Western Maryland Regional Medical Center
(210027)

FY2015
Community Benefit Report 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 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:
205 Beds 20 Bassinets	Adults: 11,882 Nursery:941 Total: 12,823	21502 21532 21539 21562	Garrett Memorial Hospital	2%	17%

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

The Western Maryland Regional Medical Center provides primary and secondary acute care services for a seven county region covering: Upper Potomac region of Maryland, Eastern West Virginia, and Southwestern Pennsylvania. However, with the majority of patients residing in Allegany County (72%) it is considered the community benefit service area and focus of the community health needs assessment. There are hot spots of high utilizers and medical assistance recipients in the 21502 zip code which is where many services are offered. Many of the strategies target more specific populations as well.

Allegany County is located in rural Western Maryland and has a population of 75,087. The county is part of the Appalachian region and has low education levels, limited racial diversity, a large elderly population, and low household incomes.

Allegany County is 51.9% male and 48.1% female. A smaller percent of the population is under 5 years old (4.7%) than in Maryland (6.3%). A larger percent of the population is 65 years and older (18.3%) than in Maryland (12.3%). There is less racial diversity in Allegany County than in the U.S.; 89% of the population is white, 8% is black, and 1.6% is Hispanic or Latino.

The average household size is 2.25 and 35% are single parent households compared to the U.S. benchmark (20%). The median household income in Allegany County (2010 Census) is well below the U.S. median ($37,952 vs. $70,017), and over 15.2% of individuals are living below the poverty line compared to 8.6% in the U.S. The percentage of Allegany County children living in poverty (25%) is higher than the Maryland rate (14%) and the U.S. benchmark (14%).

In Allegany County and the surrounding areas: 29% of employees work in management, business, science, and arts; 22% work in service; 24% work in sales or office jobs; and 15% work in production, transportation, and material moving. 16% of Allegany County residents travel outside of the county to

work. As of November 2013, the unemployment rate in Allegany County was 7%. The unemployment rate has remained unchanged at 7% as of June 2015.

While 88% of Allegany County adults have a high school diploma, the county has only 15.9% of adults with a bachelor's degree or higher compared to 35.6% in Maryland. In addition, 11.3% of Allegany County residents age 16 and over are illiterate.

Catholic Healthcare West and Thomson Reuters developed the nation's first standardized Community Needs Index (CNI). It identifies the severity of health disparity in every zip code in the U.S. and demonstrates a link between community need, access to care, and preventable hospitalizations. CNI gathers data about the community's socio-economy including barriers related to income, culture/ language, education, insurance, and housing. A score of 1.0 indicates a zip code with the lowest socio-economic barriers and 5.0 represents a zip code with the most socio-economic barriers. The closer to 5 the more community need there is in a zip code. A comparison of CNI scores to hospitalization shows a strong correlation between high need and high use. In fact admission rates for the most highly needy communities are over 60% higher than communities with the lowest need.

In Allegany County, the areas of highest need are 21532 (Frostburg) at 4.0 and 21502 (Cumberland) with a CNI of 3.8. Other high need areas include 21562 (Westernport) and 21521 (Barton) at 3.6. The area with the lowest need is 21557 (Rawlings) with a CNI of 2.2.

Table II provides demographic characteristics and social determinant data. Additional data on health status, lifestyle choices, and access to care can also be found in the Prioritized Community Health Needs section of the CHNA.

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).

Table II

Target Population Allegany County, MD: 75,087 By sex • 51.7% Male • 48.3% Female Average age • 40.9 years • (4.7% under age 5 and 17.8% 65 yrs. and over) Both the 3 and 5 year ACS estimates have the population declining.	By race & ethnicity • 89.2% White • 8% Black/African Am. • 0.1% Native American • 0.8% Asian • 1.4% Hispanic or Latino Source: US Census 2010
Median Household Income within CBSA (Allegany County)	Allegany County: $37,952 Source: US Census 2010 Allegany County: $39,293 Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey

Percentage of households with incomes below the federal poverty guidelines with in CBSA/Allegany County	Allegany County: 15.2% Source: American Community Survey 2008-2010 Allegany County: 17.4% Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey
Percentage of uninsured people (under age 65)	Allegany County: 13% Source: County Health Rankings –Univ. of Wisconsin 2013 Report Allegany County: 11% Source: County Health Rankings –Univ. of Wisconsin 2015 Report ACS 5yr estimate (2009-13) – 9.4% and SHADAC (2014) 4.7%
Percentage of Medicaid recipients by County	Allegany County: 21.9% Source: HRSA Area Resource File 2012 Allegany County: 27% Source: Maryland Medicaid eHealth Statistics
Life Expectancy by County.	Allegany County: 77.2 White 80.0 Black Source: SHIP County Profile (DHMH Vital Statistics 2010-2012 Allegany County: 77.6 White 76.8 Black Source: SHIP County Profile (DHMH Vital Statistics 2011-2013)
Mortality Rates by County	Allegany County: 7,375 per 100,000 age adjusted Source: County Health Rankings –Univ. of Wisconsin 2013 Allegany County: 6973per 100,000 age adjusted Source: County Health Rankings –Univ. of Wisconsin 2015
Limited Access to healthy food.	Allegany County: 17% Source: County Health Rankings 2012 Report Allegany County: 16% Source: County Health Rankings 2015 Report
Transportation-Percentage of households without access to vehicles	Allegany County: 11% Source: American Community Survey 2005-2009 5 yr. est. Allegany County: 10.2% Source: U.S. Census Bureau, 2009-2013 American Community Survey
Illiteracy	Allegany County: 11.3% Source: County Health Rankings 2012 Report

Pop. 25+ With Bachelor's Degree or Above %	Allegany County: 15.9% Source: American Community Survey (2008-2010) Allegany County: 16.8% Source: U.S. Census Bureau, 2009-2013 American Comm. Survey
Children living in Single Parent Households %	Allegany County: 35% Source: County Health Rankings 2013 &2015 Report
Language Other Than English spoken at home %	Allegany County: 3.8% Source: US Census 2010 Allegany County: 4.7% Source: U.S. Census Bureau, 2009-2013 American Comm. Survey
Population to Primary Care Provider Ratio	Allegany County: 1746:1 Source: County Health Rankings 2013 Report Allegany County: 1575:1 Source: County Health Rankings 2015 Report
Adults who currently smoke %	Allegany County: 24% Source: BRFSS 2008-2010 and County Health Rankings 2013 Allegany County: 23% Source: County Health Rankings 2014 & 2015 Report
Inadequate Social Support %	Allegany County: 19% Source: County Health Rankings 2013 Report Allegany County: 18.6% Source: County Health Rankings 2015 Report

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. 12/31/13 (mm/dd/yy)

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).

http://www.alleganyhealthplanningcoalition.com/pdf/Community%20Health%20Needs%20Assessment%20FY14%20(final).pdf

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

_x__Yes (mm/dd/yy) Enter date approved by governing body here: 05/22/14
___No

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

http://www.alleganyhealthplanningcoalition.com/pdf/A.%20LHAP.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

I. 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 data collected as part of the Community Health Needs Assessment is shared with the WMHS Administrative Team and Board of Directors. This information along with other hospital data and information was utilized to create the hospital's strategic plan. The following are sections of the strategic plan that apply to community benefits.

Strategic Plan FY 2015-2017

Goal 2. Expand patient centered care delivery model

Objective 2.1. Further develop and strengthen strategic relationships with community partners

Strategy2.1.1. Further develop medical and public health

Proposed tactics:

- Consider and evaluate more formal arrangements with county health departments, i.e., joint venture
- Coordinate with public health agencies to inventory program services to identify opportunities for improvement through collaboration
- Develop and implement action plan based on analysis

Strategy 2.1.2. Develop the network with community agencies to address social determinants and transitions of care

Proposed tactics:

- Establish an advisory council for Community Health Workers throughout the community
- Develop an assessment tool for patient use at registration and work with community partners to establish a referral system utilizing available resources to address social determinants
- Identify community partners to engage in a process review and pilot implementation of interagency management of individuals with multiple chronic conditions
- With agencies such as HRDC and the YMCA create a comprehensive asset map for the community identifying services for the underserved, areas of duplication, as well as gaps
- Work with a diverse advisory group (or CUW) to address duplication and/or gaps identified

Goal 3. Engage patients and families to improve personal health status

Objective 3.2 Enhance patient and family participation in care

Strategy 3.2.1. Develop and implement consumer driven health initiatives to enhance patient and family engagement

Possible Tactics:

- Collaborate with community partners to develop and implement an "is it safe to wait" program to promote a consistent message on when to go to the Emergency Department, urgent care or primary care
- Review the findings on self-care programs with the President's Quality Council, and if supported, form a team to develop a pilot proposal to consider for Implementation
- Research and determine how consumers want to access health information, test results, as well as communicate with their providers. Compile results with a summary of recommendations to consider for potential implementation

Strategy 3.2.2. Revitalize an external patient transportation program for WMHS

Goal 4. Coordinate care to provide comprehensive population health management

Objective 4.1. Expand pre and post-acute services to reduce utilization of care

Strategy 4.1.3. Further expand the service offerings at the Center for Clinical Resources to include services for hypertension, chronic kidney disease, et al

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
3. __x_Other (please specify) System Management Team

Describe the role of Senior Leadership.
The CEO, CFO, and System Management Team oversee compliance with the IRS and HSCRC regulations related to community benefits. They review the CHNA and implementation strategy with Board of Directors, and incorporate community benefits into the WMHS strategic plan and strategic transformation plan. The CFO reviews the annual community benefits spreadsheet and narrative prior to submission. The CEO provides updates to the Board of Directors, and with their approval allocates funding to support the areas of need. Senior Leadership is also directly engaged in various board and community activities.

ii. Clinical Leadership

1. _x__Physician
2. _x__Nurse
3. _x__Social Worker
4. __x_Other (please specify)Allied Health

Describe the role of Clinical Leadership
Some of the Clinical Leaders are involved with committees that review the community needs and develop implementation strategies. Others are more involved with oversight and direct implementation of community benefit activities, such as support groups, disease management, motivational interviewing, and addressing social determinants. The mission driven services and some of the healthcare support services are completely managed by the Clinical Leadership.

iii. Community Benefit Operations

1. _x__Individual (0.1 FTE) Twenty individuals assisted with the tracking and documentation of community benefit activities included in the 192 hours.

2. _x__Committee (please list members) (Scott Lutton -Director of Finance, Nancy Forlifer- Director of Community Health & Wellness, Kathy Rogers- Director of Community Relations, and Kim Repac- CFO)

3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Members of the Community Benefit Committee collectively stay abreast of the regulations and reporting requirements related to community benefits. They are all engaged in collection of community benefit data or related expenses and participate in compilation of the annual spreadsheet and narrative. The Finance Director oversees the financial aspects of the community benefit report, and its connection to the 990 Schedule H. He compiles and calculates the expenses and revenue for numerous activities, including contributions from administration and mission driven services. The Community Health and Wellness Director is co-chair of the Local Health Improvement Coalition and facilitates the community health needs assessment. She serves as a liaison between the hospital and many of the community partners to plan and track community benefit activities. Together with the Director of Community Relations, she compiles the narrative. The Community Relations Director assists with data compilation, distribution of information to the public, and tracking of financial contributions by WMHS for community benefit.

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 internal audit consists of a series of checks and balances. There are a collection of reporters that enter occurrences into CBISA, each of these entries is reviewed and imported by the System Administrator/Director of Community Health & Wellness. After each fiscal year closes, the Finance Director and System Administrator collaborate to obtain the missing data and the Finance Director compiles the expenses for numerous activities. This information is all entered into CBISA by the System Administrator and then several reports are pulled for review by the System Administrator and Finance Director (including a 3 year comparison). All members of the Community Benefits Committee review the narrative to ensure its accuracy. The CFO has the final review and sign off before it is shared with the WMHS Board of Directors Finance Committee for review and action.

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:

_____ 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
Founding Partners			
Allegany County Health Department	Jenelle Mayer Dr. Sue Raver	Director Community Health, Health Officer	Co-Chair of LHIC, Assist with CHNA & LHAP
Allegany Health Right	Sandi Rowland	Executive Director	Active review of data and selection of strategies
Tri-State Community Health Center	Susan Walter	CEO	Active review of data and selection of strategies
Western MD Area Health Education Center	Susan Stewart	Executive Director	Active review of data and selection of strategies
Allegany Human Resource Development Comm.	Courtney Thomas	Executive Director	Active review of data and selection of strategies
County United Way	Mary Beth Pirolozzi	Executive Director	Active review of data and selection of strategies
Allegany Board of Education	Kim Green	Chief Academic Officer	Active review of data and selection of strategies
Advisory Board			
Media-Allegany Radio	Joe Caporale	Sales Manager	Assist with monitoring and evaluating progress of implementation. Promote and distribute agreed upon education.
Housing	Steve Kesner	Executive Director	
Business/Economic Development-Chamber of Commerce	Stu Czapski	Executive Director	
Chapman & Assoc.	Cathy Chapman	CRNP-somatic provider	
Pressley Ridge -Provider (behavioral)	Mary Beth DeMartino	Executive Director	
Case Management	Casey Sinclair	Case Manager	

Law Enforcement	Steve Schellhaus	Officer	
Affiliates			
Office of Consumer Advocate	Yvonne Perret	Executive Director	Participate in the community health needs assessment process. Participate in the development & implementation of the LHAP. Assist in developing and promoting health solutions to identified health problems
Salvation Army	Jim Dillingham	Officer	
YMCA	Donald Enterline	Executive Director	
Western MD Food Bank	Diana Loar	Executive Director	
Local Management Board	Courtney Thomas	Chairperson	
Cumberland Ministerial Association	Rabbi Stephen Sniderman	Chairperson	
Parish Nursing Program	Joyce Hedrick	Coordinator	
Community Unity in Action	Virginia Jesse	Member	
Carver Community Center	Tawnia Austin	Chairperson	
NAACP	Ava Joubert	Board Member	
University of MD Extension	Kathy Kinsman	EFNEP Educator	
Maryland Physicians Care	Terry Hillegas	Marketing and Community Outreach Liaison	
Priority Partners	Lisa Moran	Community Health Advocate	
United Healthcare	Tracy Curry	Community Development Specialist	
Fort Recovery	Chip Bosley	Director	
Allegany College of Maryland	Kathy Condor	Coordinator	
Allegany Transit	Chris Howard	Director	
Express Medical Transporters of Baltimore	Abby Mensinger	Director	
Friends Aware	Rhonda Blubaugh	Human Resources	
Allegany County Dept. Social Services	Richard Paulman	Executive Director	
Associated Charities	Kristan Fazenbaker	Executive Director	
Pharmacies	Bill McKay	Pharmacist	
Drug Abuse Alcohol Council	Chris Delaney	Director	
Tobacco Free Coalition	Kathy Dudley	Coordinator	
Family Junction	Melanie McDonald	Executive Director	
Frostburg State University	Jesse Ketterman		
Sheriff's Office	Craig Robertson	Sheriff	
Make Healthy Choices Easy	Jen Thomas	Health Educator	
County Govt-Board of Health	Mike McKay	County Commissioner	
Park & Recreation Department	Diane Johnson	Director	
Mental Health Advisory Board	Lesa Diehl	Chairperson	
Workgroup on Access to Care	Nancy Forlifer	Chairperson	
Transportation Advisory Board	Ryan Davis	Member	
Dental Society	Diane Romaine	Chairperson	
Hyndman Health Center	Samantha Walls	Social Workdr	
Community Wellness Coalition	Marion Leonard	Chairperson	

Overdose Prevention Task Force	Becky Meyers	Director	

The following list highlights the specific responsibilities of the parties in the Allegany County Health Planning Coalition, as written in the MOU. The Local Health Action Plan lists the partners associated with each of the actions.

A. The specific responsibilities of the Western Maryland Health System under this agreement are as follows:
    - Co-Chair the Coalition which will guide Community Health Needs Assessment and Local Health Action Planning as required by the Health Services Cost Review Commission and IRS
    - Jointly report with the Allegany County Health Department on the needs assessment, local health action plan, and Coalition activity
    - Oversee with ACHD, the monitoring of progress on health status and implementation plan
    - Coordinate the various departments of the health system that are involved in this project
    - Link Coalition priorities with the WMHS Community Benefits and Strategic Planning
    - Provide staff support for the needs assessment, action planning and implementation
B. The specific responsibilities of the Allegany County Health Department under this agreement are as follows:
    - Co-Chair the Coalition which will guide Community Health Needs Assessment and Local Health Action Planning as required by Maryland Department of Health and Mental Hygiene
    - Maintain and oversee the Coalition website
    - Jointly report with the Western Maryland Health System on the needs assessment, local health action plan, and Coalition activity
    - Oversee with WMHS, the monitoring of progress on health status and implementation plan
    - Coordinate the various units of the health department that are involved in this project
    - Facilitate linkages to the State Health Improvement Plan
    - Provide staff support for the needs assessment, action planning and implementation
C. The specific responsibilities of the Advisory Board (including Founding Partners) under this agreement are as follows:
    - Jointly agree on publicity regarding Allegany County Health Planning Coalition
    - Actively participate in the Allegany County Health Planning Coalition by attending meetings and responding to requests
    - Monitor and evaluate progress on health status and implementation plan
    - Support data development and sharing of information to improve population health
    - Engage in shared development and use of resources to improve care coordination across the continuum
    - Assist in engaging support for and participation with the Coalition
    - Identify a potential replacement to represent your sector or organization when withdrawing from the Coalition
    - Leverage additional funds to support the vision and ensure sustainability of the Coalition's plans
D. The specific responsibilities of the Affiliates under this agreement are as follows:
    - Participate in an identified component of the local health action plan
    - Assist with tracking of progress and outcomes when requested
    - Support dissemination of consistent resources to enhance care and health outcomes
    - Serve as a conduit to the targeted populations in the community

E. All parties agree to:

- Participate in the community health needs assessment process
- Participate in the development & implementation of the LHAP
- Assist in developing and promoting health solutions to identified health problems thru:
  - Grants
  - Coordination with local community partners;
  - Provider and partner trainings

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?** ___x__yes _____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?

The Local Health Action Plan (implementation strategy) is divided into 6 six month time periods). Actions are assigned to one or more phases. At the end of each phase, LHIC members score progress on each action and member scores are averaged together. Progress is scored on a scale of 1 (no progress) to 5 (excellent progress). The LHIC also measures progress by assessing the selected community health data measures at least annually to determine if they have improved, declined, or stayed the same.

TABLE III

a. 1. Identified Need a. 1. Identified Need 2. Was this identified through the CHNA process?	Childhood overweight/obesity - Direct measurement from the 2009 Maryland Pediatric Access to Care WMHS Physician Needs Assessment (2014) suggests a need for 5.1 primary care providers and 4.2 mental health providers in the county. In addition to provider availability access is impacted by socioeconomic factors including: 17.4% of households in Allegany County are living below the federal poverty guidelines, 10.2% of households are without a vehicle (ACS 5yr est), and 25% of children under 18 are living in households with incomes below 200% of FPL (County Health Rankings 2015). The hospital rate of ED visits related to behavioral health (6846.8 per 100,000) is impacted by both access and social determinants. Yes this was identified through the CHNA process.
b. Hospital Initiative	Workforce Development- recruitment of physicians in identified areas of need, expansion of PCP practices to meet this need Community Health Workers- Direct support and collaboration with community partners to assist the underserved and most needy with prescription medication, food, and other social determinants Transportation –taxi and bus vouchers and partnership in a Mobility Management Program Mental Health First Aid-evidence based program to improve early identification and appropriate response to behavioral health needs
c. Total Number of People Within the Target Population	Of the 75,087 Allegany County residents, 62,322 are over the age of 18, at least 13,065 are living below the poverty line, and approximately 10.2% of households are without a vehicle, leaving about 7,659 people needing transportation support. (ACS, 2009-13 est). Based on WMHS data, there were 1851 unique patients in the emergency department during FY15 with a primary diagnosis of behavioral health.
d. Total Number of People Reached by the Initiative Within the Target Population	In FY15, the WMHS PCP practices provided access to at least 1,707 new patients. Community Health Workers made a total of 2,787 visits in FY15, and the based on cases closed by the CHWs at WMHS, there were at least 188 unique people served. At least 455 individuals were provided 3919 rides, of which 2503 were supported by WMHS. 194 individuals completed the Mental Health First Aid training in FY15, (100 completers via WMHS) with the intent of increasing early identification of behavioral health needs.
e. Primary Objective of the Initiative	To improve health outcomes, Healthy People 2020 indicates that we must address social determinants, transportation options, and resources to meet daily needs It is our goal to increase access to health care services by increasing provider availability and addressing social determinants. Primary Objectives: • Recruit PCP and MH providers to meet the identified community need • Enhance Community Health Worker Program by increasing linkages with providers and tracking outcomes #receiving resource/access referrals, # CHW clients improved health status, and # CHW clients reduced ED visits or hospitalizations • Reduce transportation barriers # calls to MM for transportation assistance and # rides provided • Educate community on when to use ED, Urgent Care, PCP • Reduce stigma associated with mental health and improve community response to those in need of support until professional help arrives # educated and reduced # of Level 1&2 visits in ED at end of year

f. Single or Multi-Year Initiative –Time Period	Multi Year Provider recruitment and provision of services to address the needs of the underserved in ongoing. CHW started in Dec. 2013 and will be ongoing. Transportation efforts and MHFA began in 2012 and are anticipated to be ongoing.	
g. Key Collaborators in Delivery of the Initiative	Western Maryland Health System (WMRMC) collaborates with the Allegany County Health Department, Western Maryland AHEC, and Allegany Health Right on Community Health Workers. Partners in transportation are WMHS, Allegany County Health Dept., Human Resource Development Commission, TriState CHC, Mental Health Systems Office, and transportation vendors. MHFA and the Core Service Agency are key to the MHFA training. Allegany County Health Planning Coalition links the efforts together.	
h. Impact/Outcome of Hospital Initiative?	In FY15, WMHS hired 4 new primary care providers and 1 mental health provider to help meet the identified need. There were also changes made to the practice hours to increase access. From the 2,787 visits by Community Health Workers there were 2,374 referrals to transportation, food, housing/utilities, prescription assistance, insurance, and other services. 602 lifestyle improvements (tobacco cessation, increase activity level, etc) were made among CHW clients. Resulting in 139 individuals with reduced ED or hospital visits and 101 individuals with reduced disease state red flags. Of the 3185 calls to the Mobility Management program, 3919 rides were provided with out of county requests and last minute calls going unmet. Analysis of the resources and requests identified the need for more education of both the patients and staff. There are now 194 more individuals certified in MHFA (including law enforcement, health care providers and schools) in our community with the knowledge to identify a behavioral health crisis and be able to provide support until the professional help arrives.	
Evaluation of Outcomes:	Access to care has been increased over the last fiscal year in the service area. Though none of these initiatives can independently claim the reduction of ED visits, it seems they contributed to a reduction of 3,561 level 1&2 visits in ED compared to FY14. The population to primary care provider ratio has improved going from 1746:1 in 2013 to 1575:1 in 2015 (County Health Rankings). In behavioral health the hospital rate of ED visits dropped from the 2010 baseline of 7517.9 to 6846.8 per 100,000 in 2011, and in the latest SHIP release it was 5654.7 per 100,000. More focused tracking to pinpoint the effective variables is desired. Additional analysis is needed to more effectively meet the transportation needs in the service area.	
i. Continuation of Initiative?	Based on the results, all of these initiatives will be continued. WMHS/WMRMC works collaboratively with community partners on all of these initiatives, and in conjunction with them will develop strategies for improvement. Communication between Community Health Workers in the hospital and CHWs at community partner sites will need to be improved, and the documentation process streamlined. Partners have begun to explore more effective and efficient strategies to address identified transportation needs in Allegany County, including coordination of available funds & resources.	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative • Workforce Development: $501,671 • CHW: $154,040 • Transportation: $34,878 • MHFA: $441	B. Direct Offsetting Revenue from Restricted Grants none

a. 1. Identified Need **TABLE III** a. 1. Identified Need 2. Was this identified through the CHNA process?	Healthy Lifestyle and Wellbeing According to the Community Health Status Reports (DHHS) half of all deaths can be attributed to lifestyle and behavioral risk factors. In Allegany County unhealthy behaviors including tobacco use, domestic violence, and low levels of physical activity contribute to poor health outcomes. According to the County Health Rankings (University of Wisconsin): • Adult smoking in Allegany County dropped from 26% to 24% in 2012 and remained at 24% in 2013. This is above the Maryland benchmark (15%). • 30% of adults in Allegany County were not engaging in any leisure time physical activity in 2011 and in 2013 this increased to 32%. Based on the same source 20% of adults in Allegany County were without social and emotional support in 2011 and in both 2012 and 2013 this has dropped to 19%. BMI data collected by school health nurses for all public elementary children shows that 20% are in the 95th percentile or higher. The number of domestic violence crimes is at 719.5 per 100,000 in Allegany County (2013) compared to 468.6 in Maryland. Yes this was identified through the CHNA process.
b. Hospital Initiative	Family Fit-family challenge to promote physical activity and healthy eating choices with adult involvement, offered via elementary schools Change to Win-10 week program also intended to increase the percentage of healthy weight adults by aiding participants in making healthy lifestyle choices that lead to permanent weight loss. Smart Moves- 12 week non-diet, family approach to weight management includes behavior modification, nutrition education, and exercise. Coaching individualized support to identify goals and steps for making healthy lifestyle choices. Community Baby Shower-education program to promote healthy choices for pregnant women and infants, includes tobacco cessation, breastfeeding, and more Parish Nursing provides information, support and resources to volunteers in Faith-based communities promoting health and wellness for mind, body and spirit. Forensic Nurse Examiner Program (FNEP)- support services for victims of domestic violence and abuse
c. Total Number of People Within the Target Population	24% of adult population smokes= 14,867 32% of adult population are physically inactive=19,823 19% of adult population lack social support=11,769 20% of elementary children are obese=785 719.5 domestic violence crimes were committed per 100,000 population
d. Total Number of People Reached by the Initiative Within the Target Population	In FY15, 17 health behavior change programs were offered with our partners reaching more than 3600 community members. • Family Fit: 1512 students from 16 elementary schools and adults • Change to Win: 69 adults • Smart Moves: 15 people • Coaching: 291 people • Community Baby Shower: 224 people • Parish Nursing: 38,809 encounters, unknown number of unique people • Forensic Nurse Examiner Program: 333 people

e. Primary Objective of the Initiative	Increase healthy choices, including availability and affordability Primary objectives • Support behavior change with use of motivational interviewing and low cost, accessible programs including: Family Fit, Change to Win, Smart Moves, Coaching and Community Baby Shower # of low cost accessible programs offered with # of participants # programs using motivational interviewing % reporting behavior change • Increase awareness of domestic violence • Promote development of positive, non-abusive relationships for improved health. #education and awareness efforts The intent will be to reduce tobacco use, physical inactivity, obesity and domestic violence.
f. Single or Multi-Year Initiative –Time Period	All of these initiatives are multi-year. Family Fit and Smart Moves began in 2014. Change to Win started in 2011.Coaching began in 2006. Community Baby Showers were new in 2015 Parish Nursing has existed since 1997, and FNEP is a long term program as well.
g. Key Collaborators in Delivery of the Initiative	WMHS facilitates a group of partners called Make Healthy Choices Easy that collaborates on many of the healthy lifestyle programs. Partners include: Allegany County Board of Education, Allegany County Health Department, Carver Community Center, Community Wellness Coalition, Evergreen Heritage Center, Family Junction, Life Fitness Management, Maryland Physicians Care, Priority Partners, University of Maryland Extension, Western Maryland Area Health Education Center, and YMCA. In addition, WMHS collaborates with 36 faith based communities, Meritus Health, and the Cumberland Ministerial Association for the Parish Nursing. Law enforcement, the courts, Family Crisis Resource Center and the Family Violence Council collaborate with the Forensic Nurse Examiner Program.
h. Impact/Outcome of Hospital Initiative?	At least 10 low cost accessible programs were offered with over 2444 participants. 4 programs used motivational interviewing. Coaching was the only program to consistently track behavior change and 94% of those participants made progress. 33 of the 69 participants in Change to Win lost weight in the program for a total of 465.6 pounds. Smart Moves was completed with six youth and their parents. Based on a comparison of the pre and post screening results, the following changes were made: 3 youth lowered their BMI and one youth had a lower BMI percentile, 4 youth showed improved self-esteem, 3 youth reduced the amount of screen time, 4 youth increased the amount of physical activity & increased their intake of fruits and vegetables, and 3 youth reduced consumption of sugary drinks and 3 youth stayed the same at one or none per day. Each youth reached one or more of their behavior change goals. Family Fit & Fun Challenge was implemented with 14 public elementary schools and 2 private schools, resulting in a total of 1,512 children, earning 108,959 points participating in physical activity and making healthy eating choices, with adult engagement in over half of the activity. The impact of the Community Baby Shower is difficult to quantify. Participant feedback was very positive and during the second event, a majority of the participants were able to answer the true/false questions about the topics presented at the exhibits. There were 7 education and awareness efforts focused on violence prevention and WMHS supported several of them including an October Focus of Month, ACM Career Ctr. video, Facebook postings-No More, and ACM Human Service Class project. Through participation on the Family Violence Council the following projects were identified for the coming year: Domestic Violence Awareness Forum, outreach to worksites, and theatre ads. 94% of the 36 parishes were engaged and the Parish Nurse Coordinator provided 9,917 support encounters to the volunteer Parish Nurses and Health Ministers.

i. Evaluation of Outcomes:	Lifestyle and behavior changes are challenging and take significant support and time. Additional health status indicators are needed as well as increased tracking of behavior change. The metrics do show slight improvements in healthy lifestyles and wellbeing. • Adult smoking in Allegany County dropped from the baseline of 26% to 24% in 2012 and 2013, to 23%. (County Health Ranking, 2015) • 30% of adults in Allegany County were not engaging in any leisure time physical activity in 2011 and in 2013 this increased to 32%, but according to the latest County Health Ranking, it has gone back down to 31%. • BMI data collected by school health nurses for all public elementary children had a baseline of 20% in the 95th percentile or higher, and for the 2014-15 school year, this number decreased to 18.8%. The measure used for domestic violence was changed by SHIP from related ED visits to the number of domestic violence crimes per 100,000 so a comparison is not feasible. Though when comparing the domestic violence crime rate for Allegany County to Maryland the county is higher.	
j. Continuation of Initiative?	Though each of these programs will be examined more closely for improvements and integration of better outcome measures, WMHS plans to continue all of them in collaboration with partners. Integration of technology into these programs will be explored and more environmental and policy changes will be promoted with the Allegany County Health Planning Coalition. The desired outcome of the Community Baby Shower will need to be clarified further and have better metrics identified. Parish Nursing continues to grow in support of community health and wellness and will be piloting a project with identified high utilizers in the next fiscal year. With the rate of DV crimes, the Forensic Nurse Examiner Program needs to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $ X # of dollars Family Fit: $7,955 Change to Win: $5,201 Smart Moves: $2,220 Coaching: $9,427 Community Baby Shower: $2,114 Parish Nursing: $65,014 Forensic Nurse Examiner Program: $194,481	D. Direct Offsetting Revenue from Restricted Grants No revenue from restricted grants

a. 1. Identified Need **TABLE III** a. 1. Identified Need 2. Was this identified through the CHNA process?	Disease Management Baseline data from SHIP (2010) shows the age-adjusted death rates in Allegany County (per 100,000) at 256.8 for heart disease and 259.8 in 2011. The rate of ED visits for hypertension was 225.1 in 2010 and 231.6 in 2011, and for diabetes ED visits went from 379.6 in 2010 to 385.6 in 2011. COPD, CHF and Diabetes are chronic diseases associated with the high utilizers having multiple chronic conditions, and are often reasons for readmission or PQI. Yes this was identified through the CHNA process.
b. Hospital Initiative	Center for Clinical Resources- clinic with disease management services for diabetes, CHF, COPD, mediation management and anticoagulation. Except for the anticoagulation lab test, there are no fees charged for the CCR Support Groups- facilitated groups focused on risk factors or disease management ranging from Better Breathers to the Diabetes Support Group
c. Total Number of People Within the Target Population	Based on BRFSS, 11.3% of Allegany County adults have diabetes= 7,000 Based on the rate of ED visits for hypertension and the discharge rate for COPD and CHF=1068
d. Total Number of People Reached by the Initiative Within the Target Population	In FY15 the CCR had 8,860 encounters including patients with diabetes, CHF, COPD, poly pharmacy needs, and anticoagulation therapy, approximately 300 high utilizers. 421 people participated in the various support groups, with 133 participating in the Diabetes Self-Management Program.
e. Primary Objective of the Initiative	Disease management targeting individuals with multiple conditions, in conjunction with primary care provider Primary Objectives • Support coordination of disease management programs, especially those for diabetes, heart disease and asthma. # of cross agency disease management initiatives • Implement educational interventions to focus on prevention and self-management of chronic diseases. # of self-mgmt programs implemented and # of participants
f. Single or Multi-Year Initiative –Time Period	Center for Clinical Resources-multiyear, opened November 2013 Support Groups- Multi-year and each one is evaluated annually to determine the ongoing value and interest.
g. Key Collaborators in Delivery of the Initiative	WMHS has collaborated with the Medical staff and area providers on the CCR. The support groups and collaborative development of support groups or other self-management programs has involved the AC Health Department, American Cancer Society, Tristate CHC, Western Maryland AHEC, Parish Nurses, YMCA, University of Maryland Extension, HRDC and Allegany County Health Planning Coalition.
h. Impact/Outcome of Hospital Initiative?	The Center for Clinical Resources continues to show a reduction, diabetic admissions by11.5%, 64% decrease in all hospital visits for OPAC, and 27% decrease in CHF admissions, resulting in savings of $3,123,753 in one year. It will be examined as a best practice through the regional transformation planning grant. In FY15, 2 cross agency disease management initiatives were initiated. The hospital supported the YMCA in establishing a National Diabetes Prevention Program to supplement the continuum of care with the CCR and collaborated with Allegany HRDC to offer the Stanford Chronic Disease Self-Management Program. Two self-management programs were implemented with 137 participants.

i. Evaluation of Outcomes:	The CCR has made a positive impact on the number of ED visits, readmission rate, and costs. It is assumed that this reflects improvements in the health status and quality of life for these patients. Further assessment of health status indicators and the timeframe for effectiveness is underway and will be analyzed further. A process to deal with the 'no shows' is also a need. Overall, the death rate for heart disease has improved along with the number of ED visits for diabetes, but the rate of ED visits for hypertension continues to increase. The age-adjusted death rates in Allegany County for heart disease went from a baseline of 256.8 down to 242.8 (HSCRC 2013-SHIP). The rate of ED visits for diabetes went down from 379.6 in 2010 to 237.5 (HSCRC 2013-SHIP). The rate for hypertension related ED visits continue to rise going from 225.1 in 2010 and 231.6 in 2011, to 236.6 (HSCRC 2013-SHIP).	
j. Continuation of Initiative?	WMHS will continue to build on and improve the effectiveness of the CCR, and is researching best practices for extending the continuum of care for disease management into the community. It is anticipated that with the all payer model, self-management and support groups will continue to be relevant.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	E. Total Cost of Initiative $ X # of dollars Center for Clinical Resources: $1,573,972 Support Groups: $4,117	F. Direct Offsetting Revenue from Restricted Grants None

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 community health needs identified through the CHNA will be addressed. With consideration of magnitude, severity, and level of need for the most vulnerable populations, a list of the most prevalent community health needs was drafted. With a desire to prioritize and focus on coordinated results, the workgroup discussed strategies for streamlining the process. It was agreed to sort the needs under three main themes; access & socioeconomics, healthy lifestyles & wellbeing, and disease management. Access & Socioeconomics since social determinants have been found to be key drivers in health status, Healthy Lifestyles and Wellbeing as leading causes of chronic disease, and Disease Management since chronic diseases lead to the most expensive care and have greatest return on investment if improvements can be made. This framework allows for consideration of both outcomes and root causes. By using overarching themes it is expected that there will be more collaboration across the continuum, less program specific focus, more consistent education, and increased community wide engagement.

In order to enhance the connection between local, state and federal planning, the county profile compiled by the state was reviewed. Of note was the continuing discrepancy between the rate of child maltreatment at the local and state level. The Allegany County Department of Social Services continues to feel this gap is based on a difference in reporting. Though not specifically addressing maltreatment, the Coalition felt that existing need will be covered as part of the domestic violence issue.

Another measure that was of concern, but after further review eliminated from the list of priorities, was the suicide rate in Allegany County (12.4 per 100,000 population) compared to the SHIP Target (9.1). It was decided that the root cause and larger issue was behavioral health and that should be the priority.

Lastly, the LHAP Workgroup identified several best practices underway in the community which may contribute to achievement of the goals and address the priority needs but do not need to be addressed independently by the hospital.

- Mountain Health Alliance- efforts to increase dental access especially for adults, as well as provider recruitment and rural medical education.
- Housing initiatives of the Homeless Resource Board and various Housing Authorities.
- Tobacco assessment tools (4P's, SCRIPT, tobacco cessation) by Allegany County Health Department and partners.
- Tracking BMI of elementary school students via school health nurses.

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)

With the framework of Access & Socioeconomics, Healthy Lifestyles & Wellbeing, and Disease Management, there are many ways in which the hospitals' community benefit activities support the State's efforts to improve population health. WMRMC works very closely with community partners to incorporate non-clinical community based assets into the care continuum. As discussed in the State

Innovation Model, WMRMC uses Community Health Workers to intervene on social and environmental determinants of health with the goal of reducing unnecessary ED visits or hospitalizations.

The Center for Clinical Resources at WMRMC meets the definition of an Integrated Program as defined on the Health Care Innovations in Maryland site. The CCR combines clinical innovations and care coordination to provide disease management and support at no cost to the patient with the goal of enhancing patient care, reducing cost, and improving population health.

As part of the community health needs assessment, the SHIP measures were reviewed and considered as part of the process. In the current cycle we have included 7 of the SHIP measures many of which relate to ED visits for various diseases. Through the CCR services, and various community health education programs, we aim to reduce the number of these unnecessary visits and provide care in a more appropriate setting.

WMRMC continues to co-chair the LHIC with the local health department. Each year WMRMC assists with reports to the State regarding achievements of the LHIC, progress toward the identified measures, and outreach to the community. We collaborate on enrollment outreach, health fairs, environmental and policy changes, professional education, and behavioral health.

WMRMC has assisted several community partners with their application to the Maryland Community Health Resources Commission and through the LHIC and its associated workgroups we monitor the success and barriers of these efforts. It was funding from the Commission that allowed our community to start the Mobility Management program, helping to address the transportation barrier.

The Allegany County Health Planning Coalition (LHIC) incorporates health literacy, cultural competency, patient engagement, behavior change, and social determinants into many of its initiatives. All of which enhance the quality of care, cost, and overall population health.

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.

Allegany County is a designated health professional shortage area (HPSA) for primary care for low-income populations, mental health care for Medical Assistance populations, and dental care for low-income populations. With the aging of primary care providers, a need for recruitment has risen as a concern again. Succession planning may be indicated. According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 1,045 persons; Allegany County has 1 primary care provider for every 1,575 individuals. WMHS is also below the US benchmark in dental and mental health providers.

For the most recent analysis by the Healthcare Strategy Group in June 2014, the WMHS's CMS designation was changed from that of a rural facility to an urban facility. Stark III requirements for a CMS-designated urban facility limit the service area to one that consists of the fewest number of contiguous zip codes representing 75% of WMHS patient volume, effectively reducing the size of the regulatory-compliant service area from past studies. Based on retirement trends for physicians, the recent analysis identified older primary care medical staff to be of particular concern. Among WMHS's active medical staff in adult primary care, 19 physicians are currently over age 60 and that number will

increase to 21 physicians in 2017, thirteen (13) of which will be over age 65 in 2017. Significant age concerns also exist in Cardiology, Endocrinology, Neurosurgery, and Ophthalmology, for which specialties the current average age is well over age 60 and most of the physicians in those specialties on WMHS's medical staff are currently over age 65.

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.

Based on the community health needs assessment and Medical Staff Development Plan, Western Maryland Regional Medical Center has included physician subsidies in the "Non-Resident house staff and hospitalists" category: hospitalists, psychiatric physician practice, obstetric physician practice, and primary care physician practice. 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. The aging of physicians has created a need for succession planning in primary care, psychiatry and obstetrics. WMHS responded by recruiting and maintaining practices in these areas. These needs were not being met by other agencies in the community and were much needed services. As a WMHS practice these physicians align with the WMHS Financial Assistance Policy and help ensure that more patients are provided with care in the most appropriate setting.

VII. APPENDICES

I. Description of Financial Assistance Policy (FAP)
II. Change in FAP since ACA Coverage Expansion
III. WMHS Financial Assistance Policy (FAP)
IV. Patient Information Sheet
V. WMHS Mission, Vision, and Values

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

Western Maryland Health System 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 Financial Assistance Policy (FAP) through the following means.

- The FAP policy/information is posted at all registration sites, is available on the WMHS web site, and is included with billing statements.

- Based on a query attached to our registration process, all self-pay patients are offered applications for FAP when they register.

- As part of the registration process, patients are also asked to identify their preferred language, so that accommodations can be made if translation or alternate resources are needed.

- Before discharge, every inpatient and/or their families is visited and offered assistance. Availability of various government benefits, such as Medicaid or state programs, and the qualification for such programs are discussed where applicable. The information is also available in our Patient Handbook.

Appendix II – FAP Change since ACA Coverage Expansion
Western Maryland Health System (WMRMC) FY15

Western Maryland Health System's Financial Assistance Program has always tried to connect patients with insurance or safety net coverage when available. Since the Affordable Care Act's Health Care Coverage Expansion Option became effective in January 2014, there has been increased support from financial counselors in the Patient Accounting Department and more patients are getting enrolled in Medical Assistance. The level of charity care and bad debt has shown some decline.

According to the FAP Policy:

Determination should be made that all forms of insurance are not available to pay the patient's bill. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs offered through Maryland Health Connections or other Healthcare Exchanges. If it is determined that a patient had or has the opportunity to obtain insurance that would have covered all or a portion of the patient's bill for medical services, but the patient failed or refuses to obtain such insurance, WMHS may consider such a decision on the part of the patient in determining whether the patient is eligible to receive Financial Assistance and/or the amount of Financial Assistance available to the patient. Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and copays. All insurance benefits must have been exhausted. Patients must follow participating provider guidelines and seek medical care from their provider network. WMHS will not grant Financial Assistance to patients who violate their provider network regulations. Patients who may qualify for Medical Assistance must apply for Medical Assistance and cooperate fully with the Medical Assistance specialist or its designated agent.

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WESTERN MARYLAND HEALTH SYSTEM DEPARTMENTAL Policy Manual	**Department\Division:** Business Office	**Policy Number:** 400-04
	Effective Date: November 12, 2010	**Reviewed/Revised:** 4/11, 12/11, 5/12, 10/12, 8/13, 6/14, 4/15, 7/15

FINANCIAL ASSISTANCE POLICY

PURPOSE:
The purpose of this policy is to describe the circumstances under which the Western Maryland Health System (WMHS) will provide free or discounted care to patients who are unable to pay for medical services, explain how WMHS will calculate the amounts of potential discounts, describe how patients can obtain and apply for Financial Assistance, and describe the eligibility criteria for Financial Assistance.

POLICY:
WMHS is committed to providing financial assistance to persons who require medically necessary health care services, but who are uninsured, underinsured, ineligible for a government insurance program, or otherwise unable to pay for medically necessary care based on their individual situation. A patient can qualify for Financial Assistance based on indigence or excessive Medical Debt by furnishing the information requested pursuant to this Policy and meeting specified financial and other eligibility criteria.

In addition, WMHS is designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, each tax-exempt hospital is required to adopt and widely publicize its financial assistance policy. WMHS will post notices of its Financial Assistance Policy at patient registration sites, Admissions, Patient Accounting Department and at the Emergency Department. Notices of its Financial Assistance Policy will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients as part of the Admission Handbook given to every admitted patient prior to discharge and upon request.

This policy covers Western Maryland Regional Medical Center and Physician Clinics and Practices owned by WMHS.

DEFINITIONS:
Medical Debt: A Medical Debt is medical expense incurred by a patient for Medically Necessary Services provided by a hospital or physicians, clinics, and practices owned by WMHS. A Medical Debt does not include a medical expense for services furnished by a non-hospital employee or other independent contractor (e.g., independent physicians, anesthesiologists, radiologists, and pathologists.

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.

Financial Hardship: Medical Debt incurred by a family over a 12 month period that exceeds 10% of family income. Financial counselors will work closely with eligible parties taking into consideration issues such as lost wages due to health and any other financial barriers that a patient may face due to a sudden health condition. Assistance plans will be considered using a sliding scale from 3-10% of gross income. (See Medical Debt definition)

Medically Necessary: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

Exclusions: Financial Assistance is not available for certain services, including the following: cosmetic procedures, elective reproductive services, acupuncture, private duty nursing, and other services at WMHS' discretion.

Free Care: Available to patients in households between 0% and 200% of Federal Poverty Level (FPL) and who otherwise meet the requirements to receive Financial Assistance under the Policy.

Reduced-Cost Care: Available to patients in households between 200% and 300% of FPL and who otherwise meet the requirements to receive Financial Assistance under the Policy.

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; or a patient may notify Patient Accounting personnel or a financial counselor that he/she cannot afford to pay a bill and request Financial Assistance. All hospital registration sites, outpatient diagnostic centers, and system owned clinics and practices will make available to patients the Financial Assistance Policy and application. Registrars are trained to offer the Financial Assistance Policy and applications to self-pay patients. All inpatients are visited by a financial counselor before discharge from the hospital. The Financial Assistance application is available on WMHS web site, and is also on the reverse side of every patient billing statement. Financial counselors are available to assist patients with this process, and can be reached by calling 240-964-8435. Western Maryland Health System will use the Maryland State Uniform Financial Assistance Application.

2. Patients must have United States citizenship to qualify for Financial Assistance. Patients may be required to provide proof documentation such as identification card, birth certificate or lawful permanent residence status (green card).

3. WMHS has a financial counselor and Medicaid eligibility specialists on site in the hospital. Financial counselors are also available in the Patient Accounting Department to support and counsel patients.

4. Determination should be made that all forms of insurance are not available to pay the patient's bill. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs offered through Maryland Health Connections or other Healthcare Exchanges. If it is determined that a patient had or has the opportunity to obtain insurance that would have covered all or a portion of the patient's bill for medical services, but the patient failed or refuses to obtain such insurance, WMHS may consider such a decision on the part of the patient in determining whether the patient is eligible to receive Financial Assistance and/or the amount of Financial Assistance available to the patient. Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and copays. All insurance benefits must have been exhausted. Patients must follow participating provider guidelines and seek medical care from their provider network. WMHS will not grant Financial Assistance to patients who violate their provider network regulations.

5. Patients who may qualify for Medical Assistance 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.

6. 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) or workers compensation.
   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 statements or brokerage statements.

   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.

7. When calculating total income for purposes of assessing eligibility for financial assistance, the following will be considered in the calculation of total income:
   a. Earned Income
   b. Social Security
   c. Pension Income
   e. Unemployment Compensation
   f. Business or Farm Income less Business or Farm Expenses
   g. Any other income such as rents, royalties, etc.
   h. Fixed income and savings allowance calculation is based on life expectancy of 85 years, income calculation should be based on age 85 and the applicant's age, allowing the necessary funds for the life of the applicant.

8. 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 Financial Assistance application process is abbreviated in that documentation of eligibility can be demonstrated by 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. Energy assistance
   e. Out of state medical assistance
   f. Unemployment under federal poverty guidelines and applicant is sole provider in the household.
   g. Patients eligible for out of state medical assistance and WMHS is not enrolled with participating provider credentials to file the claim

   Homeless patients, deceased patients with no known estate and members of a recognized religious organization who have taken a vow of poverty are also considered eligible for Presumptive Financial Assistance. Patients unable to provide sole support and relying on someone else for support may provide a "Letter of Support" for consideration of eligibility. Other documentation may be required and considered on a case by case basis.

A 25% discount will be extended for all Amish and Mennonite patients. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health insurance coverage.

Presumptive Financial Assistance is valid 6 months from date of application, at which time eligibility for Financial Assistance must be demonstrated again.

9. The application, with supporting documents, should be completed by the applicant and returned to the Financial Counseling Department within 10 business days. If partial information is returned, WMHS will provide the applicant with written notice of that describing the missing information and the applicant will be given additional time to provide the required information and supporting documents. If the applicant does not respond, the applicant's request for Financial Assistance will be considered incomplete and WMHS will provide the applicant with written notice of

10. Based on the Federal poverty guidelines published annually in the Federal Register, a patient may be eligible to receive 100% Free Care or Reduced-Cost Care, which is a discount based on a percentage of the patient's Medical Debt according to the patient's income and number of dependents. The patient's responsibility for a Medical Debt may be capped based on a percentage of the patient's income, in which case the patient/ guarantor will be responsible to pay a certain percentage of the Medical Debt and the remainder will be charged to the Financial Assistance Program. Financial counselors will use the WMHS Charity Calculation form to determine level of Financial Assistance available to the patient. Patients receiving partial financial assistance based on calculation will receive a letter stating financial assistance amount granted, and amount owed by the patient. The patient will be given a payment plan to meet their remaining financial obligation. WMHS will also provide patients with the Accounts Receivable Collection policy upon request.

11. Once the Financial Assistance application is complete, decisions on eligibility will be made within 20 business days by the financial counselor and Director, Patient Accounting. Financial Assistance grants over $5,000 will also require the approval of Chief Financial Officer. The Director and Chief Financial Officer have the ability to make exceptions as circumstances deem necessary for all applications. In the event a patient has medical services scheduled within this 20 day review period, all reasonable measures will be taken to expedite review of the application. The applicant will be notified in writing by the WMHS financial counselor of the determination.

12. If the patient's application for Financial Assistance is approved, it will be made effective for medical services furnished within the 12-month period prior to the approval date and remain effective for 12 months after approval date.

13. 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 Financial Assistance, the two year period may be reduced to 30 days from the date of initial request for information.

14. If a patient account has been assigned to a collection agency, and patient or guarantor requests Financial Assistance, the collection agency will be notified and the account will be placed on hold pending the completion of the application for Financial Assistance within ten business days. WMHS will also provide patients with the Accounts Receivable Collection policy upon request. In the event the application is not completed by the patient within a reasonable amount of time, the application will be denied and the account will be returned to the collection agency.

15. If the application for Financial Assistance is denied, the patient has the right to request the application be reconsidered, in which case the application will be reviewed by the Chief Financial Officer for final evaluation and decision.

CHARGES:
Charges for medical care provided to uninsured patients will be same as or equal to patients who have insurance. WMHS determines the amounts generally billed to patients and insurers based on Maryland HSCRC regulations.

EMERGENCY MEDICAL CARE:
Any patient seeking urgent or emergent care [within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)] at WMHS shall be treated without discrimination and without regard to a patient's ability to pay for care or whether the patient may be eligible for Financial Assistance. WMHS operates in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). WMHS' emergency medical care policy prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provision, without discrimination, of emergency medical care.

APPROVAL

_____
Director, Business Operations – Trivergent Health Alliance

_____
Sr. Vice President, Chief Financial Officer

2015/2016 SLIDING SCALE ADJUSTMENTS
WMHS FINANCIAL ASSISTANCE PROGRAM

Patient Responsibility Percentages

Size of Family Unit	0%	10%	20%	30%	40%
1	$11,770-$23,540	$23,541-$26,365	$26,366-$29,307	$29,308-$32,250	$32,251-$35,310
2	$15,930-$31,860	$31,861-$35,683	$35,684-$39,666	$39,667-$43,648	$43,649-$47,790
3	$20,090-$40,180	$40,181-$45,002	$45,003-$50,024	$50,025-$55,047	$55,048-$60,270
4	$24,250-$48,500	$48,501-$54,320	$54,321-$60,383	$60,384-$66,445-	$66,446-$72,750
5	$28,410-$56,820	$56,821-$63,638	$63,639-$70,741	$70,742-$77,843	$77,844-$85,230
6	$36,570-$65,140	$65,141-$72,957	$72,958-$81,099	$81,100-$89,242	$89,243-$97,710
7	$36,730-$73,460	$73,461-$82,275	$82,276-$91,458	$91,459-$100,640	$100,641-$110,190
8	$40,890-$81,780	$81,781-$91,594	$91,595-$101,816	$101,817-$112,039	$112,040-$122,670
FPL Range	Thru 200%	201%-224%	225%-249%	250%-274%	265%-300%

Appendix IV – Patient Information Sheet
Western Maryland Health System FY15

Hospital Financial Assistance

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 that 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.

Patients' Rights and Obligations

Patients' Rights:

Those patients that meet the financial assistance policy criteria described above may receive assistance from the Health System 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 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.

The Western Maryland Health System 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. 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. 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 to discuss this matter. (See contact information below).

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 **240-964-8435** and 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 the business office or download the uniform financial assistance application from the following link:http://www.hscrc.state.md.us/consumers_uniform.cfm

The WMHS/Maryland Uniform Financial Assistance Form. Is also available on our website at www.wmhs.com.

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. West Virginia residents may contact 1-800-642-8589 orwww.wvdhhr.org.Pennsylvania residents may contact, 1-800-692-7462 or www.compass.state.pa.us

Important Billing Information

Services provided by the following medical specialists are not included in the hospital bill you will receive from WMHS:

Anesthesiologists	Neonatologists
Cardiologists	Observation Unit Providers
Emergency Department Providers	Pathologists
Hospitalists	Radiologists

These providers may be involved in your care or the interpretation of your test results. They are required by law to bill separately for their professional services. These specialists **may not** necessarily participate in the same insurance plans as the hospital.

If you have any questions about your medical provider's participation in your insurance plan, please let us know.

Mission Statement

We are dedicated to providing patient-centered care and improving the health and well-being of people in the communities we serve.

Vision Statement

Shaping dynamic partnerships in advancing health and well-being.

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