Western Maryland Health System

FY 11 Community Benefits Narrative

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
275 beds and 20 bassinets	Adult -15,521 Nursery-1,011 Total- 16,532	21502 21532 21539 21536 21562	Garrett Memorial Hospital	15%- Allegany Co.	22.3%-Allegany Co.

Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

The Western Maryland Health System provides primary and secondary acute care services for a six county region covering: Upper Potomac region of Maryland, Eastern West Virginia, and Southwestern Pennsylvania. With almost 87% of the patients residing in either Allegany County, Maryland (72.5%) or Mineral County, WV (13.94%), WMHS considers these communities to comprise its Community Benefit Service Area. This is an expansion beyond the primary service area zip codes listed above but does not include the communities of 100 percent of our patients.

In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary). Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II

Community Benefit Service Area(CBSA)	Allegany County, MD	Mineral County, WV	Source
Target Population	72,598	26,960	American Community Survey 2005-2009 5 yr est.
• By sex	50.3% Male 49.7% Female	49.2% Male 50.8% Female	American Community Survey 2005-2009 5 yr est.
• By race	91.4% White 6.2% Black/African Am. 1.1% Hispanic or Latino 0.6% Asian	95.7% White 2.8% Black/African Am. 0.8% Hispanic or Latino	American Community Survey 2005-2009 5 yr est.
• Average age	40.5 years (4.6% under age 5 and 18.1% 65 yrs and over)	40.5 years (5.6% under age 5 and 15% 65 yrs and over)	American Community Survey 2005-2009 5 yr est.
Median Household Income	$36,810	$37,681	American Community Survey - 2009 inflation adj
Percentage of households with incomes below the federal poverty guidelines	9.5%	11.1%	American Community Survey 2005-2009 5 yr est.
Percentage of uninsured people (under age 65)	15%	21%	County Health Rankings – Univ. of Wisconsin 2011 Report
Percentage of Medicaid recipients by County	22.3%	16.5%	HRSA Area Resource File 2008
Life Expectancy by County.	76.3	75.2	MD Vital Statistics and Community Health Status Indicators (DHHS-2009)
Mortality Rates by County	8073 per 100,000 age adj	8649 per 100,000 age adj	County Health Rankings – Univ. of Wisconsin 2011 Report
Access to healthy food.	46%	38%	County Health Rankings – Univ. of Wisconsin 2011 Report
Transportation-Percentage of households without access to vehicles	11%	9%	American Community Survey 2005-2009 5 yr est.
Population to Primary Care Provider Ratio	1023:1	2465:1	County Health Rankings – Univ. of Wisconsin 2011 Report

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process.
Examples of sources of data available to develop a community health needs assessment include, but are not limited…

1. Identification of Community Health Needs:

Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

In October 2010 a proposed plan for complying with the ACA requirements was reviewed and approved by WMHS System Management. The needs identification process was completed in FY 11. However, the Community Health Needs Assessment will be completed and reported to the public with an adopted implementation plan in FY12.

Connections with the WMHS strategic planning process were identified. There was consensus that the assessment will include health issues and related social issues identified as barriers to care, along with a physician needs assessment to comply with Stark and Anti-Kickback regulations. The Community Health & Wellness Director was assigned the responsibility of coordinating the needs assessment process. Representatives from Community Relations and Marketing were also responsible for data collection and analysis. The Vice President of Mission Services provided administrative direction. The WMHS Board of Directors delegated oversight of the efforts to the WMHS Community Advisory Board, which includes representatives from various sectors of the community.

Utilizing the Association of Community Health Improvement Toolkit, WMHS compiled a list of desired data and potential sources. By January 2011, there were several discussions with the Allegany County Health Department about collaborating on the community health needs assessment and data sources. Raw data from the over 40 sources listed on Attachment 1 (Source List), was compiled and put on a dashboard, along with additional narrative for consideration in April 2011. Resources included DHMH's State Health Improvement Plan, Healthy People 2020, and other secondary sources as well as patient satisfaction information, admission data, consultation with community coalitions and a transportation survey.

Management teams from both the health department and WMHS reviewed the raw data, narrative, and sources, to identify missing elements, raise questions, and begin analysis. Criteria to identify the most significant health issues included magnitude, severity or the degree to which it is worse than the target, and level of need for vulnerable populations.

From the analysis, the following framework was created and presented to the Community Advisory Board in May along with a list of community organizations and focus groups that would be asked to participate in the process.

- Demographics- Characteristics of community and patients
- Lifestyle choices and environment
- Health needs & disease status
- Access to care (payors & providers, barriers)

Utilizing this framework, WMHS worked collaboratively with the health department to create a powerpoint presentation to be used when seeking input from the various community organizations. The presentation was done for WMHS System Administration in June, and the community presentations were scheduled to start in July (our next fiscal

year). By December 31, 2011, the data sources, analysis, identified community priorities and an implementation plan will be posted on the WMHS website for the public to utilize. The complete process describing the 3 year cycle is outlined on Attachment 2 (Timeline Chart).

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

   Information about community health needs was sought from the Allegany County Health Officer and various public health experts at both the local health department and state health department. Western Maryland Area Health Education was contacted regarding provider availability. Allegany Transit and the County Administrator were contacted about transportation. A local pharmacy network and Associated Charities were contacted about prescription usage and payors.

   Community needs related to health improvement and access to care are regularly discussed via community partners and the Workgroup on Access to Care. The groups usually meet bimonthly and include representatives from the local health department, social services, local non-profit organizations, health care organizations, and community leaders. The Workgroup on Access to Care met in FY11 on September 16, November 18, January 13, March 24 and May 19. The WMHS Community Advisory Board reviewed the initial results and will continue to oversee the process. Representatives on this Board come from local businesses, universities, health care agencies and neighborhoods.

3. When was the most recent **needs identification process** or community health needs assessment completed?
   Provide date here. _06/01/11__ (mm/dd/yy)

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?

   ___Yes
   _x__No, not completed in FY11. Will be complete in FY12.

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Does your hospital have a CB strategic plan?

_x__Yes- Community Benefits and the Community Health Needs Assessment are a part of the WMHS strategic plan. Access to quality, cost effective health care and prevention remain community priorities. WMHS's community benefits initiatives continue to include health improvement, community investment, and access for the low income uninsured.

___No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. __x_CEO
2. _x__CFO
3. __x_Other (please specify)- all members of WMHS System Administration (COO, CNO, and all VPs)

ii. Clinical Leadership

1. _x__Physician
2. _x__Nurse
3. _x__Social Worker
4. _x__Other (please specify)-Allied Health professionals
5.

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. _x__Committee (please list members) Scott Lutton, Nancy Forlifer, and Kathy Rogers, Mark Sullivan, Kevin Turley & Donna Pope
3. ___Other (please describe)

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet	___x__yes	_____no
Narrative	____x_yes	_____no

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	_x____yes	_____no
Narrative	__x___yes	_____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. *Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).*

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

a. *Identified need: This includes the community needs identified in your most recent community health needs assessment.*
b. *Name of Initiative: insert name of initiative.*
c. *Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)*
d. *Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?*
e. *Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.*
f. *Date of Evaluation: When were the outcomes of the initiative evaluated?*
g. *Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).*
h. *Continuation of Initiative: Will the initiative be continued based on the outcome?*

Though the needs assessment process described above occurred in FY11 the planning process will not be complete until FY12. Several of the needs identified are ongoing concerns and our efforts to address them in FY11 are described in the attached Tables. Community service priorities remain to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable. These categories encompass many of the thirteen priorities identified in the recently completed needs assessment process including:

Tobacco Cessation (especially during pregnancy)
Obesity
Access to Care & Providers
Emotional & Mental Health (suicide rate and self diagnosed depression)
Substance Abuse (alcohol & drugs)
Screening & Prevention-Diabetes, Hypertension, Cancer
Heart disease & Stroke
Health Literacy
Prenatal Care – Healthy Start
Dental
Cancer
Immunization (flu)
Chronic Respiratory Disease

More extensive plans are underway for implementation in FY12.

2. Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?

There were no primary community health needs identified through a community needs assessment that were not addressed by the hospital. There is however a significant need for mental health services in our community and at times throughout FY11, the WMHS did not have sufficient providers to accept new patients. This was only for short

timeframes and recruitment efforts and community partnerships were ongoing to address the needs of patients on a case by case basis.

V. PHYSICIANS

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

   According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 631 people, Allegany comes closest with 1023:1 and Hampshire is the most off target at 2518:1. In Maryland the ratio of population to mental health providers is 1617:1. Again, Allegany is closest with 2271:1 and Bedford is most off target with 49799:1
   The most recent assessment in compliance with Stark regulations, the top needs for WMHS are primary care (5.8FTE) and psychiatry (4.8 FTE). In addition there is a lesser need (<2 FTE) for specialists in the areas of Medical Oncology, Gastroenterology, Vascular Surgery, and Urology. The average net need is based on the current supply and calculated demand, based on population needs, causes of death, age of physicians and more. Based on the emergency call schedule, **GI** was the only area identified as not having good coverage.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

   Western Maryland Health System has included physician subsidies in the following categories:
   - Hospitalists
   - Physicians recruited to meet community need

   With a growing number of area physicians electing to concentrate on their office practice and not admit their patients to the hospital, WMHS needed to expand the Hospitalist program to respond to community need. Physician shortages were identified in primary care, psychiatry and obstetrics and WMHS responded by recruiting and supporting practices in these areas. These needs were not being met by other agencies in the community and based on the demographics and health indicators in the area, were much needed services.

VI. APPENDICES

1. Appendix 1- Description of Charity Care policy
2. Appendix 2- WMHS Charity Care Policy
3. Appendix 3- WMHS Mission, Vision, and Value Statement(s)

Attachment 1: WMHS Source List FY11

Code	Source	Timeframe
1.	American Community Survey/ Census 2010 Data	2005-2009 5 year estimates Md, All & Garr, PA-Bed & Somer, WV-Min & Hamp.
2.	Community Health Status Indicators (DHHS)	2009 Report –using data sources 2001-2009 Md, All & Garr, PA-Bed & Somer, WV-Min & Hamp.
3.	County Health Rankings (U of Wisconsin)	2011 Report- Data elements have varied timeframes
4.	Data Resource Center for Child and Adolescent Health	2007 National Survey of Children's Health-State level only
5.	KIDS COUNT (Annie E Casey Fdn) County Profiles	Most recent 5 years varies 2005-2011
6. N	Community Need Index (Catholic Healthcare West) Standardized index -severity of health disparity by zip code based on income,language/culture,education, insurance & housing. 5 means zip code has most need	2011- support data elements proprietary to Thomson Reuters
7. N	AgingStats.Gov Trends in Population, Economics, Health Status & Risks, Health Care-US Older Americans	2010 Report using various data & trend periods
8. N	NCI-State Cancer Profiles (Incidence Rate by State & County, Death Rate)	Rate Period 2003-2007, as reported to CDC Cancer Registry(NCPR-CSS) Nov. 2009-Jan. 2010
9. N	MD Vital Statistics and WV & PA equivalent PABureau of Health Statistics &Research www.health.state.pa WV www.wvdhhr.org/bph/hsc/statserv	2006-08 (2009 report unavailable) Birth data 2009 PA-2005-07, WV-2006-08(some older)
10.	MD Behavioral Risk Factor Surveillance Survey (Dental Care-Allegany County)	2006 &2008 AC only
11.	ACHD Program & Clinic Report-Mental Health Clinic Utilization *NIMH & NCHS-Mental Health prevalence	2008-2010 Alleg. Co *2009
12.	Demographics from WMHS Strategic Plan (Finance)	2010
13.	Physician Needs Assessment-WMHS Foundation	2011
14. N	On Call Coverage Utilization	2010 anecdotal
15. N	Most Prevalent Diagnoses in ED (IT)	CY2010
16. N	Payor Mix (Payor Mix for WMHS and ED only-by Ins Group IP,OP & combined and the same by just payor mix)	CY2010
17.	Workforce Development Network Baseline Assessment (W Md AHEC)	2011
18. N	Patient Satisfaction (HCAHPS, OP Survey, HomeCare CAHPS, Pt. Satisfaction Team Plan)	FY10 (July 1, 2009-June 30, 2010)

Attachment 1: WMHS Source List FY11

	Source	**Timeframe**
19. N	Patient Feedback (Dept Comparison Report, Volume Complaint Type)	CY2010 (Jan-Dec)
20.	ACHC Environmental Health Report-Rabies, New Wells MDE-Lead Poisoning Annual Report, DHMH Water & Food Bourne Illnesses	CY2007-10 AC only CY2006,2008, 2009 CY2008-10
21.	CDC-County/State Data & Trends Diabetes Diagnosed, Physical Inactivity,Obesity	2008
22. N	Diversitydata.org	US Census Bureau 2000 & 2010, MSA-Cumberland, MD-WV
23.	ACHD Clinic Records and Report- Alcohol & Substance Abuse (utilization, ED visits, arrests, etc)	2008-10 AC only 2001-05 Need for Substance Abuse Treatment-Maryland Final Report
24.	DHMH Injuries (ED visits, discharges & death rates)	2005-08 AC only
25.	CESAR-Uniform Crime Report MSP (drug arrests and alcohol related crashes)	2001-05 (2009 crashes) AC only
26.	ACHD Perinatal Substance Abuse Intervention Program DHMH Division of Outreach & Care Admin. MD Prenatal Risk Asst.	FY10 and FY11 Mid Year Reports FY08-10 AC only
27.	DHMH Tobacco Use Prevention & Cessation Program-prevalence	2000, 2002, 2006, 2008 AC only
28.	ACHD Mental Health Systems Office FY12-14 Plan	FY08-10 data AC only
29. N	Allegany County Transit –Fares, Routes, Benefits	2010
30. N	Local Findings-Community Strategies & Measurements to Prevent Obesity in US (various data sources)	Report 2010
31. N	Cumberland CDBG Consolidated Plan (2005-09)	2005
32. N	WMHS Community Benefit Report -Narrative	FY 10
33. N	Gallup-Healthways Well Being Index Congressional Districts	Cy2010
34. N	Inpatient Admissions (# patients, costs, % , by code groups)	FY10 & 11 thru 4-15
35. N	Maryland Network Against Domestic Violence Crime Report	FY10 MD only
36. N	Health Indicator Warehouse via HealthyPeople.gov	Dates vary with source
37. N	Inpatient Characteristics & Payor	FY10 & Fy11 YTD
38. N	Nursing Vacancy Rate-Board Dashboard Human Resources	FY10
39. N	Outmigration of Patients by Service Line	CY2008
40. N	National Plan to Improve Health Literacy	2011 Report
41. N	Birth Data WMHS	CY10
42. N	PharmaCare Network Top Rx and Payers	CY10
43. N	Burden of Chronic Disease (MD VSA& BRFSS)	2009 AC only
44.	HRSA Area Resource File (Provider data from AMA 2007)	2008
45.	HRSA Shortage Designation	2011
46.	ED use for Dental Reasons (WMHS)	FY10
47.	Transportation Survey (ACHD, WMHS-ED & TSCHC)	July 2011

N-A source that will be used for narrative portions of report.

Attachment 2: WMHS Timeline for CHNA

WMHS Community Health Needs Assessment

	FY11		FY12				FY13				FY14
Tasks	Jan-Mar'11	Apr-Jun'11	Jy-Spt 2011	Oct-Dec '11	Jan-Mar'12	Apr-Jun'12	Jy-Spt 2012	Oct-Dec '12	Jan-Mar'13	Apr-Jun'13	Jy-Spt 2013 and beyond
Data Collection & Analysis											
Presentations & Priorities											
Service Line Coordination											
Summary of Needs, Gaps & Resources											
5 Priorities, Best Practices & Partners											
Approve Action Plan & Metrics											
Community Benefit Report											
Report to Public											
Implement Plan & Report Quarterly											
Update Timeline for Next 3 yr. cycle											

Complete Remaining

Attachment 2: WMHS Timeline for CHNA

WMHS Community Health Needs Assessment

	FY11		FY12				FY13				FY14
Tasks	Jan-Mar'11	Apr-Jun'11	Jy-Spt 2011	Oct-Dec '11	Jan-Mar'12	Apr-Jun'12	Jy-Spt 2012	Oct-Dec '12	Jan-Mar'13	Apr-Jun'13	Jy-Spt 2013 and beyond
Data Collection & Analysis											
Presentations & Priorities											
Service Line Coordination											
Summary of Needs, Gaps & Resources											
5 Priorities, Best Practices & Partners											
Approve Action Plan & Metrics											
Community Benefit Report											
Report to Public											
Implement Plan & Report Quarterly											
Update Timeline for Next 3 yr. cycle											

Complete Remaining

Table III

Initiative 1: Access to Care for Vulnerable Populations.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
14.2% households living below poverty level	Community Health Access Program (CHAP)	To link low income, uninsured adults to a primary care home, diagnostic services, care coordination, and support with specialty care	Multiyear since 2001	Joint venture of WMHS and Allegany Health Right, with support from area physician offices, Tri-State Community Health Center	Monthly dashboard of encounters, Quarterly review of ED usage	30% reduction in emergency room use by providing medical home	Continue
15% uninsured 11% illiterate 20% of adults report lack of emotional and social support	Workgroup on Access to Care	To enhance coordination of services among community agencies for the low income, uninsured population	‘’	Workgroup- ACHD, Dept Social Services, Western Maryland AHEC, U of Md Extension, Associated Charities, Cumberland Ministerial Assn, Mental Health Systems Office, Tri-State CHC, 3 MCOs for Medical Assistance.	Bimonthly review of intakes, referrals and service	Over 8% increase from 14,214 to 15, 385 in CAP database Average of 1.5 services per completed intake each month	Continue
	Parish Nursing	To bring information to the population and provide needed emotional and spiritual support	Multiyear	43 active Faith Based Communities	Monthly dashboard of community encounters	3,012 volunteer hours from the parish nurses and health ministers which resulted in 36,070 outreach encounters	Continue

Table III

Initiative 2; Chronic Disease Prevention.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Higher death rate compared to MD and the target-heart disease, cancer, stroke and chronic respiratory disease. Higher % of adults with BMI>30, diagnosed with diabetes, and/or having hypertension. 76.3% Allegany Co. adults report eating fewer than 5 fruits & vegetables per day and -30% of the adults in Allegany report no leisure time physical activity.	Screenings-Cholesterol, Blood Pressure, BMI, HbA1c Health Fair Community Outreach & Education-such as Win Big By Losing	To increase awareness of health status and risk factors for chronic disease To promote healthy lifestyles and increase physical activity &healthy eating in the community	Multiyear-focus of the initiatives change based on annual review of needs	Screenings-Worksites, HRDC, & Frostburg State University Health Fair-Allegany Co Health Dept., Community Wellness Coalition, American Cancer Society, Maryland Physicians Care, Western Maryland Medical Supply and PharmaCare Community Outreach & Education- YMCA, Life Fitness Management, ACHD, HRDC-Head Start, Country Club Mall, etc.	Annual and post screening Post event, April 2011 Post service and/or challenge	Encounters for education and screening increased by 8% from FY10 to FY11, increasing from 9,964 to 10,754 1058 screening/assessments, and 1050 interactive educational activities, with participants reporting and increase knowledge 829 people participated in Win Big By Losing and lost 3,191 pounds	Continue screening based on USPTF Discontinue Annual Health Fair-desire greater impact Continue education & outreach. Replace weight loss challenge with ongoing weight management program

Table III

Initiative 3: Workforce Enhancement.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
Shortage of Providers **HPSA**- Allegany Primary-Low Income and correctional institutions Dental-Low Income and correctional institutions, MA pending Mental-correctional institutions and MA Other counties have varying types of HPSA designations, only areas with none-Hampshire-primary care and Mineral-dental. Though many limits to type.	Physician Recruitment Support of clinical education	To increase the number of providers in identified area of need. FY 11 focus was on …primary care -To collaborate with regional partners to increase long term supply of health care providers in the community- Garrett Allegany Workforce Development Network	Multiyear-ongoing Multiyear-3 years	Western Maryland AHEC, Garrett Memorial Hospital, Allegany & Garrett Health Departments, Tri-State Community Health Center, University of Maryland, etc.	Annual	18 physicians were needed and 6 were recruited in FY 11 10 primary care nurse practitioners/physician assistants were needed and 7 were recruited in FY11	Continue

Appendix 1- Informing Patients of Eligibility
Western Maryland Health System FY11

Description of the Charity Care Policy

The Western Maryland Health grants charity care to those patients who demonstrate a financial need. WMHS has signs posted at all sites where patients are admitted for inpatient care and all sites where patients receive outpatient services, including the emergency room.

The WMHS website describes the Financial Assistance Policy as:

• The Western Maryland Health System provides care to all patients seeking care, regardless of their ability to pay. A patient's ability to pay is based on a review which is done by a member of the Health System's Business Office. This review assures that all patients who seek emergency or urgent care receive those services regardless of the patient's ability to pay.

• In accordance with Maryland law, the Western Maryland Health System has a financial assistance policy and you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.

• The Western Maryland Health System meets or exceeds the state's legal requirement by providing financial assistance based on income established by and published by the Federal Government each year. In order to determine eligibility for assistance, you will be asked to provide certain financial information. It is important that we receive accurate and complete information in order to determine your appropriate level of assistance.

Applications for Financial Assistance are made available to patients at the time services are rendered. Applications for Financial Assistance are also made available to any patient or their family members who request the form be mailed to them.

WMHS contracts with an outside agency to interview all inpatients who do not have insurance coverage. When feasible the initial contact is made prior to discharge. The contractor explains to the patient or their family member(s) the benefits that may be available to them through the federal, state and local programs including Medical Assistance, Primary Adult Care and Medicare. The contractor assists the patient or their families in completing applications and accompanies them if needed to any appointments for the purpose of obtaining benefits through the various public programs.

WMHS provides a telephone number for financial assistance on patient statements. WMHS also has staff dedicated to follow-up and assist any patient or their family member(s) who needs support in obtaining financial assistance.

Patients determined to be ineligible for government benefits may be referred to WMHS Community Health & Wellness and its Community Health Access Program, (CHAP). This unique program, a joint venture of the Western Maryland Health System and Allegany Health Right, links participants to a primary care physician and appropriate health and social services, such as prescription programs, nutritional counseling, and diagnostic care. Through CHAP enrollment individuals are screened for potential eligibility in over 40 area programs.

WESTERN MARYLAND HEALTH SYSTEM DEPARTMENTAL Policy Manual	**Department\Division:** Business Office	**Policy Number:** 400-04
	Effective Date: November 12, 2010	**Reviewed/Revised:** April 2011

FINANCIAL ASSISTANCE POLICY

POLICY

Western Maryland Health System is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual situation. A patient can qualify for Financial Assistance either through lack of sufficient insurance or financial hardship due to excessive medical debt.

It is the policy of Western Maryland Health System to provide Financial Assistance based on indigence or excessive medical debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

Western Maryland Health System will post notices of availability at patient registration sites, Admissions, Business Office and at the Emergency Department. Notice of availability will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients via the Admission Handbook given to every admitted patient. This is provided to patients prior to discharge and is also available to all patients upon request.

DEFINITIONS

Medical Debt-Out-of-Pocket Expenses: Medical expenses excluding co-payments, co-insurance, and deductibles, for medical costs billed by a hospital.

Immediate Family: If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, and natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.

Family Income: Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, retirement/pension income, Social Security benefits and other income defined by the Internal Revenue Service, for all members of immediate family residing in the household.

Supporting Documentation: Pay stubs, workers compensation, Social Security or Disability award letters, bank or brokerage statements, tax returns, Explanation of Benefits to support medical debt.

Financial Hardship: Medical debt incurred by a family over a 12 month period that exceeds 25% of family income. (See Medical Debt definition)

Medically Necessary: For this policy does not include cosmetic procedures.

Free Care: Available to patients in households between 0% and 200% of Federal Poverty Level (FPL)

Reduced-Cost Care: Available to patients in households between 200% and 300% of Federal Poverty Level (FPL).

PROCEDURE

1. Evaluation for Financial Assistance can begin in a number of ways. A patient may present to a hospital service area seeking medical care and inquire about financial assistance; a patient may notify Business Office personnel/ financial counselor that he/she cannot afford to pay a bill and requests assistance, or any health care provider referral. All hospital and outpatient diagnostic centers have financial assistance applications to

offer to patients. Registrars are trained to offer financial assistance applications to self pay patients. Western Maryland Health System will use the Maryland State Uniform Financial Assistance Application.

2. WMHS has a financial counselor and a Medicaid eligibility specialist on site in the hospital. Financial counselors are also available in the Business Office to support and counsel patients.

3. Determination should be made that all forms of insurance are not available to pay the patient's bill. All insurance benefits must have been exhausted.

4. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance specialist or its designated agent, unless the financial representative or supervisor can readily determine that the patient would fail to meet the eligibility requirements and thus waive this requirement.

5. Determination of income will be made after review of all required documents. The following supporting documents must be provided with the application:

   a. 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 as defined by Medicaid regulations.)
   b. A copy of the four (4) most recent pay stub (if employed) or other evidence of income of any person whose income is considered part of the family income as defined by Medicaid regulations.
   c. Proof of disability income (if applicable)
   d. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, or statement from current source of financial support, etc.
   e. Bank statement.

   WMHS may consider monetary assets in addition to income, excluding up to $150,000 in a primary residence, and certain retirement benefits where the IRS has granted preferential treatment. At a minimum, the first $10,000 in monetary assets is excluded.

6. Presumptive Financial Assistance Eligibility- These are instances when a patient qualifies for financial assistance based on the enrollment in the following government programs. In these instances the application process is abbreviated. The application must be completed and the only additional required document is proof of acceptance and participation in one of the following programs.
   a. Food Stamps
   b. Women's, Infants and Children (WIC Program)
   c. Households with children in the free and reduced lunch program
   d. Primary Adult Care Program (PAC)

   Homeless patients and members of a recognized religious organization who have taken a vow of poverty are also considered eligible for Presumptive Financial Assistance. Presumptive Financial Assistance is valid 6 months from date of application.

7. The application, with supporting documents, should be completed by the applicant and returned to the Collections Department within 10 days. If partial information is returned, the applicant will be given additional time to provide the required documents. If the applicant does not respond, the applicant is considered not interested.

8. By using the Federal poverty guidelines published annually in the Federal Register, a patient may be found to receive 100% Free Care or Reduced Cost Care which is based on a percentage of their bill according to their income and number of dependents. The patient's responsibility will be capped based on a percentage of their

income. In such cases, a percentage of the bill is charged to the Financial Assistance Program and the patient /guarantor is required to pay the remainder not charged to the Financial Assistance Program. Financial counselors will use WMHS Charity Calculation form to determine level of financial assistance.

9. Decisions on eligibility will be made within seven business days of application. The applicant will be notified in writing by the WMHS financial counselor.

10. The Financial Assistance application, when approved, is backdated for services rendered 12 months prior to approval and valid 12 months after approval.

11. If within a two year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25.00. If documentation demonstrates lack of cooperation in patient/guarantor in providing information to determine eligibility for free care, the two year period may be reduced to 30 days from the date of initial request for information.

12. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency will be notified and the account will be placed on hold pending the completion of the application within 10 days. In the event the application is not completed by the patient, the patient will be deemed uncooperative and the account will be returned to the collection agency.

13. If the application is denied, the patient has the right to request the application be reconsidered. The financial counselor will forward the application to the Director of Business Operations for final evaluation and decision.

14. The Director, Business Operations or designee will approve all applications.

APPROVAL

_____ _____

Director, Business Operations Date

_____ _____

Vice President, Financial Services Date

SLIDING SCALE ADJUSTMENTS Based on FPL 2011

WMHS Financial Assistance Program (Charity Care) and Community Health Access Program

PATIENT RESPONSIBILITY PERCENTAGES

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%	30%	40%
1	0 ($10,890) - $21,888	$21,889 - $24,502	$24,503 - $27,224	$27,225 - $29,947	$29,948 - $32,670
2	0 ($14,710) - $29,566	$29,567 - $33,097	$33,098 - $36,774	$36,775 - $40,452	$40,453- $44,130
3	0 ($18,530) - $37,244	$37,245 - $41,692	$41,693 - $46,324	$46,325 - $50,957	$50,958 - $55,590
4	0 ($22,350) - $44,923	$44,924 - $50,287	$50,288 - $55,874	$55,875 - $61,462	$61,463 - $67,050
5	0 ($26,170) - $52,601	$52,602 - $58,882	$58,883 - $65,424	$65,425 - $71,967	$71,968 - $78,510
6	0 ($29,990) - $60,279	$60,280 - $67,477	$67,478 - $74,974	$74,975 - $82,472	$82,473- $89,970
7	0 ($33,810) - $67,957	$67,958 - $76,072	$76,073- $84,524	$84,525 - $92,977	$92,978- $101,430
8	0 ($37,630) - $75,635	$75,636 - $84,667	$84,668 - $94,074	$94,075 - $103,482	$103,483-$112,890
FPL range	**Thru 200%**	**201% -224%**	**225% - 249%***	**250% - 274%**	**275%-300%**

Each additional person, add $3,820 to base FPL.

***CHAP- stops at 250% FPL**

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	$32,490	$43,320	$54,150
2	$43,710	$58,280	$72,850
3	$54,930	$73,240	$91,550
4	$66,150	$88,200	$110,250
5	$77,370	$103,160	$128,950
6	$88,590	$118,120	$147,650
7	$99,810	$133,080	$166,350
8*	$111,030	$148,040	$185,050
Allowance to Give:	50%	35%	35%

*For family units with more than 8 members, add $11,220 for each additional person at 300% of FPL, $14,960 at 400% at FPL; and $18,700 at 500% of FPL.

Mission, Vision & Values

Mission Statement

Superior care for all we serve

Vision Statement

Demonstrated leader in the delivery of exceptional healthcare services throughout the tri-state region

Core Values – i2care

Integrity – Demonstrate honesty and straightforwardness in all relationships

Innovation – Pursue continuous improvement through creative new ideas, methods, and practices

Compassion – Show care and kindness to all we serve and with whom we work

Accountability – Ensure effective stewardship of the community's trust

Respect – Demonstrate a high regard for the dignity and worth of each person

Excellence – Strive for superior performance in all that we do