was a 55% increase in opioid related deaths and the overall opioid related death rate increased by 5%.
- Infants born low birth weight is slightly higher at 9.4 per 1,000 births than the state average.
- The childhood rate of obesity has increased 2.3 since measured in 2013 slightly higher than the state average.

- For Washington County, the reported rate of child maltreatment has declined since 2012, but is higher than the state average.
- The rate of teenage births is trending down in a positive direction, however at 25.8 remains higher than the rest of the state.
- Rates of tobacco use among adults have decreased among adults (-4%) but remain above state of Maryland average.
- Reported rates of smoking and vaping among adolescents have decreased more than 3% over a two year period.
- 37.1% of middle school children reported carrying a weapon to school in the past 30 days (+6.3%).
- Teens who reported feeling sad or hopeless nearly every day for more than 2 weeks 30.2% (+3.4%).
- High school graduation rate remains above 91.1%.
- More than 30% reported having at least one adverse childhood experience in their past, and of those who answered 27% reported having four or more.
- Seniors are the fastest growing segment of the Washington County community population.
- The hospitalization rate for Alzheimer's dementia has steadily declined over five years, but there is a slight increase in the rate of death attributed to Alzheimer's, similar to the state.
- 10.8% of seniors are considered "food insecure" with a current waiting list of more than 50 persons for free at home meal delivery.
- When asked what information is needed for health, people most desire information about diet and nutrition 38.6% (-7.3%), exercise and physical activity 29.8% (-6.3%), Advance Directives and living wills 23.7% (-0.2%), mental health and depression 18.7% (+1.2%), blood pressure 17.7% (-3.5%), cholesterol 15.6% (3.5%), diabetes 14.9% (-4%), and allergies 13.1%.
- The services needed to most improve health were identified as wellness services 20.6%, safe places to walk and play 16.9%, recreation facilities 14.7%, help to pay for medicine13.8%, job opportunities 12.5%, mental health services 12.2%, specialty physicians 11.4%, and affordable dental services 10.6%.
- Survey responses identified the top five health needs in Washington County as: substance abuse treatment 34.6% (+19.5%), mental health treatment 18.7% (+7.9%), obesity and the need for weight loss 12.4% (-9.2%), affordable health care 9.2% (-4.8%), and affordable dental care 4.8% (-2.4%).
- There is a clear correlation between health, wellness and the rate of poverty which is higher in Washington County (13.7%) than is found in the state of Maryland (9.4%).

- 10.8% of seniors in Washington County were identified as being “food insecure” with more than 50 persons currently on a waiting list for meal home delivery.
- 41% of Washington County households struggle to afford basic household necessities like housing, food, health care, child care, and transportation, despite being employed.
- Transportation to outpatient medical services is reported as a barrier for patients who do not have independent transport.

Identified Health Service Gaps

- Being over-weight is a primary health concern and people desire information regarding diet, nutrition, weight loss, and how to make healthy lifestyle changes.
- There are delays stretching an average of more than 30 days for a new patient to be seen by a psychiatrist.
- There is a shortage of primary care and specialty providers availabile in Washington County.
- There are no mental health crisis beds in the county.
- There is a delay to timely access for substance abuse treatment when a person desires help; specifically the lack of detoxification or crisis services or ability to be admitted for inpatient/residential treatment levels of care.
- There is a lack of community case management for all complexities of health needs; physical health, mental health, and substance abuse.
- There is inadequate, affordable transportation to medical services that can reach persons living in all parts of the county.

Health Needs Prioritization

On November 20, 2018, Healthy Washington County sponsored a public forum for the community with invitations to local health providers, government and community leaders, and members of the public to publically review the data, findings, needs and issues identified from the Community Health Needs Assessment process. A directed exercise was completed to prioritize and rank our community's health needs to begin the process of formulating potential intervention strategies into a comprehensive implementation plan. Upon reviewing all the key data and findings, attendees participated in a prioritization exercise using the criteria listed in **Table 20** to evaluate the community's health needs:

Table 20. Prioritization Criteria

		Scoring		
Item	**Definition**	**Low (1)**	**Medium**	**High (10)**
1. Magnitude of the problem	The degree to which the problem leads to death, disability or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected and/or risk for epidemic	Moderate numbers/ % of people affected and/or risk for epidemic	High numbers/ % of people affected and/or risk for epidemic
2. Variance against benchmark or goals	This would include variance with selected benchmarks, state standards or state data, Healthy People 2010 goals and/or other prevention agenda standard or state data	Local / regional rates meet or exceed the goal or standard	Local/ regional rates are somewhat worse than the goal or standard	Local/ regional rates are significantly worse than the goal or standard
3. Impact on other health outcomes	The extent to which the issue impacts health outcomes and/or is a driver of other conditions	Little impact on health outcomes or other conditions	Some impact on health outcomes or other conditions	Great impact on health outcomes or other conditions

The "Dotmocracy Method", an established facilitation method for collecting and recognizing levels of agreement among groups of people, was used to help rank and prioritize the community's most urgent health needs. This tool makes group decision making an easier and faster process, especially for big groups. The participants were randomly divided into two groups (Green or Orange) and completed the prioritization exercise to rate/rank the issues based on the various criteria during the November 20, 2018, session.
A summary of all prioritized data is included for reference in **Table 21**.

Table 21. Community Health Public Report Ranking Results

CHNA Public Report Results

Health Need Priority	Green	Orange	Total	
Substance Abuse	21	24	45	16.1%
Mental Health	16	21	37	13.3%
Obesity/Weight loss	10	24	34	12.2%
Wellness	10	13	23	8.2%
Diabetes	11	10	21	7.4%
Heart Disease & HTN	10	11	21	7.4%
A.C.E.s	5	10	15	5.4%
Senior/Elderly	3	11	14	5.0%
Cancer	5	8	13	4.7%
Nutrition/Eating	4	8	12	4.7%
Transportation	6	5	11	4.3%
Homeless	3	6	9	3.6%
Rec/Exercise	1	5	6	2.5%
Access to Healthcare	4	1	5	2.2%
Poverty	3	2	5	1.8%
Teenage Pregnancy	3	1	4	1.8%
Dental	2	1	3	1.0%
Education	1	2	3	1.0%
Affordable Healthcare	2	1	3	1.0%
Smoking	1	1	2	1.0%
Medication	1	1	2	1.0%
Child health	1	1	2	0.7%
Employment	1	1	2	0.7%
Crime	0	1	1	0.3%
Affordable Housing	0	0	0	0
Vision/Hearing	0	0	0	0
Total	124	161	285	

There was agreement across both groups in the ranking of the top six health priorities for Washington County as substance use, mental health, obesity /weight loss, wellness, diabetes, and heart disease / hypertension.

A full list of the top 20 health priorities identified for Washington County in ranked order include:

1. Substance Abuse
2. Mental Health
3. Obesity/Weight loss
4. Wellness
5. Diabetes
6. Heart Disease & HTN
7. A.C.E.s
8. Senior/Elderly
9. Cancer
10. Nutrition/Eating
11. Transportation
12. Homeless
13. Rec/Exercise
14. Access to Healthcare
15. Poverty
16. Teenage Pregnancy
17. Dental
18. Education
19. Affordable Healthcare
20. Smoking

The top ranked health priorities for the Washington County community include:

#1 Substance Abuse

#2 Mental Health

#3 Nutrition and Weight Status

#4 Wellness

#5 Diabetes

#6 Heart Disease and Hypertension

The top ranked community health priorities for Meritus Medical Center implementation plan includes:

1. Reducing **substance abuse** and overdose fatalities to protect the health, safety and quality of life for all

2. Improving **mental health** through prevention and by ensuring access to appropriate, quality mental health treatment

3. Promoting **health** and reducing the risk of chronic disease through consuming a **healthy diet** and achievement of **body weight**

4. Improving **health** related **quality of life** and **well-being** for persons living in the community

5. Improving the management of **diabetes** and reducing mortality

6. Reducing **heart disease** mortality and managing **hypertension**

7. Reducing the mortality of **cancer** cases and improving earlier detection and diagnosis

The top ranked community health priorities for Brook Lane Health Services implementation plan includes:

1. Lessen **substance abuse** to improve the **health, safety** and **welfare** of all

2. Improving **mental health** through prevention, early intervention and education

Planning and Implementation

The Community Health Needs Assessment provides a framework for community action, coordination, engagement, and accountability in addressing the health needs of our citizens. The CHNA's significance as a resource to community organizations is paramount as it identifies our health need priorities and establishes a framework to begin addressing these issues collectively. Continued community partnerships and collaborations are needed to efficiently and effectively address the health and social needs of our community. Brook Lane, Meritus Medical Center and the Healthy Washington County coalition developed plans of action based on the identified health needs, community strengths, resources, service gaps and new collaborative initiatives to be implemented. The plans were reviewed and approved by the Board of Directors from Brook Lane and Meritus, as well as the Healthy Washington County coalition as the parties responsible for the coordination of resources to address the identified needs, implementation of action steps and measurement of outcomes.

Healthy Washington County Implementation Plan

The FY2019 Executive Steering committee members developed a summary of the identified health needs, community strengths, resources, and new initiatives. On January 8, 2019 the top health priorities were reviewed by Healthy Washington County and divided into three work groups; Behavioral Health, Wellness / Quality of Life, and Health Management. Initial objectives and goal directions were established in January 2019 and finalized in May 2019.

The HWC workgroups developed strategies for each of the top identified health needs based on the strengths, resources and participation of organizations across the community. From the strategies, short and long term goals are being set to measure change, impact and improvement over time, still a work in progress at the time of publishing this report. The implementation plan may be adjusted over time based on meeting goals, achieving outcomes and the availability of resources.

As the local WCHIC, Healthy Washington County will work collaboratively with all of our community partners to efficiently direct resources to help meet the identified community health needs. As the community goals and objectives have been established, the Healthy Washington County will be the conduit to monitor and measure progress on a bi-annual basis. A primary goal for Healthy Washington County is to **establish a public dashboard** to assess local health needs and **track population health data** in our community that will help demonstrate goal achievement and outcomes over time. As new needs or barriers are encountered, the leadership of the Healthy Washington County will work to make needs known and identify possible solutions. An annual summary will be completed and publicized as a means of promoting transparency and accountability and will encourage collaborative work.

Implementation Plan

BEHAVIORAL HEALTH

#1 Substance Abuse

Objective: Improve substance abuse prevention, education and reduce substance abuse to protect the health, safety, and quality of life for all residents

Goal direction: Prevention, improve access to care, reduce overdose deaths

Strategies:

- Proactive measures to reduce the number of drug overdose fatalities
- Harm-reduction measures are being provided at local points of entry in the community
- Behavioral Health Crisis Stabilization and Walk-in Center is being planned to provide 24/7 access to substance use resources and stabilization
- Coordinated "drug take-back" opportunities are made available to reduce the availability of prescription drugs
- Emergency Department and medical staff have been trained in Screening Brief Intervention and Referral to Treatment (SBIRT) and have implemented a protocol to screen all adults for drug and alcohol abuse
- Peer Support personnel who are in recovery will provide outreach to persons who need help throughout the community; some location points include the Emergency Department, the hospitals, outpatient medical and substance abuse treatment offices, the Washington County Health Department, residences and shelters
- New addictions treatment providers that include Medication Assisted Treatment (MAT) for buprenorphine maintenance, outpatient education and counseling are being made available
- Increased access to longer term treatment, rehabilitation programs, residential treatment and sober living options are being made available
- Educational activities are planned to help reduce stigma and improve provider understanding of opioid dependence, pain management and harm prevention measures
- Provide training for Naloxone emergency administration and expand availability in public spaces
- Build community support and understanding through "Washington Goes Purple"

#2 Mental Health

Objective: Improve mental health through prevention and ensure access to appropriate, quality mental health services

Goal direction: Timely access to care, crisis stabilization, education, early identification, reduce stigma

Strategies

- Expand access to "walk-in" evaluation services for immediate mental health treatment
- Expand mobile and crisis services in the community
- Provide and promote educational opportunities to increase mental health awareness, understanding and to decrease stigma
- Provide Mental Health First Aid, trauma training, Applied Suicide Intervention Skills training, Safe Talks-Suicide Alert classes
- Support the "Walk Out of Darkness" to promote suicide awareness and access to help
- Provide depression screening to promote earlier identification and treatment
- Improve clinical integration of behavioral health professionals as a resource in primary care practices to increase access to care
- Expand access to behavioral health counseling in the schools
- Provide school-based mental health services on an as needed basis for elementary students throughout Washington County Public Schools
- Schools participate in mental health awareness week
- Middle and High School student participation in Maryland Youth Risk Behavior Survey
- Provide free or sliding-scale mental health treatment to the uninsured and persons who cannot afford co-pays
- Increase community case management for persons with serious and persistent mental illness who require support for daily living
- Explore nurse practitioner residency program to help address shortage of psychiatry providers
- Revitalize a Washington County Chapter of the National Alliance on Mental Illness (NAMI)

Behavioral Health Work Group Goals (being finalized May, 2019)

- Reduce suicide
- Reduce stigma of substance abuse and mental health treatment
- Increase access to treatment, support and resources whenever needed

WELLNESS and QUALITY OF LIFE

The Wellness and Quality of Life working group strategy will develop activities, interventions and programs that are guided by the four pillars of Wellness: 1. Healthy Nutrition, 2. Medication Adherence, 3. Smoking Cessation, and 4. Physical Activity.

#3 Nutrition and Weight Status

Objective: Promote health and reduce chronic disease risk through the consumption of healthful diet and achievement and maintenance of healthy body weight

Goal direction: Reduce overweight and obesity by increasing physical activity and promote eating a healthy, balanced diet

Strategies

- Promote nutritious diets and healthy food options
- Increase access to healthy foods through strategically placed farmer's markets and a new mobile farmer's market
- Include healthy food and beverage choices in vending machines
- Increase green space available for community gardens
- Promote physical activities including use of walking and biking trails
- Decrease the rate of childhood obesity by implementing evidenced-based programs with children and adolescents in schools, after school, summer camps, churches and community centers
- Provide increased access to health screenings, wellness initiatives, healthy foods, mobile treatment and educational programs in neighborhoods where disparities exist
- Lend resources to develop and/or improve workplace wellness initiatives

#4 Wellness

Objective: Improve the lives of residents by supporting wellness through the empowerment of citizens to make healthier choices

Goal direction: Promote four enablers of wellness; healthier food choices, exercise, smoking cessation and medication adherence

Strategies

- The One for Good initiative**
- Leverage health provider expertise to provide employers the necessary resources to implement wellness initiatives in the workplace
- Promote need for "well visits" with primary care
- Promote importance of vaccinations
- Increase promotion of yoga, meditation, and other stress reduction programs

**One for Good is a partnership between Healthy Washington County and the Consumer Goods Forum's Collaboration for Healthier lives. The partnership brings together retailers, manufacturers, and public health organizations to support wellness, a Healthy Washington County priority, through the empowerment of citizens to make healthier choices. One for Good promotes four enablers of wellness: healthier food choices, exercise, smoking cessation and medication adherence. A combination of regular programming at local retail stores and community-led programs offer health screenings, pharmacist consultations, nutrition store tours, cooking demonstrations and classes, and healthier product promotions. The initiative is supported by the following organizations and companies: AARP, Alhold Delhaize, Barilla, Campbell Soup Company, Colgate-Palmolive, Danone NA, EnsembleIQ, General Mills, Healthy Washington County, Hagerstown-Washington County Chamber of Commerce, Johnson & Johnson, Kellogg Company, Martin's, Merck, Meritus Medical Center, Nestlé, Numerator, Oliver Wyman, US Chamber of Commerce Foundation, PepsiCo, Walgreens Boots Alliance, Walmart, Washington County Health Department and the YMCA Hagerstown.

Wellness and Quality of Life Work Group Goals (being finalized May 2019)

- Participation and adherence/smoking cessation: increase participation rates in community based wellness activities.
- Outreach: develop an effective communication outreach tool to connect consumers to available community resources.

- Awareness and nutrition: increase awareness to healthier eating behaviors and healthier choices available to consumers.
- Physical resources and exercise: develop new physical activity resources while promoting and maintaining existing resources.

HEALTH MANAGEMENT

#5 Diabetes

Objective: Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM

Goal direction: Education, prevention, behavior changes

Strategies:

- Provide National Diabetes Prevention Program
- Provide evidenced-based self-management program Living Well with Diabetes at no cost in various community locations
- Provide Diabetes Self-Management Education to accompany treatment for improved management of diabetes
- Conduct in-store shopping tours and food demonstration for healthy diabetic diet

#6 Heart Disease and Hypertension

Objective: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart disease

Goal direction: Early detection, education, management blood pressure and cholesterol, changes

Strategies:

- Conduct health screening events include blood pressure and Body Mass Index screenings in local neighborhoods and work sites
- Improve understanding of the social determinants related to health and how to help support or alleviate these stressors
- Develop and disseminate provider resource materials to encourage collaborative care with community programs/agencies to include:
    - information regarding diabetes mellitus and cardiovascular health

- community resources for individuals who have screened positive
- instructions providing follow-up information to be used by all community partners at health screening events which will be given to individuals that have abnormal BP readings, BMI, labs, etc.

Health Management Work Group Goals (being finalized May, 2019)

- Ensure all community partners are collecting the same data. Suggest use same collection of data measurements as either Healthy People 2020 or HEDIS (the Healthcare Effectiveness Data and Information Set) to allow comparison against national benchmarks.
- Ensure that all community partners have access to the same best practice information and encourage standardized use. Utilize the Healthy Washington County website to post best practice information.
- Develop unified educational campaign with prevention message in cooperation with One for Good (focusing on Healthy Eating, Physical Activity, Smoking Cessation and Medication Adherence as a means to prevent or manage chronic disease)
- Explore feasibility of a mobile health clinic

Other Health Needs

At the conclusion of the CHNA health needs ranking it was recognized that many more needs were identified and exist than the top six identified health needs alone. Some of the health needs that were not identified as the highest ranked priorities for the community include **cancer**, access to **dental care, teen pregnancy, senior needs, homelessness, and poverty** among others. Our community providers are using the results of the CHNA to help target these unmet needs based on the strengths, expertise and resources of individual organizations, and when interests are shared, new collaborative relationships between organizations can be formed (refer to **Appendix O**). Findings from the FY2019 CHNA may be used to support grant procurement, donations and gifts to fund new program services.

Cancer continues to be the second leading cause of death for Washington County residents. Meritus Medical Center will continue investment in the cancer service programs to include the development of the Meritus Hematology Oncology Specialists practice, providing four Registered Nurse Clinical Navigators, adding registered dietitian services, and initiating the Hope Soars Survivorship Program as a support to patients in recovery.

Hagerstown Family Healthcare (FQHC) has expanded access to **dental care** to persons in Washington County. The Hagerstown Family Healthcare Dental Practice provides comprehensive dental care to children and adults. They provide a pediatric dentist who specializes in the dental needs of children of all ages, as well as special needs patients. The Healthy Smiles in Motion mobile dental program provides dental care to students of Washington County Public Schools on-site at their home schools.

Healthy Washington County is using the CHNA to **address access to affordable healthcare issues** and a **lack of health insurance** by providing locations for the MD Health Exchange Navigators to reach uninsured persons. Both Brook Lane Health Services and Meritus Medical Center have a **financial assistance policy** for persons deemed unable to afford the cost of care. The county is fortunate to have two Federally Qualified Health Centers, (FQHC) located in Hancock and Hagerstown, MD, both of which are committed to **providing quality healthcare services** on **a sliding-scale basis.** The Community Free Clinic located in Hagerstown provides **quality, comprehensive outpatient health care services, free of cost,** to all Washington County residents who are **uninsured** and is launching expanded **mental health services**.

To **help prevent teen pregnancy** The Community Free Clinic provides "Services We All Get" (SWAG), a program operated by the Clinic for Washington County teens ages 13-19. Teens may present to the Clinic without appointment to **receive strictly free and confidential services** including **contraception, STI testing, HIV testing, pregnancy testing, counseling, educational information and appropriate referrals** to other community resources. The program offers honest conversation around lifestyles, behavioral concerns and seeks to answer questions. Substance abuse, assault, violence and general safety are also addressed at each visit.

Health care organizations and community resource agencies must work collaboratively across sectors to address **health, wellness, housing, transportation, food insecurity, and child development needs** in both practice and policy. The United Way of Washington County will use this report as another tool that helps determine appropriate **funding for local programs** that are tackling pressing community issues. The funding process begins with funding strategies that are formulated with data, and input from multiple community members, businesses and nonprofit organizations. Data is very important and is used to set goals that help meet the mission: "The United Way of Washington County inspires collaborations to impact community improvement. To do this, we function as a rallying point for attracting and fostering leadership to advance collective action."

Meritus Medical Center Implementation Plan

Meritus Medical Center, Western Maryland's largest health care provider has committed to caring for the community for more than a century. Meritus Medical Center exists to improve the health status of our region by providing comprehensive health services to patients and families. The most recent strategic plan includes partnering with community agencies and programs on health, prevention, and wellness with a focus on the Community Health Needs Assessment priority areas of need. Meritus Medical Center CHNA objectives and strategies for FY2020 – 2022 include:

- **Reduce substance abuse** and overdose fatalities with screening, intervention, initiation of treatment and referrals, support, increased education and decreased stigma
- **Improve mental health** through early identification, intervention, access to quality services, **prevention and education**
- **Promote health and reduce risk of chronic disease** by promoting consumption of a **healthy diet, physical activity, smoking cessation** and **maintaining a healthy body weight**
- **Improve health-related quality of life** and **well-being** by providing **annual wellness visits, health screenings** and the **promotion of workplace wellness initiatives**
- **Improve management of diabetes** through **evidenced based treatment, education, screening and prevention**
- **Reduce heart disease mortality** and **manage hypertension**
- **Reduce the mortality of cancer cases** and improve **earlier detection** and **diagnosis**

The FY2019 CHNA key findings and prioritized health needs were used to develop a draft action plan that includes objectives, baseline data, and expected outcomes over the next three years, strategies, tactics, accountability and budget (see **Appendix P**). The plan includes a collaborative strategy between Meritus Medical Center and Healthy Washington County to guide and implement community-wide initiatives that will help address the prioritized health needs and improve the overall health of people living in the region.

The plan for implementation was developed from September 2018 to March 2019 in coordination with Community Health leadership, Strategic Planning and the Board of Director's Strategic Planning Committee. The Meritus Medical Center final implementation plan with objectives, action goals and responsibility was approved by the Board of Directors and are summarized as **Appendix Q**. As resources become available and can be allocated, the action plan will incorporate additional needs and goals. The plan will be reviewed periodically to measure progress towards goal achievement and modify any action steps or goals as needed.

Brook Lane Implementation Plan

Brook Lane will enact the action plan to lessen substance abuse by growing our Intensive Substance Use Treatment Program and increasing community education on substance abuse. Brook Lane will monitor the volumes of service by tracking the numbers of individuals assessed for treatment as well as the numbers of individuals that complete treatment on an on-going basis. To provide more community education, Brook Lane will hold at least two professional continuing education programs and two community programs related to substance abuse annually. Brook Lane will track and increase our referral of family members to the Concerned Persons support group. The Brook Lane organization will support and partner with other community agencies by participating in at least six health or resource fairs per year. We will partner with and promote Washington Goes Purple, attend and participate in the Local Addiction Authority Provider Council Meetings and collaborate with Healthy Washington County.

Brook Lane will implement our action plan to improve mental health through prevention, early intervention and education. Brook Lane will conduct eight Mental Health First Aid trainings to decrease stigma, promote education and increase awareness annually. Brook Lane has a goal to screen 400 individuals for depression each year and will accomplish this by distributing a self-screening tool at a variety of events and making the tool available on the website. Another option is to hold a community depression screening event for the public to provide education and resource information. Community education will be enhanced by providing ten professional continuing education programs and four community programs focused on mental health per year. The Brook Lane organization will continue to collaborate with other community agencies to provide educational materials at six or more health or resource fairs yearly and maintain our involvement with Healthy Washington County.

The Brook Lane implementation plan with action goals was drafted (**Appendix R)** and finalized as **Appendix S.**

Board Approval of Implementation Plans

Based on the findings of the CHNA and the prioritization exercise, the Healthy Washington County submitted an outline of priority health needs and goal direction to Meritus Medical Center and Brook Lane Health Services in early January 2019. The respective hospitals developed an implementation strategy, outlining objectives, action steps and draft goals that will address the prioritized community health needs and identified resources to commit towards improvement. The FY2019 CHNA Action Plan was adopted by the Meritus Medical Center Board of Directors on March 28, 2019 (see **Appendix Q**). The FY2019 CHNA Action Plan was adopted by the Brook Lane Board of Directors on April 16, 2019 (see **Appendix S**).

On May 7, 2019, Healthy Washington County formally recommended adoption of the joint implementation strategy and action plans as received from the respective hospital Boards of Directors. The hospital plans were incorporated into a comprehensive strategy to address the top health priorities of people living in our community.

Publication

Following the approval of the Action Plans, the final FY2019 CHNA report was published May 10, 2019 and was made widely available to the public as posted on the following websites:
www.brooklane.org
www.meritushealth.com
www.unitedwaywashcounty.org
www.hagerstown.org
www.washcohealth.org

REFERENCES

Appendices

A. FY2019 Community Health Needs Assessment Executive Steering Committee Members
B. 2018 Washington County Health Improvement Coalition Members
C. 2018 MD SHIP Measures Washington County
D. Maryland Dept. of Planning – Washington County Projection Profile July 2014
E. FY2019 CHNA Survey – English
F. FY2019 CHNA Survey – Spanish
G. Washington County Community Health Assets and Resources
H. 2018 Community Health Rankings Maryland RWJ
I. FY2019 Survey Talking Points
J. FY2019 CHNA Survey Results and Comments
K. MD Health Exchange Enrollment Report January 2019
L. National Survey Drug Use and Health 2017
M. Bester Community of Hope Neighborhood Survey, Fall 2016
N. Focus Group Summaries
O. Community Organizations Using the CHNA
P. FY2019 Meritus Action Plan – DRAFT
Q. FY2019 Meritus Action Plan – FINAL
R. FY2019 Brook Lane Action Plan – DRAFT
S. FY2019 Brook Lane Action Plan - FINAL

Community Health Needs Assessment FY2019
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin addiction	Meritus Community Health
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line
		Decrease number of opioid prescriptions by 25%	Determine data	TBD	TBD	TBD	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line
							Support county-wide effort to obtain funding for a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach
		Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health
		Children self-report an increase in physical activity and a decrease in screen time by a minimum of 50% each year	Determine data	50% or <	50% or <	50% or <	Partner with area organizations to promote and participate in physical activity events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of the population that report food insecurity by 5%	2018 12% MD BRFSS	10%	9%	7%	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health
Wellness #4	Improve health-related quality of life and well-being for all	Medicare annual wellness visits at rate of > 90% to beneficiaries	10%	25%	50%	75%	Provide an annual Medicare Annual Wellness Visit to each eligible Medicare beneficiary	Outpatient RN Care Managers to begin completing Medicare AWVs in MMG Primary Care Offices in 2019, transitioning the AWV to MMG office teams over the next year.	ACO, CTO, MPA
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept.**, Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability
Diabetes #5	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2%	10.7 per 100 adults MD Vital Stats 2015	10%	9.4%	8.7%	Make the evidenced-based Diabetes Prevention Program widely available in Washington County	Partner with the local **Dept. of Healt**h to provide diabetes prevention program and **community providers** and **pharmacists** to identify at-risk patients	Meritus Community Health
		Decrease the diabetes mortality rate by 2% over three years	35.9 per 100,000 MD Vital Stats 2016	< 35.7	< 35.5	< 35.2	Increase availability of diabetes education and support to primary care practices	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO
		Reduce # of ED visits for diabetes by 5%	FY18 778 visits Meritus	< 764	< 752	< 739	Provide diabetes education, dietary counseling and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	Partner with the **Hagerstown Parks & Rec, the Health Dept and the Senior Center** to provide Living Well and outreach services	Meritus Community Health
		ACO measure: 90% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%.	Determine data			90% pts HbA1c < 9 %	Provide individualized Diabetes Education and 1:1 Self-Management support to high risk patients to improve disease control and decrease unnecessary hospital utilization.	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO
Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1%	194 per 100,000 MD Vital Stats 2016	193	192	< 192	Provide community and employer health education events to increase heart health awareness	Partner with the **Health Department, Meritus Cardiac Services** to promote healthy lifestyle education and evironments	Meritus Community Health
		Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months	2%	10%	20%	25%	Provide evidence-based smoking cessation program to teens and adults	Partner with the **Meritus School Health** and **Health Department** to provide smoking cessation programs and support	Meritus Community Health
		Decrease the # of ED visits for hypertension by 5%	FY18 375 visits Meritus	368	362	< 356	Provide heart health screening and educational interventions at the community level	Partner with **local churches** to provide blood pressure screening and education	Meritus Parish Nursing Program
							Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	Partner with **Zion Baptist, Wash. Co. Parks and Rec** and the **Senior Center** in the provision of screenings and cardiac health education to their populations	Meritus Community Health
		ACO Measure: 90% of patients age 18-75 with a diagnosis of HTN will have a BP < 140/90.	Determine data			90% pts BP 140/90 or <	Provide individualized hypertension education and 1:1 self-management support to improve blood pressure control	Utilize Meritus outpatient care managers to provide education, discharge follow up, transition of care, and chronic disease management services	MPA, ACO, CTO
Cancer #7	Reduce the mortality of cancer cases and improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10%	475	459	443	428	Earlier detection of lung cancer	Low dose CT screening, Physician education, Utilize EHR reminders	Oncology Service Line
		Increase 5 yr. survival rates for head and neck cancer diagnosis by 5%	Stage 3 65% Stage 4 28%			Stage 3 70% Stage 4 33%	Improve coordination of care for head & neck cancer patients	Create head & neck dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator
		Reduce Stage III & IV diagnosis of colon cancer by 10%	136	132	126	122	Earlier detection of colon cancer	Increase colonoscopy screening awareness, provide physician education, utilize EHR reminders	Oncology Service Line
		Increase 5 yr. survival rates for colon cancer by 5%	Stage 3 59% Stage 4 10%			Stage 3 64% Stage 4 15%	Improve coordination of care for colon patients	Create colon dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator

CHNA Dashboard
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY21 Outcomes
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line	
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin addiction	Meritus Community Health	**80 (26% increase)**
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line	
		Decrease number of opioid prescriptions by 25%	2717 MEPPE	2038 MEPPE	1705 MEPPE	1359 MEPPE	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO	1702 MEPPE (37%
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines	
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines	
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line	788 (44% reduction)
							Support county-wide effort to fund and operationalize a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line	
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line	
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line	4367 (18% reduction)
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line	
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line	
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line	15% (reduced by 2%)
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO	

pending Lori A

CHNA Dashboard
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY21 Outcomes
		Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach	**31.5% (+3.3%)**

Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health	Suspended FY21 due to Covid
		Children self-report an increase in physical activity and a decrease in screen time by a minimum of 50% each year	Determine data	50% or <	50% or <	50% or <	Partner with area organizations to promote and participate in physical activity events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health	Suspended FY21 due to Covid
		Decrease the percentage of the population that report food insecurity by 5%	*Changed 2021 to Conduent Index		151.93	Reduce by 10% (136)	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health	151.93 Index
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health	**28% (+2%)**
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health	**37% (+3%) RWJ CHR**
Wellness #4	Improve health-related quality of life and well-being for all	MMG practice patient population has SDOH documented; unique patients with visits each month	10%	New	10%	25%	Screen for SDOH with percentage of adult MMG patients per month	Outpatient RN Care Managers to begin completing SDOH screen and provide linkage to resources to address, PRN.	ACO, CTO, MPA	17% (+7%)
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health	41 Partners Go for Bold
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept**., Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health	16.4% (decrease 2.4%)
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program	Suspended FY21 due to Covid

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	
Diabetes #5	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2%	10.7 per 100 adults MD Vital Stats 2015	10%	9.4%	8.7%	Make the evidenced-based Diabetes Prevention Program widely available in Washington County	Partner with the local **Dept. of Healt**h to provide diabetes prevention program and **community providers** and **pharmacists** to identify at-risk patients	Meritus Community Health	**10.3%**
		Decrease the diabetes mortality rate by 2% over three years	35.9 per 100,000 MD Vital Stats 2016	< 35	< 34	< 33	Increase availability of diabetes education and support to primary care practices	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	32 MD Vital Stats 2019
		Reduce # of ED visits for diabetes by 5%	FY18 778 visits Meritus	< 764	< 752	< 739	Provide diabetes education, dietary counseling and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	Partner with the **Hagerstown Parks & Rec, the Health Dept and the Senior Center** to provide Living Well and outreach services	Meritus Community Health	**830 ED visits (+6.3%)**
		ACO measure: 90% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%.	Determine data	75%	80%	85%	Provide individualized Diabetes Education and 1:1 Self-Management support to high risk patients to improve disease control and decrease unnecessary hospital utilization.	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	79.4%

Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1%	194 per 100,000 MD Vital Stats 2016	193	192	< 192	Provide community and employer health education events to increase heart health awareness	Partner with the **Health Department, Meritus Cardiac Services** to promote healthy lifestyle education and evironments	Meritus Community Health	184.6 per 100k MD Vital Stats 2019
		Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months	2%	10%	20%	25%	Provide evidence-based smoking cessation program to teens and adults	Partner with the **Meritus School Health** and **Health Department** to provide smoking cessation programs and support	Meritus Community Health	Measure suspended
		Decrease the # of ED visits for hypertension by 5%	FY18 375 visits Meritus	368	362	< 356	Provide heart health screening and educational interventions at the community level	Partner with **local churches** to provide blood pressure screening and education	Meritus Parish Nursing Program	Data says 1734 pulling secondary dx
							Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	Partner with **Zion Baptist, Wash. Co. Parks and Rec** and the **Senior Center** in the provision of screenings and cardiac health education to their populations	Meritus Community Health	1,979 BP screens 2021
		ACO Measure: 90% of patients age 18-75 with a diagnosis of HTN will have a BP < 140/90.	Determine data			90% pts BP 140/90 or <	Provide individualized hypertension education and 1:1 self-management support to improve blood pressure control	Utilize Meritus outpatient care managers to provide education, discharge follow up, transition of care, and chronic disease management services	MPA, ACO, CTO	Measure suspended
Cancer #7	Reduce the mortality of cancer cases and improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10%	158	152	148	142	Earlier detection of lung cancer	Low dose CT screening, Physician education, Utilize EHR reminders	Oncology Service Line	145 (8.2% reduction)
		Increase 5 yr. survival rates for head and neck cancer diagnosis by 5%	Survival 5 yr 65%	66%	68%	Survival 70%	Improve coordination of care for head & neck cancer patients	Create head & neck dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 78%
		Reduce Stage III & IV diagnosis of colon cancer by 10%	45	43	42	41	Earlier detection of colon cancer	Increase colonoscopy screening awareness, provide physician education, utilize EHR reminders	Oncology Service Line	37 (17.7% reduction)
		Increase 5 yr. survival rates for colon cancer by 5%	Survival 5 yr 59%	61%	63%	Survival 5 yr 64%	Improve coordination of care for colon patients	Create colon dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 68%

DEPARTMENT:	Patient Financial Services
POLICY NAME:	Financial Assistance
POLICY NUMBER:	0436
ORIGINATOR:	Patient Financial Services
EFFECTIVE DATE:	8/97
REVISION DATE(s):	03/99, 03/00, 03/03, 02/04, 03/04, 06/04, 10/04, 6/05, 3/06, 2/07, 3/07, 1/08, 3/09, 8/10, 2/11, 1/12, 1/14, 11/15, 1/18, 7/19, 2/20, 11/20
REVIEWED DATE:	12/00, 2/03, 3/04

SCOPE

This policy applies to all patients seeking emergency or other medically necessary care at Meritus Medical Center. This policy also applies to patients seeking treatment at any Meritus owned physician practice. These entities are hereinafter collectively referred to as "Meritus."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom outstanding "self-pay" balances exceed their own ability to pay. The underlying theory is that a person, over a reasonable period of time can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as financial assistance.

PURPOSE

Meritus is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, sex, age, color, national origin, creed, marital status, sexual orientation, gender identity, or disability. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment. The procedures describe how applications for financial assistance should be made, the criteria for eligibility, and the steps for processing applications.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and has been adopted by Meritus' Board of Directors.

POLICY

A. OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within thirty (30) days.
    a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a discount to qualifying patients.

b. A list of our health care service providers is available at www.meritushealth.com/financialassistance. Only providers employed by Meritus are covered under this policy and are indicated on the provider list.

c. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.

2. Notice of the Availability of Financial Assistance:

   a. Meritus will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within Meritus locations.

   b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.

   c. A statement on the availability of financial assistance will be included on patient billing statements.

   d. A Plain Language Summary of Meritus' Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.

   e. Meritus' Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at Meritus, through mail (postal service), and on Meritus' website at www.meritushealth.com/financialassistance.

   f. Meritus' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.

      i. On an annual basis, Meritus shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: Meritus retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

   a. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

   b. All patients presenting for emergency services will be treated regardless of their ability to pay.

      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

a. Meritus' rate structure is governed by the HSCRC rate setting authority. As an "all-payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

b. Charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

B. PROGRAM ELIGIBILITY

1. Meritus strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Meritus reserves the right to grant financial assistance without formal application being made by patients. These patients may include the homeless or individuals with returned mailed and no forwarding address.

2. Patients who are uninsured, underinsured, ineligible for a government programs, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for Meritus' Financial Assistance Program.

3. All residents of Meritus' service area will be considered for financial assistance regardless of United States immigration status. Financial assistance consideration is available to non-service area residents requiring emergency services at Meritus.

4. For non-emergent services for patients residing outside of Meritus' service area, including patients traveling to the United States to obtain health care services, Meritus reserves the right to screen patients for insurance coverage and ability to pay. Meritus may only offer financial assistance to non-service area residents for non-emergency services on a case-by-case basis.

5. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:

   a. Emergency medical services provided in an emergency room setting;

   b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual;

   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

   d. Medically necessary services.

      i. A medically necessary service is one which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.

      ii. A service or item is not medically necessary if there is another service or item that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all.

iii. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary.

6. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance Program include the following:
   a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
      1) Exceptions to this exclusion may be made, in Meritus' sole discretion, considering medical and programmatic implications.
   b. Unpaid balances resulting from cosmetic or other non-medically necessary services; and
   c. Patient convenience items.
7. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:
   a. After being notified by Meritus, for refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).
   b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance program that denies access to Meritus due to insurance plan restrictions/limitations.
   c. Failure to pay co-payments as required by the Financial Assistance Program.
   d. Failure to keep current on existing payment arrangements with Meritus.
   e. Failure to make appropriate arrangements on past payment obligations owed to Meritus (including those patients who were referred to an outside collection agency for a previous debt).
   f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless Meritus can readily determine that the patient would fail to meet the eligibility requirements.
8. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
9. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section C.2. below).
   a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Meritus' Senior Finance Executive for approval.
   b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

10. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in ***Appendix 1.***

C. PRESUMPTIVE ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance Application and/or supporting documentation on file. Often there is adequate information, provided by the patient or other sources, that is sufficient for determining financial assistance eligibility.
    a. In the event there is no evidence to support a patient's eligibility for financial assistance, Meritus reserves the right to use outside agencies or propensity to pay modeling in determining financial assistance eligibility.
    b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service.
2. Presumptive eligibility will be determined on the basis of individual life circumstances that may include:
    a. Active Medical Assistance pharmacy coverage;
    b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
    c. Homelessness;
    d. Maryland Public Health System Emergency Petition patients;
    e. Participation in Women, Infants and Children Programs ("WIC");
    f. Food Stamp eligibility;
    g. Eligibility for other state or local assistance programs;
    h. Deceased patient with no known estate; and
    i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.
3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
4. Exclusions from consideration for presumptive eligibility include:
    a. Purely elective procedures (e.g., cosmetic procedures).
    b. Uninsured patients seen in the Emergency Department under Emergency Petition unless and until the Maryland Behavioral Health Administration (BHA) has been billed.

5. All Amish and Mennonite patients will be extended a 25% reduction to charges. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health coverage.

D. FINANCIAL MEDICAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Medical Hardship Program.
    a. Patients may qualify under the following circumstances:
        1) Combined household income less than 500% of the current federal poverty level; or
        2) Having incurred collective family hospital medical debt at Meritus exceeding 25% of the combined household income during a 12-month period.
            (a) Medical debt excludes co-payments, co-insurance, and deductibles.
2. Meritus applies the criteria above to a patient's balance after any insurance payments have been received.
3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in ***Appendix 1*****.**
4. If determined eligible, patients and their immediate family qualify for reduced-cost, medically necessary care for a 12-month period effective on the date the medically necessary care was initially received.
5. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Program, Meritus is to apply the greater of the two discounts.
6. The patient is required to notify Meritus of their potential eligibility for reduced cost-care due to financial medical hardship.

E. ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES: Meritus reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management level review and approval.

F. ASSET CONSIDERATION

1. Assets are generally not considered as part of the financial assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.

2. The following assets are excluded from consideration:
   a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families;
   b. Up to $150,000 in primary residence equity;
   c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal;
   d. One motor vehicle used for the transportation needs of the patient or any family member of the patient;
   e. Any resources excluded in determining financial eligibility under Maryland Medicaid; and
   f. Prepaid higher education funds in a Maryland 529 Program account
3. Monetary assets excluded from the determination of eligibility shall be adjusted annually for inflation in accordance with the Consumer Price Index.

G. APPEALS

1. Patients whose Financial Assistance Applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Meritus Medical Center, 11116 Medical Campus Road, Hagerstown, Maryland 27142 Attn: Financial Counseling Team.
2. Upon denial, patients shall be informed that the Maryland Health Education and Advocacy Unit (HEAU) is available to assist patients in filing and mediation of a reconsideration request. The HEAU contact information is:

   HEAU Hotline:
   Mon-Fri 9am-4:30pm
   410-528-1840
   Toll free: 1-877-261-8807
   FAX: 410-576-6571
   heau@oag.state.md.us

   https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx
3. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
4. Appeals are documented and reviewed by the next level of management above the representative who denied the original application.
5. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
6. Appeals can be escalated up to the Chief Financial Officer, who will render the final decision.
7. Patients who have formally submitted an appeal will receive a letter of the final determination.

8. If a patient, or a patient's representative, feels Meritus is in violation of the financial assistance requirements as detailed in Maryland Code, Health-General §19-214.1 and §19-214.3, they may file a complaint with the Health Services Cost Review Commission (HSCRC) by emailing hscrc.patient-complaints@maryland.gov.

H. PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under Meritus' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where Meritus' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for financial assistance after Meritus has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, Meritus will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

I. OPERATIONS

1. Meritus will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        1) To facilitate this process, each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. Meritus will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
        1) Patients may be required to submit the following documentation with their completed application:
            (a) A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
            (b) Proof of disability income (if applicable);
            (c) A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;

(d) Proof of social security income (if applicable);

(e) A Medical Assistance Notice of Determination (if applicable);

(f) Reasonable proof of other declared expenses; and

(g) If unemployed, reasonable proof of unemployment, such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance Application or any required supporting documentation within 30 days after a formal application request, a letter will be sent reminding the patient that financial assistance is available and informing the patient of the collection actions that may be taken if no documentation is received.
   a. A deadline for submission, prior to initiation of extraordinary collection actions, will be included in the letter. Such deadline may not be earlier than 30 days after the date on which the reminder letter is sent.
   b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).
   c. If documentation is received after collection actions have been initiated, but within 240 days after patient receipt of the first post discharge billing statement, Meritus shall cease all collection actions and determine whether the patient is eligible for financial assistance.
4. A Plain Language Summary of this policy shall be included with the letter and Meritus staff shall make a reasonable effort to orally notify the individual of Meritus' Financial Assistance Program.
5. Once a patient has submitted all the required information, appropriate personnel will review the application and forward it to the Patient Financial Services Department for final determination of eligibility based on Meritus guidelines.
   a. For complete applications, the patient will receive a letter notifying them of approval/denial within 14 days of submitting the completed applications.
   b. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information.
   c. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
   d. If a patient is determined to be ineligible after receiving services, a payment arrangement may be obtained, subject to Meritus approval, on any balance due by the patient.
6. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective as of the date treatment is received and the following six (6) calendar months.

a. For those who qualify for reduced-cost care due to medical hardship, such qualification will apply for a twelve (12) month period.

b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

7. The following may result in the reconsideration of financial assistance approval:

   a. Post approval discovery of an ability to pay; and

   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to Meritus.

8. Meritus will track patient qualification for financial assistance or medical hardship. However, it is ultimately the responsibility of the patient to inform Meritus of their eligibility status at the time of registration or upon receiving a statement.

J. CREDIT & COLLECTIONS POLICY

1. Meritus maintains a separate Credit & Collections Policy that outlines what actions Meritus may take in the event a patient fails to meet their financial responsibility.
2. A copy of this policy may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

K. PROVIDER LIST

1. Meritus maintains a list of all Meritus and non-Meritus providers who may care for patients while at Meritus. This list indicates whether the provider is covered by this policy. Non-Meritus providers are not covered and bill separately for their services.
2. A copy of this list may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

RESPONSIBILITY
Vice President, Revenue Cycle and Clinical Support Services

REFERENCES
I.R.C. § 501(r) (2015).
26 C.F.R. § 1.501(r)-4 (2015).
Md. Code Regs. 10.37.10.26.

RELATED POLICIES
Meritus Policy 0444, Credit & Collections

Sliding Scale

US Federal Poverty guidelines are updated annually by the Department of Health and Human Services. Below is an example of the sliding scale Meritus shall use to determine patient eligibility for financial assistance or medical hardship.
https://aspe.hhs.gov/poverty-guidelines

Size of Family Unit*	2020 FPL Income	% of Federal Poverty Level Income					
		200%	250%	300%	350%	400%	500%
		Approved % of Financial Assistance					
		100%	**80%**	**60%**	**40%**	**20%**	**0%**
1	$12,140	$25,520	$31,900	$38,280	$44,660	$51,040	(3) $63,800
2	$16,460	$34,480	$43,100	(2) $51,720	$60,340	$68,960	$86,200
3	$20,780	$43,440	$54,300	$65,160	$76,020	$86,880	$108,600
4	$25,100	(1) $52,400	$65,500	$78,600	$91,700	$104,800	$131,000
5	$29,420	$61,360	$76,700	$92,040	$107,380	$122,720	$153,400
6	$33,740	$70,320	$87,900	$105,480	$123,060	$140,640	$175,800
7	$38,060	$79,280	$99,100	$118,920	$138,740	$158,560	$198,200
8	$42,380	$88,240	$110,300	$132,360	$154,420	$176,480	$220,600

Example # 1	**Example # 2**	**Example # 3**
1. Patient earns $57,000 per year. 2. There are 4 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 80% (they earn more than $52,400 but less than $65,500)	1. Patient earns $54,000 per year. 2. There are 2 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 40% (they earn more than $51,720 but less than $60,340)	1. Patient earns $61,000 per year. 2. There is 1 person in the patient's family. 3. The balance owed is $20,000. 4. If the patient qualifies for Hardship coverage, they would owe $15,250 (25% of 61,000).

* Family unit includes spouse, biological, adopted, or step-children, and anyone for whom patient claims a personal exemption in a state or federal tax return; if patient is a child, family unit includes biological, adopted, or step-parents or guardians; biological, adopted, or step-sibling, and anyone for whom the patient's parents or guardians claims a personal exemption in a state or federal tax return