COMMUNITY BENEFIT NARRATIVE

FY2015 Community Benefit Report

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BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA), as provided in the ACA, must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

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.

Examples of sources of data available to develop a CHNA include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;

(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. 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 acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

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:
23	2177	21550 26764 21561 21520 21531 21536	None	Garrett County – 13 Preston and Grant County, WV – 19 Tucker County, WV - 20	Garrett County – 13 Preston County, WV 15.2 Grant County, WV 13.6 Tucker County, WV 13.4

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

Open since 1950, Garrett County Memorial Hospital, now doing business as Garrett Regional Medical Center (GRMC) is located in the westernmost county in Maryland, separated from the rest of Maryland by the Appalachian Mountain chain. GRMC provides services for the residents and visitors of Garrett County and surrounding counties in West Virginia (Grant, Preston, Tucker), All of Garrett County has been designated a Medically Underserved Area (MUA) with a score of 42.4. In addition, the county is designated as a Health Professional Shortage Area (HPSA) for primary care, mental health, and dental care. Furthermore, all of the proximate counties in WV are also entirely or partially designated as MUAs.

GRMC services include a 24-hour Emergency Department, Inpatient Care, Observation Services, a 10-bed Sub-Acute Rehabilitation Unit, Obstetrics, Pediatrics, Medical/Surgical Intensive Care Unit, Operating Room, Radiology, Lab, Cardiopulmonary Services, Community Wellness, Work-Site Wellness and other ancillary programs.

There are a total of 11 family practice physicians, 6 emergency room physicians, 3 general surgeons, 2 orthopedic surgeons, 9 nurse practitioners, 6 physician assistants, and 2 ophthalmologists that practice in Garrett County.

As the only hospital in the County, GRMC must be prepared at all times to meet the clinical and emergent needs of the region's population. The mountainous topography, severe weather, and considerable distances make it difficult for residents to access healthcare outside the county. Garrett County averages 120 inches of snow each year. The nearest referral hospitals are sixty miles to the east or west. Additionally, Garrett County's population is aging, and there is no public transportation, such as bus lines or taxi service, available for them.

In an effort to maximize resources, avoid duplication of services and meet growing local service demand, GRMC collaborates closely with the Garrett County Health Department, Social Service Agencies, County Commissioners, Community Action Agency, local Management Board and other agencies to create a health care delivery system which is accessible, inclusive and makes efficient use of each organization's potential. As the largest healthcare provider in the continuum, the community primarily looks to Garrett Regional Medical Center to plan, execute and deliver the majority of these new services

b. In Table II, describe the population within the CBSA, including 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, transportation, education and healthy environment, 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 State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA Source: Maryland Department of Health and Human Services and U.S. Census Reports http://www.census.gov/quickfacts/table/PST045214/24023,54077,54057,54023,00	The median household income in Garrett County is $46,096 as compared to $53,248 for the State of Maryland. Bordering areas of West Virginia counties included in the GRMC service area are Preston with median household income of $45,806; Tucker with median household income of $37,591; and Grant with median household income of $41, 600. The median household income for the State of West Virginia is $53,482 which makes the West Virginia residents utilizing hospital services from the more impoverished areas of West Virginia.
Percentage of households with incomes below the federal poverty guidelines within the CBSA http://www.census.gov/quickfacts/table/PST045214/24023,54077,54057,54023,00	Garrett County has 15.9% people in poverty, Preston County, WV has 17%; Tucker County, WV has 16.3%; Grant County, WV has 16.7%.
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml http://www.countyhealthrankings.org	Garrett County has 13% uninsured; West Virginia counties of Preston – 19%; Tucker – 20%; Grant - 19%.
Percentage of Medicaid recipients by County within the CBSA. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html	Garrett County has Medicaid population of 13%, while our West Virginia counties list Medicaid eligible for Grant County as 13.6%; Tucker County as 13.4% and Preston County as 15.2%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Life Expectancy for Garrett County males is 75.2 and females is 81; Preston County, WV - males is 74.1, females are 80.2; Grant County WV – males is 74.3, females are 80.2 and Tucker County WV - males is 73.1

http://www.worldlifeexpectancy.com/usa/west-virginia-life-expectancy-by-county-male	and females are 79. Information was not available for the counties by race and ethnicity.
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://www.worldlifeexpectancy.com http://www.menshealthnetwork.org	Mortality rate for Garrett County is 816 per 100,000 populations. Statistics show 691.93 deaths per 100,000 for white; 809.74 deaths per 100,000 for African American; 350.74 deaths per 100,000 for Asian/Pacific and 365.71 deaths per 100,000 for Hispanic.
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx http://www.countyhealthrankings.org http://www.census.gov/quickfacts/table/HSG445214/54023,54077,54093,00	HEALTHY FOOD Garrett County has a food environment index of 8.7. Surrounding West Virginia counties as follows: Grant , Preston and Tucker – 7.9 TRANSPORTATION In Garrett County 76% drive to work alone and 28% have long commute; In Tucker County West Virginia 79% drive to work alone and 45% have a long commute; Preston County, West Virginia 80% drive to work alone and 45% have a long commute; Grant County, West Virginia 79% drive to work alone and 35% have a long commute. There is no taxi service or public bus line available in the Hospital's service area. EDUCATION Garrett County has a high school graduation rate of 94% with 49.1% having some college; Tucker County, WV has a high school graduation rate of 88% with 53.9% having some college education; Preston County, WV has a high school graduation rate of 78% with 42% having some college: Grant County, WV has a high school graduation rate of 93% with 29.7 having some college.

	HOUSING QUALITY Garrett County has a homeownership of 75.5% with a median value of $168,600 and 13% severe housing problems; Tucker County, WV has a homeownership of 81% with a median value of $104,200 and 11% severe housing problems; Preston County, WV has a homeownership of 79.6% with a median value of $107,800 and 9% severe housing problems; Grant County, WV has a homeownership of 77% with a median value of $121,100 and 9% severe housing problems. ENVIRONMENTAL FACTORS Garrett County Air pollution – particulate matter – 13.3 and 12% drinking water violations. Tucker County, WV Air pollution – particulate matter – 13.2 and 0% drinking water violations. Preston County, WV Air pollution – particulate matter – 13.4 and 0% drinking water violations. Grant County, WV Air pollution – particulate matter - 13.1% and 0% drinking water violations.
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx http://www.census.gov/quickfacts/table/PST045214/24023,54077,54057,54023,00	Garrett County Population 29,679 White Alone -97.5% Black or African American – 1.1% American Indian or Alaskan Native – 0.2% Asian – 0.5% Two or more races -0.8% Language other than English – 4.6% Female – 50.3% Preston County, WV Population 33,788 White Alone -97.4% Black or African American – 1.3% American Indian or Alaskan Native – 0.2%

	Asian – 0.2% Two or more races -0.9% Language other than English – 2.0% Female – 48.5% Grant County, WV Population 11,687 White Alone -94.9% Black or African American – 3.1% American Indian or Alaskan Native – 0.2% Asian – 0.4% Two or more races -1.4% Language other than English – 2.0% Female – 50.3% Tucker County, WV Population 6,986 White Alone -97.5% Black or African American – 0.4% American Indian or Alaskan Native – 0.3% Asian – 0.2% Two or more races -0% Language other than English – 1.0% Female – 49.3%
Other	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

_X__Yes
____No

Provide date here. 11/06/2012

If you answered yes to this question, provide a link to the document here.

https://www.gcmh.com/wp-content/uploads/file/Community%20Health%20Needs%20Assessment%202012%20-%202013.pdf

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

_x_Yes 02/27/2013

If you answered yes to this question, provide the link to the document here.

https://www.gcmh.com/wp-content/uploads/file/GCMH%20Strategic%20Initiatives%20and%20Implementation%20Strategy.pdf

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? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

a. Is Community Benefits planning part of your hospital's strategic plan?

__X Yes
___No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

The addition of new services or changes to existing services is based upon what is needed by the community. As the financial feasibility of the service is considered, the need for the

service is also considered. While administration must be good stewards of the hospital finances, they also determine the value of the service to the community when making the decision to move forward.(For example: the Cardiac and Pulmonary Wellness Program detailed in Table III.)

"Formalize and strengthen the health and wellness services available to the community at large and encourage attitudes that foster a long-term commitment to achieving optimal health by offering tools for overall health and well-being with a primary focus on those health issues identified through the Hospital's Community Health Needs Assessment"

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 describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. _X__CFO

ii. ___Other (please specify)

a. Chief Nursing Officer
b. Chief Information Officer
c. Human Resource Director

Describe the role of Senior Leadership.

The Senior Leadership Team, listed above, monitors all aspects of hospital operation, service and performance to ensure that each patient or potential patient is provided consistent, quality service. They monitor the healthcare needs of the community to ensure that the hospital is meeting the needs of the community as efficiently as possible. Leadership strives to provide as many medical services locally as feasible. Based on their ongoing review and evaluation, programs are developed and implemented for the benefit of the health of the community that meets the guidelines of a community benefit program.

iii. Clinical Leadership

1. _x__Physician
2. ___Nurse
3. ___Social Workers
4. ___Other (please specify)

Describe the role of Clinical Leadership

A Chief Physician Officer serves as a member of the Hospital's Senior Leadership team to represent the medical staff in the decision making process.

iv. Community Benefit Operations

1. _x__Individual (please specify FTE)
    a. Senior Director of Marketing and PR
    b. Accounting clerk

2. ___Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. _x__Other (please describe)
    a. Wellness Coordinator

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

Senior Director of Marketing and Public Relations works with the accounting department and leadership team to develop the narrative report, while the accounting staff collects the data from staff members involved in each community benefit activity.

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

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

The Community Benefit Report is prepared and submitted to the full Leadership team for review and editing. Final approval is agreed upon by the Leadership as a team.

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

Spreadsheet	__x___yes	_____no
Narrative	__x___yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and

outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

_ _x___ Other hospital organizations
__ x___ Local Health Department
___x__ Local health improvement coalitions (LHICs)
___x__ Schools
___x__ Behavioral health organizations
__x___ Faith based community organizations
__x___ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Name of Key Collaborator	Title	Collaboration Description
Health Department	Rodney Glotflety	Health Officer	Provided input as a survey participant
Health Department	Kendra Todd		Kendra Todd helped with the development of the survey document
STEPS Committee	Dr. Karl Schwalm	Chairman	The STEPS committee is made up of representatives of health oriented facilities, board of education, nursing homes and general public to identify and address health and wellness issues in the community.

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

_____yes __x___no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

___x__yes _____no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.

For example: for each principal initiative, provide the following:

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)

(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

The primary health needs identified in the GRMC Community Health Needs Assessment included cancer, heart disease, general aging problems and obesity. GRMC is making strides toward addressing cancer by adding the Cancer Care Patient Navigator to assist patients and families as they seek and obtain cancer treatment and related services. Long term plans include the opening of a Cancer Care and Infusion Center in Garrett County, which is slated to open in January 2016.

Heart Disease is the highest cause of death in Garrett County and was recognized as a concern by our survey group. Cardiac patients are treated in the Emergency Department and admitted to the Hospital's Intensive Care Unit unless their condition warrants testing or treatments that are currently not available at GRMC. Cardiac Catheterization is one of the procedures that is not available locally at this time. GRMC has added the Cardiac and Pulmonary Wellness Program that helps to address the issue of heart and lung disease after the initial episode. Components of this program also address patient mobility, exercise and other problems associated with the general aging process. While diabetes was not recognized by our survey group, it has been identified as a major problem in Garrett County by the Maryland SHIP indicators. The GCMH Diabetes Prevention Program emphasizes the importance of weight management and increased exercise.

Also noted in the survey is that tobacco use among both adults and school age children is an issue in the County that impacts many health issues including heart disease. The smoking impact is currently being addressed through programs offered by the Garrett County Health Department with the assistance of Federal funding. The Health Department has an excellent working relationship with the Board of Education to work directly in the school system to discourage smoking among the youth. The Health Department also has implemented programs that help address issues of selling cigarettes inappropriately at the business level. GRMC fully endorses the Health Department's smoking cessation efforts and refers patients into that system.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
HEALTH CARE INNOVATIONS IN MARYLAND
http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

The Well Patient Program works to address the following population health measures through individualized patient follow up:

- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED Visits from asthma
- Reduce hospital ED visits related to behavioral health

The Cardiac and Pulmonary Wellness Program helps patients increase life expectancy through increased exercise and treatment compliance.

The Cancer Patient Navigator Program helps patient increase life expectancy by having assistance to navigate the complicated system of obtaining cancer treatment. The Navigator helps patients with payment issues, transportation and in general how to get access to the treatment they need.

VI. 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.

Garrett Regional Medical Center's size and rural location limit the number of physicians who provide specialty services. The community is simply not large enough to support full time specialists. In addition, a physician shortage is predicted over the next five to ten years since approximately 50% of the area's family practice physicians and surgeons are approaching retirement age. Rural Maryland counties are at a disadvantage when it comes to recruiting physicians because they lack the resources to offer attractive incentives for setting up a practice.

Garrett County has consistently been designated as a Medically Underserved Area and has a "Low Income" designation as a Health Professional Shortage Area for primary care, dental and mental health. Over nineteen percent of the population has no form of health care coverage. Historically, the underinsured residents of the area came to the hospital's Emergency Department for treatment of minor illnesses since we provide care regardless of the ability to pay. A Federally Qualified Health Center, opened in 2006, offers an alternative for obtaining quality health care services regardless of their ability to pay. However, the Emergency Department continues to be a convenient source of obtaining non-emergent care for the underinsured individual.

Since GRMC does not employ physicians for certain specialty areas, some patients requiring Neurology, Pulmonary and Cardiology services, as well as major trauma patients, are stabilized and transferred to an appropriate facility for treatment.

While there are some gaps in the availability of specialty providers, Garrett Regional Medical Center maintains excellent relationships with surrounding facilities to ensure continuity of care for patients needing transfer for specialty care. Garrett Regional Medical Center will always strive to offer high-quality health care services for all patients

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.

Although included in the workforce development category, Garrett Regional Medical Center plays an active role in physician recruitment. As the only healthcare facility in the area, the community relies on the Hospital to ensure that an adequate number of physicians are available to serve the community's healthcare needs.

Physician recruitment is difficult in rural areas. Garrett Regional Medical Center includes some physician subsidy funds as part of its recruitment for physicians to fill specific specialties that would otherwise be impossible to fill and would limit the availability of services, such as orthopedic and gynecological surgeons.

VII. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

For ***example***, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
    - in a culturally sensitive manner,
    - at a reading comprehension level appropriate to the CBSA's population, and
    - in non-English languages that are prevalent in the CBSA.
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;

- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
c. Include a copy of your hospital's FAP (label appendix III).
d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix V).

Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SLECTED POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight

- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to behavioral health
- Reduce Fall-related death rate

Table III Initiative I –Cardiac and Pulmonary Wellness Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	The Community Health Needs Assessment and the Maryland SHIP Data identified a high incidence of heart disease and lung disease in Garrett County. The rate of heart disease deaths per 100,000 are 226.4 which is higher than the State of Maryland and is also the number one cause of death in Garrett County. Issues faced by this target group include high blood pressure, heart disease, peripheral vascular disease, high cholesterol, obesity and chronic lung disease. Yes this was identified through the CHNA process.
b. Hospital Initiative	Cardiac and Pulmonary Rehabilitation Center To offer an interactive program for those living with these chronic conditions to learn more about their disease process. The educational sessions will help them understand their disease process, learn disease management skills, develop an exercise regimen and activity modifications to meet their situation, and what signs of complications to be aware of. This program will also help us achieve our goals of reducing the rate of preventable hospitalizations.
c. Total Number of People Within the Target Population	Statistics from the CDC indicate that approximate 8,000 people in the Hospital CBSA would benefit from the services offered by the Cardiac and Pulmonary Wellness Program
d. Total Number of People Reached by the Initiative Within the Target Population	Twenty (20) people have completed the program during the first year, with six (6) continuing in a maintenance component of the program.
e. Primary Objective of the Initiative	To improve the overall level of health and quality of life for those living with these chronic conditions. To educate the patients dealing with these specific chronic conditions on how to manage their symptoms, increase mobility and ability to exercise, advice on what symptoms warrant seeking expert consultation and adherence to medication compliance. Aid these patients in managing anxiety and depression.
f. Single or Multi-Year Initiative –Time Period	Multi Year - This is the second year for this program.
g. Key Collaborators in Delivery of the Initiative	Garrett Regional Medical Center Cardiac and Pulmonary Rehabilitation staff, GRMC Wellness Coordinator/Nurse, GRMC Exercise Physiologist, GRMC Diabetic Educator, Primary Care Physicians in the County and the Cardiologists and Pulmonologists from the surrounding areas.
h. Impact/Outcome of Hospital Initiative?	Participants benefit by gaining knowledge regarding chronic disease, how to manage their symptoms, when to seek intervention and overall, enhancing their quality of life. Outcomes are evaluated concurrently during the program. The Program Administrators (Registered Nurses) evaluate these outcomes on each participant, both during the visit, and by the participant's self-report. They are also evaluated after the program is complete by looking at rates of readmissions and utilization of the Emergency Department.
i. Evaluation of Outcomes:	The following measures will be monitored: • Participant involvement and attendance from initial enrollment • Exercise tolerance and statistical improvement

	• Episodes of acute exacerbations • Decrease in symptoms • Surveys evaluating quality of life, nutrition, and psychosocial status • Competition of education component and overall competition of the program • Tracking the rates of readmissions and emergency room visits • Data entry and generation of an outcomes report of quantitative data depicting the patient improvement. Outcomes are reported to the referring physician and/or primary care physician	
j. Continuation of Initiative?	This program has been fully integrated into the services offered through our Cardiac and Pulmonary Department as well as the Wellness Department. GRMC is committed to providing this service to the community on a long term basis. In year two the program has been enhanced with the addition of a Maintenance Exercise Program for those in the Well Patient Program (explained in another initiative in this report).	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 6,512	B. Direct Offsetting Revenue from Restricted Grants C. None

Table III Initiative II – Cancer Patient Navigator Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	The Community Health Needs Assessment (November 2012) identified Cancer as the most common health problem impacting the Hospitals community and surrounding service area. Cancer is the second leading cause of death in the U.S., as well as in MD, WV and PA. Cancer is also the second leading cause of death in Garrett County. CDC, http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm CDC, http://www.cdc.gov/chronicdisease/states/pdf/maryland.pdf, http://www.cdc.gov/chronicdisease/states/pdf/west_virginia.pdf, http://www.cdc.gov/chronicdisease/states/pdf/pennsylvania.pdf Garrett County Health Department, Yes this was identified through the CHNA process.
b. Hospital Initiative	The ongoing operation of the Cancer Patient Navigator Program with the Navigator becoming the central point for coordinating communication with all care team members, to ensure that community cancer care patients receive quality cancer care, and to assist cancer patients, caregivers, and families in "bridging gaps" within the healthcare system. Garrett County has higher mortality rates for Breast and Colorectal Cancer Patient Cancers than the rest of the state of Maryland. It is for this reason that the Cancer Patient Navigator Program will have a primary focus on the prevention and treatment for these cancers
c. Total Number of People Within the Target Population	3,649
d. Total Number of People Reached by the Initiative Within the Target Population	50 Contacts in the first year.
e. Primary Objective of the Initiative	Provide outreach to the community about cancer prevention and screening to reduce the high rate of cancer mortality in the region. Increase access to cancer treatment and support services. Increase access to transportation services which is the biggest barrier to cancer care delivery in the area. The Navigator Program will eliminate some of the disparities for the cancer patient, as the Navigator will help the patient and families work through the complicated system of cancer treatment, qualifying for financial assistance, obtaining necessary transportation and other obstacles.
f. Single or Multi-Year Initiative –Time Period	This is a multi-year program with projected long term sustainability. During FY 2014 a Cancer specific Needs Assessment was completed. Support was enlisted from departments/organizations involved in the care of patients. Potential obstacles to implementation were evaluated. Opportunities and alternatives were considered. The program scope, cost and implementation strategy were determined. 50 contacts to be made in the first year. Partnerships were developed with West Virginia University, Red Devils, and Cindy's Fund. The Program was implemented in 2015
g. Key Collaborators in Delivery of the Initiative	Garrett County Memorial Hospital will work with the following Consortium Partners for this Program: Garrett County Health Department, Garrett County Community Action Committee, West Virginia Medical Center and the American Cancer Society.
h. Impact/Outcome of Hospital Initiative?	With these initial 50 patients, the navigator has coordinated transportation to treatments, referrals to specialists, and provided assistance with social needs and end of life care as needed. Outcomes will be measured through the implementation of evidence-based models and the achievement of performance measures. The primary evidence-based model used for the Cancer Patient Navigator is the Cancer Patient Navigation Program Toolkit from the Kansas Comprehensive Cancer Control & Prevention's Kansas Cancer Partnership. This

	model was recognized for excellence on the Rural Assistance Center Online Rural Community Health Gateway as a pillar for evidence-based program models for replication nationally. Cancer Patient Navigation Toolkit, http://www.cancerkansas.org/download/Cancer_Patient_Navigation_Toolkit.pdf RAC Online Health Gateway, http://www.raconline.org/communityhealth/care-coordination/2/care-coordinator-model/patient-navigators	
i. Evaluation of Outcomes:	The Performance Improvement Measures that will be tracked include: • Number of counties served in project • Number of people in target population • Number of direct unduplicated encounters (people) • Number of direct duplicated encounters (events) • Type of services provided through grant funding • Number of people served by age group • Among unique individuals who received direct services, track the number of people enrolled in public assistance, private insurance, and who pay out of pocket • Number of new clinical staff recruited to work on this project • Number of new non-clinical staff recruited on work on this project • Identify types and number of non-profit organizations in the consortium • Electronic Medical Records • Patient/disease registry • Number of quality improvement clinical guidelines /benchmarks adopted by the consortium Number of people who participated in health promotion/disease management activities offered to the public	
j. Continuation of Initiative?	GCMH will pursue grant funding through federal agencies, as well as private funders. However, the Cancer Patient Navigator Program has long-term goals for growth and evolution, and sustainability for the project is based on three main factors. First, GCMH has established itself as a healthcare leader in the region with allocated financing for growth and innovation. Second, the program is fully integrated into the Hospital's ongoing mission and vision and has been subsequently integrated in the budgeting plan going forward. Third, GCMH leadership is committed to the mission of the Cancer Patient Navigator Program and will commit the necessary funds to ensure the program's future sustainability.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $16,356	B. Direct Offsetting Revenue from Restricted Grants None

Table III Initiative III –The Well Patient Program ®

a. 1. Identified Need 2. Was this identified through the CHNA process?	Hospital utilization rates reflect individuals with chronic medical conditions, limited family support, limited financial resources or poor coping mechanisms which lead them to a higher level of medical services than necessary to meet their perceived needs. No, this is a program being addressed state wide by Hospitals.
b. Hospital Initiative	The Well Patient Program is a multidisciplinary collaborative approach to chronic disease management. Garrett Regional Medical Center High Utilizers will be enrolled in the Well Patient Program to develop a comprehensive plan in collaboration with the patient, family, Patient Care Management Department and Primary Care Physician in order to assist them with navigation through the health care continuum and ensure a favorable outcome.
c. Total Number of People Within the Target Population	89
d. Total Number of People Reached by the Initiative Within the Target Population	35
e. Primary Objective of the Initiative	• To improve care coordination for chronic disease conditions in the region over the next twelve months as measured by referrals to the *Well Patient Program* and decreased readmissions to the facility. • To decrease the Potentially Avoidable Utilization rate at GRMC from our current rate of 10.7%. • To develop a program to manage patients in the appropriate care setting for their health care needs as evidenced in decreased hospital inpatient utilization for chronic diseases
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	• Garrett Regional Medical Center – Cardiac & Pulmonary Rehab, Wound Care, SubAcute, Diabetes Education, Patient Nurse Navigator • Garrett County Health Department – Home Health, Adult Evaluation Services, Behavioral Health Services • Western Maryland ACO withMedChi Support – TCM and CCM code assistance • Mountain Laurel FQHC – Case Management • Nursing Homes and Assisted Living Facilities • Hospice • Community Action – Area Agency on Aging, Transportation, Medicaid Waiver, MAP Program, Housing, Energy Assistance, Homemaker Services • Garrett County Lighthouse – Psychiatric Rehabilitation Program, Safe Harbor, Case Management
h. Impact/Outcome of Hospital Initiative?	This program is being implemented in 2015. Projected outcomes are a decrease to the potentially avoidable utilization rate at GRMD from the current rate of 10.7%.
i. Evaluation of Outcomes:	• Metrics include ED visits per 6 months, Potentially Avoidable Utilization (PAU) Rate, Readmission Rate, and percentage of high utilizer patients enrolled in the *Well Patient Program,* internal data tracking and PAU charges. • Metrics include Potentially Avoidable Utilization Rate, Readmission Rate, ED visits per 6 months, PAU charges, and Total Health Care Cost per beneficiary. • Metrics include number of telemedicine consults, Shared Care Profile with

Table III Initiative III –The Well Patient Program ®

	percentage of patients that have shared care plans with a telemedicine provider, patient satisfaction level with telemedicine consult. Strategy 4: Metrics include number of primary care providers that are interfaced into care plan program, Encounter Notification Alerts • Metrics include number of referrals to community agencies for care coordination, Readmission rates, and PAU rate.	
j. Continuation of Initiative?	This program is projected to be ongoing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $12,467	B. Direct Offsetting Revenue from Restricted Grants None

Garrett County Memorial Hospital
Community Benefits Report
Fiscal Year 2015

APPENDIX I: Describe your Financial Assistance Policy

Garrett Regional Medical Center's "Caring Program" offers financial assistance to underprivileged, underemployed, and/or underinsured patients for healthcare services they may not be able to pay for due to circumstances beyond their control. The qualifying criteria are wide-ranging so the hospital can apply maximum flexibility to offer financial assistance to program applicants.

Financial assistance is available at varying levels based upon income. From 100% financial assistance for incomes at or below 200% of the current Federal Poverty Guidelines to 5% financial assistance for incomes at 291% - 300% of the Federal Poverty Guidelines.

Garrett Regional Medical Center informs patients about the Caring Program through various means of communication. Signs with summary and contact information are posted in the reception areas of the Patient Financial Services Department, Admissions Department and Emergency Admissions Department. Information is included in the *Patient Handbook* given to every patient admitted to the facility. Information is included on the hospital's website. Advertisements and information is placed in the local newspaper on an annual basis to remind people the program is available. Automated monthly statement messages are generated and included in all patient bills to advise the individual about the Caring Program and to encourage them to apply for financial assistance.

Language in the Hospital's Community Benefit Service Area is predominately English, however, a written summary of the Financial Assistance Policy is available in Spanish. Garrett Regional Medical Center contracts with Translate International via telephone for instances needing other language services. We would be able to accommodate patients through this service as needed.

The Financial Assistance Program is one that tends to be somewhat complex and difficult to comprehend for individuals with limited education. GRMC routinely reviews the materials for opportunities to make the program more user-friendly. Additionally, our patient financial services staff can make the process more easily understood in a one on one situation.

APPENDIX II

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

The change with Health Care Coverage Expansion has shown an increase in the number of covered patients compared to previous years. This has decreased the number of patients eligible for Caring Program.

GARRETT COUNTY MEMORIAL HOSPITAL	Department: Patient Financial Services	Policy Title: Caring Program (Financial Assistance)	
	Original Date: 09/01/01	Policy Number: 8520.000	Page Number: 1 of 8
	Effective Date: 09/01/01	Reviewed/Revised Dates: 06/03/03; 04/01/06; 03/14/08; 01/20/09;03/06/09; 11/11/09; 03/22/10;04/06/10;01/21/11; 02/01/12; 02/07/13	
Approval Signature & Title: Katherine Rhoden, Director Patient Financial Services Date:02/07/13	Approval Signature & Title: Tracy D. Lipscomb, CFO, VP Finance Date: 2/8/13	Approval Signature & Title:	

Policy Statement:

The "Caring Program" enables Garrett County Memorial Hospital (GCMH) to offer financial assistance for healthcare services rendered to underprivileged, underemployed, and/or underinsured patients who have difficulty providing themselves with life's necessities, i.e., food, clothing, shelter, and healthcare. In an effort to assist those in need and to further the hospital's charitable mission, GCMH has established a financial assistance program to allow the write-off of unpaid account balances upon determination of the "Caring Program" eligibility. GCMH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Individuals with a demonstrated inability to pay rather than unwillingness to pay are eligible to apply for the financial assistance program at GCMH. Patients are expected to cooperate with GCMH's procedures for obtaining financial assistance and to contribute to the cost of their care based on their individual ability to pay.

Objective:

The qualifying criteria are minimal and broad so GCMH can exercise maximum flexibility to offer financial assistance to program applicants. GCMH retains the right to use its discretionary judgement in making final decisions regarding eligibility to the "Caring Program." Eligibility to the "Caring Program" represents "free" or reduced healthcare and as such, is included as part of the hospital's charitable mission.

Guidelines:

A. GCMH will grant financial assistance for eligible applicants for medically necessary services that are urgent, emergent, or acute in nature. Services included in the program are emergency room visits, inpatient admissions, and outpatient laboratory, radiology and cardiopulmonary services. Elective surgical procedures may also be eligible for

financial assistance for eligible applicants through the "Caring Program" and will require individual consideration by management.

B. Screening for Medicaid eligibility is required.

a. If Medicaid eligibility is likely, the patient must apply for Medicaid within 60 days of the service date or the date the patient assumes financial responsibility for the services rendered.

b. If Medicaid eligibility is not likely, i.e., no extraordinarily high medical bills, no children in the household, any disability, etc., a formal denial from Medicaid is not required; however, all Patient Financial Services Representatives have the authority to request the Medicaid application whenever there is a chance of Medicaid eligibility.

c. Patients who qualify for Maryland or West Virginia Medicaid's Primary Adult Care (PAC) Program do not need to apply for Medicaid as their financial need has already been proven to the State. The Caring Program Application is still required and income and assets will be reviewed.

d. Parents of children with Medical Assistance do not need to apply for Medicaid as the State has already determined they are not eligible.

e. Patients who are eligible for food stamps, state-funded prescription programs, WIC, subsidized school lunch program, or subsidized housing do not need to apply for Medicaid as the state has already determined they are not eligible.

f. Any patient who is not eligible for fully covered Medicaid services may apply for financial assistance through "The Caring Program."

g. Any patient who is eligible for Medicaid but has a "spend-down" requirement to meet before Medical Assistance begins to cover charges may apply for "The Caring Program.

h. Incomplete applications and/or failure to apply and follow through with the Medicaid application will result in a denial from the "Caring Program."

C. The "Caring Program" application must be completed and returned via the U.S. Postal Service, delivered in person, or completed over the telephone within 60 days of date the patient becomes financially responsible for services rendered. The patient, a family

member, a close friend, or associate of the patient, subject to applicable privacy laws, may make a request for financial assistance.

a. All applications require the signature of the individual who is financially responsible for the unpaid bills as well as proof of financial information used to determine program eligibility. If the applicant cannot read/write, PFS will read the policy to the applicant and assist with the form completion, requiring only a witnessed signature of an "X."

b. Any additional information requested by a Patient Financial Services Representative must be returned to the Patient Financial Services (PFS) Department within 30 days of the request. If the information is not returned within that time, the patient is ineligible for assistance through the "Caring Program" for those service dates that related to the application.

D. In order for an individual to qualify, he/she must have exhausted all other sources of payment, including assets easily liquidated, i.e., bank accounts, money market accounts, Certificate(s) of Deposit, savings bonds, etc. Calculation of the applicant's income excludes net assets of $10,000 or less.

E. The following definitions of family size and income will assist in the "Caring Program" eligibility determination:

1. Family: Using the Census Bureau definition, a family is a group of two or more persons related by birth, marriage, or adoption, living in the same residence, sharing income and expenses. When a household includes more than one family, GCMH will use each separate family's income for eligibility determination. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for the purposes of the provision of financial assistance.

2. Individual: An individual is a person who is emancipated, married, or 18 years of age or older (excluding inmates of an institution) who is not living with relatives. An individual may be the only person living in a housing unit, or may be living in a housing unit with unrelated persons. An individual is also, for the purposes of this policy, someone 18 years of age or older who lives with relatives but has his/her own source of income.

3. Income: Before taxes from all sources, as follows:

   a. Wages and salaries

   b. Interest or dividends

   c. Cash value of stocks, bonds, mutual funds, etc.

   d. Net self-employment income based on a tax return as calculated by GCMH. Non-cash deductions (depreciation), income tax preparation fees,

expenses for use of part of a home, entertainment, and any other non-essential expense will be subtracted from the reported business expense deductions in determining financial need and program eligibility.

e. Regular payments from Social Security, railroad retirement, unemployment compensation, veterans' payments, etc

f. Strike benefits from union funds

g. Workers' compensation payments for lost wages

h. Public assistance including Aid to Families with Dependent Children

i. Supplemental Security Income

j. Non-Federally funded General Assistance or General Relief money payments

k. Alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household

l. Private pensions or government employee pensions (including military retirement pay)

m. Regular insurance or annuity payments

n. Net rental income, net royalties, and periodic receipts from estates or trusts

o. Net gambling or lottery winnings

p. Assets withdrawn from a financial institution one year or less before program application

q. Proceeds from the sale of property, a house, or a car

r. Tax refunds

s. Gifts of cash, loans, lump-sum inheritances

t. One-time insurance payments or compensation for injury

F. Eligibility for 100% financial assistance at GCMH is available to applicants whose income is at or below 200% of the current Federal Poverty Guidelines when the applicant has less than $10,000.00 in net assets. Any Individual treated at GCMH, regardless of permanent State residence, may apply for financial assistance through "The Caring Program." Partial assistance is available with incomes up to 300% (after the $10,000 net asset exclusion) of the Federal Poverty Guidelines, as follows:

1. Eligibility for 95% financial assistance is available for incomes at 201%-210% of the Federal Poverty Guidelines.

2. Eligibility for 85% financial assistance is available for incomes at 211%-220% of the Federal Poverty Guidelines.

3. Eligibility for 75% financial assistance is available for incomes at 221%-230% of the Federal Poverty Guidelines
4. Eligibility for 65% financial assistance is available for incomes at 231%-240% of the Federal Poverty Guidelines.
5. Eligibility for 55% financial assistance is available for incomes at 241%-250% of the Federal Poverty Guidelines.
6. Eligibility for 45% financial assistance is available for incomes at 251%-260% of the Federal Poverty Guidelines.
7. Eligibility for 35% financial assistance is available for incomes at 261%-270% of the Federal Poverty Guidelines.
8. Eligibility for 25% financial assistance is available for incomes at 271%-280% of the Federal Poverty Guidelines.
9. Eligibility for 15% financial assistance is available for incomes at 281%-290% of the Federal Poverty Guidelines.
10. Eligibility for 5% financial assistance is available for incomes at 291%-300% of the Federal Poverty Guidelines.

G. If ineligibility results from the financial guidelines stated above or the applicant is eligible for partial assistance only and the applicant indicates an inability to pay the outstanding balance, the applicant will be asked to complete a financial statement to determine if his/her available monthly income is consumed by the daily necessities of life. Individual consideration of eligibility for applicants in this situation will apply to assure members of our community who cannot pay for their hospital care are included in our financial assistance program.

1. Mutually agreed upon interest-free monthly payments (based on available income after expenses) will be discussed and offered to those who are otherwise ineligible for the "Caring Program" and have expressed a need for an extended repayment period.

H. Individuals with a need for financial assistance who are unable to apply or do not have an individual to apply on their behalf are not overlooked for financial assistance through the "Caring Program." This includes anyone determined to be homeless, patients who have filed for bankruptcy, and/or patients who are deceased with no estate or with an estate too small to cover the patient's hospital bills. Any patient falling into these categories will be eligible for 100% coverage of his/her hospital bills through The Caring Program. The following indicates the available methods for GCMH to obtain information needed for eligibility determination in these situations and for whom a completed, signed application is not required:

1. Telephone contact, including TTY communication and verbal information about the individual's financial situation

2. Discussion of the situation with the individual's state Medicaid office to obtain a preliminary determination of Medicaid eligibility
3. Research the applicant's other GCMH accounts
4. Information from the next of kin or other person able to speak about the individual's financial condition
5. Have personal knowledge of the individual's living situation
6. Observation of applicant's appearance

I. Documentation requirements include the application for financial assistance, proof of income and/or any unusual expenses, financial statement, release of information, etc.

J. GCMH has posted signs publicizing the Program at all registration areas and in the reception area of the Patient Financial Services (PFS) Department. Information about the program is printed in the "Patient Handbook" and on the hospital's web site. Monthly self-pay statements include a pre-printed notification of the financial assistance program and instructions for applying to the "Caring Program." Included with every self-pay statement is the "Maryland Hospital Patient Information Sheet" that mentions the hospital's financial assistance program. Automated monthly statement messages also encourage applications for financial assistance. Whenever a patient/guarantor inquires about the availability of a financial assistance program at GCMH, staff members should refer the inquiry to the PFS Department; offer to supply the telephone number of the PFS department, and/or direct patients to the PFS department. All PFS personnel review the financial assistance policy annually, at a minimum, discuss policy changes at departmental meetings, and have access to the current financial assistance policy during all work hours.

K. GCMH will post, at least on an annual basis, an ad in the local newspaper informing residents of the availability of its financial assistance program, or upon approval of updates to the program guidelines. Printed copies of the application forms are available at the time of registration or at any registration location. Copies of the financial assistance policy and applications are also available in the Patient Financial Services Department upon request and may be picked up in person or mailed to the patient's or guarantor's home.

L. Self-pay accounts will be screened for financial assistance regardless of the dollar amount of the account; however, self-pay balances resulting from insurance company payment to the individual or from the individual's failure to respond to an insurance or GCMH query will not be considered eligible for the program.

M. Financial assistance is not available for any account already referred to a collection agency or attorney for formal collection action. Excluded from this statement are accounts where an individual/family has declared bankruptcy or has deceased with no estate or has an estate too small to pay our claims. All third party collection agencies

receive a copy of the financial assistance policy on an annual basis, or when changed, which ever occurs first.

N. Financial assistance through the "Caring Program" will continue for a period of one year after the eligibility approval date, unless income significantly changes, when based on fixed incomes such as social security or retirement, or the tax return of a self-employed individual. Eligibility based on the guarantor's past three months of income or annual tax return of someone who is not self-employed will qualify for a six-month eligibility to the Caring Program unless the income of the applicant changes significantly.

1. After the designated period of eligibility, a new application for financial assistance must be completed/signed by the guarantor. Fixed income verification is required annually and applies for one calendar year (January through December) for eligibility determination if the applicant completes the renewal application at the appropriate time.
2. Upon application approval, GCMH will write-off eligible account balances. GCMH may reverse the determination of eligibility if any of the information supplied on the application was incorrect.
3. If an individual's financial status deteriorates and he/she cannot pay the agreed upon monthly payment amount, GCMH will again review (upon request) the individual's eligibility to the program.
4. Once GCMH has determined that an account is eligible for financial assistance or is not collectible, that financial classification is final.
5. GCMH will post payments received from any source (after the eligible account balance is written-off) to the appropriate hospital account and will adjust the amount of the financial assistance write-off accordingly. GCMH will refund self-pay payments of $25.00 or more received on eligible accounts within 12 months of the application approval date.

O. Individuals who have incurred hospital expenses for care and/or treatment ordered through the Garrett County Health Department (GCHD) as part of the Garrett County Cancer Control Program shall be eligible for financial assistance for balances remaining after payment from GCHD. GCHD is responsible for notifying GCMH of all claims that fall into this category.

P. Individuals or families with an income below 500% of the federal poverty level that can prove medical hardship will be eligible for The Caring Program for a15% financial assistance or reduction in charges. In order to meet the medical hardship criteria, the patient/family must have medical debt at Garrett County Memorial Hospital (excluding co-pays, co-insurance, and deductibles) that exceeds 25% of the individual's/family's annual income. Medical debt is any out-of-pocket expense (excluding co-pays, co-insurance, and deductibles) for medically necessary care that the individual/family has incurred at Garrett County Memorial Hospital in a 12 month period. Medically necessary care, for the purposes of this policy, does not include elective or cosmetic procedures. If an individual/ family meets these criteria and is found eligible for The Caring Program, that eligibility will last for 12 months

from the date on which the reduced-cost medically necessary care was initially received, unless there is a significant change in the individual or family's income. Once found eligible, The Caring Program covers medical bills for all members of the household. Eligible medical debt does not include any accounts which the patient chooses to opt out of insurance coverage or insurance billing.

Q. Upon receipt or notification of an individual's or a guarantor's notice of bankruptcy filing, all accounts with an outstanding self-pay balance for that individual or guarantor will become eligible for 100% financial assistance through the Caring Program.

R. Self-pay accounts for individuals who are deceased and have no assets or estate shall be eligible for 100% financial assistance through the Caring Program.

S. A probable eligibility determination will be given to the applicant within 2 business days of the patient's request.

T. A final approval or denial letter will be mailed out to the applicant within 2 weeks of receipt of the completed application.

U. In implementing this Policy, GCMH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to the Policy.

GARRETT COUNTY MEMORIAL HOSPITAL
MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy:

- The hospital provides emergency or urgent care to all patients regardless of ability to pay.

- You are receiving this information sheet because under Maryland law, this hospital must have a financial assistance policy and must inform you that 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.

- This hospital meets the legal requirement by providing financial assistance based on an annual income that is up to 150% of the federal poverty level. A sliding fee scale is applied to individuals/families with an annual income that is between 151% and 200% of the federal poverty level. An individual is someone who is single and does not live with any blood relatives. A family consists of all members of the same family who are related by marriage or birth that live in the household.

- Financial assistance is provided to individuals or families based on annual income and the number of family members living in the household. Assets in excess of $10,000.00 will be included as income on the financial assistance application.

- It is very important to fill out the financial assistance application completely, provide the requested proof of income and Medicaid screening information within 60 days of the date the individual becomes responsible for the balance on the account.

- Once an account has been referred to a collection agency, it is no longer eligible for financial assistance.

Patients' Rights and Obligations:

Patients' Rights

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.

- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (see contact information below).

- You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments that pays the full cost of health coverage for low-income individuals who meet certain criteria (see contact information below).

Patients' Obligations:

- For those patients with the ability to pay their bill, it is the obligation of the patient to pay the hospital in a timely manner.

- This hospital makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. This summary statement is available on inpatient accounts only. It is your responsibility to provide correct insurance information.

- If you do not have health coverage, we expect you to pay the bill in a timely manner (60 days). If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office promptly at 301-533-4209 to discuss the matter.

- If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

- If you have questions about your bill, please contact the hospital business office at 301-533-4209. A hospital representative will be glad to assist you with any questions you may have.

- If you wish to get more information about or apply for the hospital's financial assistance plan, you may call 301-533-4209 or download the uniform financial assistance application from the following link: http://www.hscrc.state.md.us/consumers_uniform.cfm

- If you wish to get more information about or apply for Maryland Medical Assistance you may contact your local Department of Social Services by phone 1-800-332-6347; TTY 1-800-925-4434; or internet www.dhr.state.md.us .

- If you live in West Virginia and wish to get more information about or apply for West Virginia Medical Assistance, please contact the Social Services Department of the county in which you live.

Physician Services:

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Welcome to The CARING Program…….
What every participant needs to know!

Garrett County Memorial Hospital has established The Caring Program in an attempt to financially assist our patients who may not have the resources to pay for their medical treatment at our facility. This program is available to any patient who meets the established guidelines of the program regardless of his or her insurance eligibility. Now that you have completed the necessary steps and have been approved for this program, there are a couple of things we would like to explain.

The Care Program is a financial assistance program, and the information you have provided to the Patient Financial Services Department remains confidential. Please present the business card you received with this mailing to the registration clerk whenever you come to the hospital for healthcare services. When visiting our facility, you will check in like any other patient, and be treated no differently.

If you should receive a bill from Garrett County Memorial, you are required to contact your Patient Financial Services representative, and inform them of the bill. At that time, based on your eligibility percentage, the bill will be resolved or set up on payment arrangements for your remaining balance. Again, it is your responsibility to notify us when you receive a bill.

The Caring Program will cover any out patient services performed at Garrett County Memorial Hospital during your eligibility period. Inpatient services may be covered once all other payment sources have been utilized. This program will only cover services for Garrett County Memorial, Professional Emergency Physicians Services, LLC, and McKesson Group anesthesia bills. This program will not cover doctor bills, radiologist bills, MRI bills, or bills from other hospitals. These bills are your responsibility.

Eligibility in our program varies in time, due to the financial situation of each participant. You are notified of your eligibility period when your application is processed. At the end of your eligibility period, you are encouraged to reapply for the program if your financial situation has not improved.

Please feel free to contact your Patient Financial Services representative with any other questions you may have. The Patient Financial Services office is open Monday thru Friday from 8 AM to 4:30 PM, and can be reached by calling 301-533-4209.

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Dear Sir/Madam:

Garrett County Memorial Hospital (GCMH) is pleased to offer financial help to individuals of our community who need help to pay for their medical services at GCMH.

In order for us to complete our Caring Program Application, you will need to apply for medical assistance through the state in which you reside. For Maryland residents, please contact the Department of Social Services of Garrett County at 301-533-3000 to schedule an appointment, or if out-of-state, you may need to contact your county health department.

You may complete and return your Caring Program Application now so we can determine if you qualify for the program while awaiting the outcome of your Medicaid application. Once your Medicaid eligibility is either granted or denied, we will finalize your Caring Program Application and notify you of our findings. **(Household members on the enclosed form only include those you claim on your Federal Income Tax Form.)**

___ I have completed and am **returning the Caring Program Application along with my Required proof of Income. (Acceptable proof of income as follows):**

*Fixed monthly income: Current bank statement showing auto deposit, or Award letter

*Self employed income: Current Federal Income Tax form including Schedule C

*Employed: Current pay stubs for the last 3 months or current Federal Income Tax return

___ I have scheduled an appointment with a case worker to determine if I am able to receive Medicaid.

Please keep our office informed of your Medicaid appointment date so we can add this information to the Caring Program Application you are now forwarding to our office. **To be eligible, we must have your application returned within 30 days.**

If you have any questions about the completion of the financial assistance application or other paperwork, please don't hesitate to contact me at the number below.

Last name beginning with	A-FIZ	call Roberta	301-533-4213
	FJ-LIZ	call Trisha	301-533-4211
	LL-SGZ	call Jayne	301-533-4212
	SH-Z	call Jessi	301-533-4354

GARRETT COUNTY
MEMORIAL HOSPITAL
MISSION STATEMENT

OUR MISSION

To promote the health of our regional community and provide safe, high-quality care and health services for our patients.

GARRETT COUNTY MEMORIAL HOSPITAL VISION STATEMENT

Garrett County Memorial Hospital:

1. ***Will be viewed as the provider of choice in the region and be recognized for our progressive personal service encompassing the full continuum of care.***

2. ***Will be known for our excellence across the region.***

3. ***Will continue as a community partner and resource, striving to proactively respond to the health and wellness needs of our region.***

4. ***Will provide a high level of community service and stewardship for the resources with which we have been entrusted.***

5. ***Will recruit and retain the most talented and caring employees through continuous efforts to be the employer of choice in the region through employee friendly programs and policies.***

6. ***Will collaborate and partner with other providers, as needed, to achieve our strategic direction.***

7. ***Will be characterized by cohesive leadership, efficiency, sound management, financial strength and a positive work environment.***

8. ***Will maintain a collaborative partnership between the Board of Governors, Medical Staff and Administration.***

9. ***Will strive to exceed the expectations of those we serve.***

10. ***Will be dedicated to the process of never-ending improvement.***

11. ***Will be more obvious in our expression and fulfillment of our charitable mission and community benefit.***

12. ***Will be dedicated to providing the best technological tools possible to assist our caregivers in providing the highest level of medical care achievable within our rural location.***

GRMC VALUES

Others First	• Anticipate and exceed expectations to serve others (internal and external) • Listen empathetically at all times • Teamwork – Collaboration and effective communication • Embrace and honor diversity • Recognize the contributions of others • Respect one another at all times • All interactions are characterized by fairness, compassion and dignity
Compassion	• Consistently treat others with courtesy, respect, kindness and patience • Show genuine interest in what is important to others • Display a helpful and friendly attitude • Support and encourage always
Innovation	• Embrace evidence based practices • Learn from experience and share with others • Create unique ways to provide remarkable care • Incorporate technology to improve patient and team member experience/outcomes • Always think outside the box
Accountability	• Provide safe care – always • Lead by example at all times • Be open and honest about successes and failures • Take initiative for personal growth and development • Make appropriate decisions in difficult situations
Stewardship	• Demonstrate ownership of continuous performance improvement • Actively participate in financial success by optimizing resources • Make a positive contribution to our community and region