COMMUNITY BENEFIT NARRATIVE

FY2016 Community Benefit Report

Garrett County Memorial Hospital,
DBA Garrett Regional Medical Center
251 North Fourth Street
Oakland, MD 21550

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);

(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(16) CRISP Reporting Services

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

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

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

HSCRC Community Benefit Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).
    a. Bed Designation – The number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;

e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
Adult acute: 25 Newborns: 12 Sub-Acute: 10 **TOTAL: 47**	Adult acute: 2,020 Newborns: 333 **TOTAL: 2353**	21550 21561 21520 21531 21538 21541	None	1.27%	25.8%	44.5%

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

(i) A list of the zip codes included in the organization's CBSA, and

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

(iii) Describe how the organization identified its CBSA, (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 community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	21550 21561 21520 21531 21538 21541 All zip codes have vulnerable populations.	HSCRC
Median Household Income within the CBSA (*we are including information from the hospital's entire primary service area, which includes areas of West Virginia*)	Garrett County, MD: $46,096 Grant County, WV: $41,600 Preston County, WV: $45,806 Tucker County, WV: $38,663 **CBSA Median: $43,703**	www.census.gov QuickFacts
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Garrett County, MD: 12.4% Grant County, WV: 17.0% Preston County, WV: 17.6% Tucker County, WV: 17.1% **CBSA Median: 17.05%**	www.census.gov QuickFacts
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Garrett County, MD: 9.4% Grant County, WV: 11.4% Preston County, WV: 11.2% Tucker County, WV: 10.8% **CBSA Median: 11.0%**	www.census.gov QuickFacts
Percentage of Medicaid recipients by County within the CBSA.	Garrett County, MD: 18% Grant County, WV: 16% Preston County, WV: 13% Tucker County, WV: 10% **CBSA Median: 14.5%**	www.towncharts.com
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Garrett County, MD: White 79.6, All 79.5 Grant County, WV: All 77.4 Preston County, WV: All 76.9 Tucker County, WV: All 76.9 **CBSA Median: 77.15**	Maryland Vital Statistic Annual Report 2014; www.healthdata.org

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). Number of deaths 2014.	Garrett County, MD: White 284, Black 1	Maryland Vital Statistics Annual Report 2014;
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**Food: Scale of 0 (worst) to 10 (best)** Garrett County, MD: 8.3 Grant County, WV: 7.2 Preston County, WV: 7.8 Tucker County, WV: 7.9 **Transportation:** *Garrett County, MD*: mean travel time to work 25.7 minutes; 83.8% travel alone, 9.25% carpool, 0.09% bike, 1.24% walk. There is no regular mass transit. *Grant County, WV*: mean travel time to work 25.8 minutes. No public transportation. *Preston County, WV*: mean travel time to work 31 minutes. There is no mass transit. *Tucker County, WV*: mean travel time to work 27.4 minutes. There is no mass transit. **Education:** *Garrett County, MD:* 87.1% have high school diploma; 18.4% have Bachelor's Degree. *Grant County, WV:* 81.6% have high school diploma; 12.6% have Bachelor's Degree *Preston County, WV:* 82.7% have high school diploma; 12.9% have Bachelor's Degree *Tucker County, WV:* 86.8% have high school diploma; 13.8% have Bachelor's Degree **Housing:** *Garrett County, MD:* owner occupied housing 75.8%; median home value $165,500; median gross rent $657; 15% report lack of heating/plumbing or other severe housing issue. *Grant County, WV:* owner occupied housing 77%; median home value $121,100; median gross rent $583; 9% report lack of heating/plumbing or other severe housing issue. *Preston County, WV:* owner occupied housing 79.6%; median home value $107,800; median gross rent $584; 8% report lack of heating/plumbing or other severe housing issue. *Tucker County, WV:* owner occupied housing 81%; median home value $104,200; median gross rent $529; 11% report lack of	www.countyhealthrankings.org www.census.gov QuickFacts www.bestplaces.net www.census.gov QuickFacts www.census.gov QuickFacts www.countyhealthrankings.org

	heating/plumbing or other severe housing issue. **Environmental Factors:** *Garrett County, MD:* air pollution particulate matter, 13.3 average daily density (MD range 11.9 – 13.3). No drinking water violations. *Grant County, WV:* air pollution particulate matter, 13.1 average daily density (WV range 12.9 – 14.1). No drinking water violations. *Preston County, WV:* air pollution particulate matter, 13.4 average daily density. No drinking water violations. *Tucker County, WV:* air pollution particulate matter, 13.2 average daily density. No drinking water violations.	www.countyhealthrankings.org
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	**Garrett County, MD:** White 97.4%, Black 1.1%, American Indian 0.2%, Asian 0.5%, Hispanic 1.1%, Two or more races 0.9% **Grant County, MD:** White 97.7%, Black 1.0%, American Indian 0.2%, Asian 0.2%, Hispanic1.4%, Two or more races 0.9% **Preston County, WV:** White 97.3%, Black 1.4%, American Indian 0.2%, Asian 0.2%, Hispanic 1.0%, Two or more races 0.9% **Tucker County, WV**: White 98.1%, Black 0.5%, American Indian 0.3%, Asian 0.2%, Hispanic 0.8%, Two or more races 0.8%	www.census.gov QuickFacts
Other		

Garrett Regional Medical Center was founded in 1950 through a combination of private philanthropy and Hill-Burton Act Funds, and is the sole community acute care provider. The Hospital's primary service area includes Garrett County and communities in the surrounding West Virginia counties of Preston, Tucker and Grant.

Services at the Hospital include a 24-hour emergency department; inpatient care; observation services; sub-acute rehabilitation unit; obstetrics and Family Centered Maternity Suite; pediatrics; medical/surgical intensive care; inpatient and outpatient surgical services; radiology; laboratory; wound care center; cardiopulmonary services; community and worksite wellness programs; CPR programs; and other ancillaries intended to meet the primary medical and surgical needs of the region.

Most recently the Garrett Regional Medical Center has opened a Cardiac and Pulmonary Rehabilitation Unit, a Cancer Center affiliated with the West Virginia University Cancer Institute, and a Chronic Kidney Disease Clinic to address previously identified community healthcare needs.

Garrett County is the western most county in the State of Maryland. Isolated by mountainous topography, the community is far from metropolitan areas and residents have few choices regarding medical care. In fact, Garrett Regional Medical Center is 60 miles from the closest regional health facilities providing comparable care, one located to the east in Cumberland, MD, and the other to the west in Morgantown, WV.

As part of the Appalachia poverty belt, all of Garrett County is designated as a Medically Underserved Area (MUA) and carries a "Low Income" designation as Health Professional Shortage Area (HSPA) for primary care, dental, and mental health. The Maryland Department of Health and Mental Hygiene confirm that over 45% of all county residents live at or below 200% of the federal poverty guidelines.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   __X_Yes
   ____No

   Provide date here. 05/18/2016

   If you answered yes to this question, provide a link to the document here.
   https://www.gcmh.com/wp-content/uploads/file/CommunityHealthNeedsAssessment5-16.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

   _X__Yes
   ___No

   Provide date here: 02/27/2013

   If you answered yes to this question, provide the link to the document here.
   https://www.gcmh.com/wp-content/uploads/file/GCMH%20Strategic%20Initiatives%20and%20Implementation%20Strategy.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)**

   a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

      _X__Yes
      ___No

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

      The addition of new services or changes to existing services is based on community need. As the financial feasibility of a service is considered, an assessment is done of the need for the service in the area. The administration must be good stewards of hospital finances; however, they also must determine the value of the service to the community in the long term when making the decision to move forward.

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

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. _X__CFO
3. _X__Other : Chief Nursing Officer, Chief Information Officer, Human Resource Director, Chief Physician Officer

Describe the role of Senior Leadership.

The Senior Leadership Team, above, monitors all aspects of hospital operations and performance to ensure consistent, quality service is provided all patients. This includes monitoring the healthcare needs of the community to ensure that GRMC is meeting those needs as efficiently and effectively as possible. Leadership strives to provide as many medical services locally as is feasible. Based on ongoing review and evaluation, programs are developed and implemented to meet the guidelines of the community benefit program.

ii. Clinical Leadership

1. _X__Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

The Chief Physician Officer serves as a member of the hospital's Senior Leadership Team in order to provide medical staff representation in the decision making process.

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)
2. __X__ Other population health staff (please list staff)
   Chief Nursing Officer

Describe the role of population health leaders and staff in the community benefit process.

The Chief Nursing Officer acts as the Population Health Leader within the Leadership Team, ensuring that Population Health issues are acknowledged and addressed in the Community Benefit process.

iv. Community Benefit Operations

1. _X__Individual (please specify FTE): Director of Grant Development
2. ___Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. _X__Other (please describe): Accounting Department

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

The Director of Grant Development works with the Accounting Department to compile the information needed for the Community Benefits Narrative. Data is collected from staff members involved in each Community Benefit activity.

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

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

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

The Community Benefit Report is prepared and submitted to the Senior Leadership Team for review and editing. Final approval is determined by the Team as a group.

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

Spreadsheet	___X__yes	_____no
Narrative	___X__yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations

of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

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

__X__ 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
Garrett County Health Department	Rodney Glotfelty	Garrett County Health Officer	Provided input as a survey participant.
Health Department	Kendra McLaughlin	Garrett County Health Department Director, Health Education	Assisted with the development of the survey document.
STEPS Committee	Dr. Karl Schwalm	Chairman	The STEPS Committee consists of health focused agencies, nursing and rehab centers, the Board of Education, and consumers working to identify and address health and wellness issues in the community.

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

_____yes ___X__no

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

___X__yes _____no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)
(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? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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

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

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

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

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

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

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

information may be copied directly from the CHNA that refers to community health needs identified but unmet.

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)

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

VI. PHYSICIANS

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

Garrett Regional Medical Center's size and rural location limit the number of physicians who provide specialty services. The community is simply not large enough to support full time specialists in all disciplines. In addition, a physician shortage is predicted over the next several years since approximately 50% of the area's existing family practice physicians and surgeons are approaching retirement age. Rural communities are at a disadvantage in recruiting physicians because they lack the resources needed to offer attractive incentive packages.

Garrett County has consistently been designated a Medically Underserved Area and has a "Low Income" designation as a Health Professional Shortage Area for primary care, dental, and mental healthcare. Fully 18% of the Garrett County population has no healthcare coverage. Historically, the underinsured and uninsured residents of the area used the hospital's Emergency Department (ED) for treatment of minor illnesses because it provides care regardless of ability to pay. An FQHC offers an alternative for obtaining quality health services for those unable to pay, but the ED remains a source of non-emergent care for the region's uninsured population.

Since GRMC does not employ physicians for certain specialty areas, such as Neurology, some patients are stabilized and transferred to appropriate facilities for treatment. GRMC manages excellent relationships with other medical facilities to ensure continuity of care for patients needing transfer for specialty services. GRMC will continue to offer high-quality healthcare services for all patients.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**

Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

To Be Attached as Appendices:

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

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

    - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - besides English, in what language(s) is the Patient Information sheet available;
    - 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) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Reduce infant mortality
- 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
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- 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 hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

Table III Initiative I –Cardiac and Pulmonary Wellness Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	The Community Health Needs Assessment (2016) and the Maryland SHIP Data identified a high incidence of heart disease and lung disease in Garrett County. The rate of heart disease deaths per 100,000 is 226.4, which is higher than the State of Maryland and is also the number one cause of death in Garrett County. Issues faced by this target group include high blood pressure, heart disease, peripheral vascular disease, high cholesterol, obesity and chronic lung disease. Yes this was identified through the CHNA process.
b. Hospital Initiative	Cardiac and Pulmonary Rehabilitation Center The Center offers an interactive program for those living with these chronic conditions to learn more about their disease process. The educational sessions help them understand their disease process, learn disease management skills, recognize signs of complications, and develop an exercise regimen and activity modifications to meet their situation. This program will help reduce the rate of preventable hospitalizations.
c. Total Number of People Within the Target Population	Statistics from the CDC indicate that approximate 8,000 people in the Hospital CBSA would benefit from the services offered by the Cardiac and Pulmonary Wellness Program
d. Total Number of People Reached by the Initiative Within the Target Population	169 individual cardiac and pulmonary patients were served in 2016.
e. Primary Objective of the Initiative	To improve the overall level of health and quality of life for those living with these chronic conditions, educate the patients dealing with these specific chronic conditions on how to manage their symptoms and recognize symptoms that warrant expert consultation, increase mobility and ability to exercise, teach medication compliance, and aid anxiety and depression management.
f. Single or Multi-Year Initiative –Time Period	Multi Year; program is ongoing.
g. Key Collaborators in Delivery of the Initiative	Garrett Regional Medical Center Cardiac and Pulmonary Rehabilitation staff, GRMC Wellness Coordinator/Nurse, GRMC Exercise Physiologist, GRMC Diabetic Educator, Primary Care Physicians in the County, and the Cardiologists and Pulmonologists from the surrounding area.
h. Impact/Outcome of Hospital Initiative?	Participants benefit by gaining knowledge regarding chronic disease, managing symptoms, understanding when to seek intervention, and overall enhancing their quality of life. Outcomes are evaluated concurrently during the program. The Program Administrators (Registered Nurses) evaluate these outcomes on each participant, both during the visit and through the participant's self-report. Outcomes are also evaluated after the program is complete by looking at rates of readmissions and utilization of the Emergency Department.
i. Evaluation of Outcomes:	The following measures are monitored: • Participant involvement and attendance from initial enrollment • Exercise tolerance and statistical improvement • Episodes of acute exacerbations • Decrease in symptoms

	• Surveys evaluating quality of life, nutrition, and psychosocial status • Completion of education component and overall completion of the program • Tracking the rates of readmissions and emergency room visits • Data entry and generation of an outcomes report of quantitative data depicting the patient improvement Outcomes are reported to the referring physician and/or primary care physician	
j. Continuation of Initiative?	This program has been fully integrated into the services offered through the Cardiac and Pulmonary Department as well as the Wellness Department. GRMC is committed to providing this service to the community in perpetuity.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 9,992.44	B. Direct Offsetting Revenue from Restricted Grants C. None

Table III Initiative II – Diabetes Education Program

a. 1. Identified Need 2. Was this identified through the CHNA process?	Respondents to the Community Health Needs Assessment (2016) cited obesity, or being overweight, as the risky health behavior of greatest concern in the area. While they did not mention diabetes specifically, statistics show that 90% of people with Type II Diabetes are overweight, and the correlation between weight and risk for developing Type II Diabetes is well established. In addition, according to the Maryland Department of Health and Mental Hygiene, 10% of Garrett County's population is diabetic. Yes, the program need was identified through the CHNA process.
b. Hospital Initiative	The Outpatient Diabetic Education Program at Garrett Regional Medical Center provides comprehensive diabetic education to those diagnosed with the disease and those in danger of developing it. The program is instructed by a certified diabetic educator who works with the patient's Primary Care Provider to develop a plan to keep the patient's blood sugar under control or prevent the development of the condition. Patients learn about disease management as well as healthy eating, the need for physical activity, reducing risks associated with a diabetes diagnosis, and monitoring one's condition. Patients also receive assistance with insulin adjustments, insulin pumps, or continuous glucose monitors.
c. Total Number of People Within the Target Population	2,946
d. Total Number of People Reached by the Initiative Within the Target Population	115 fist visits; 239 visits total
e. Primary Objective of the Initiative	Provide education and support that will help area residents with a diabetes diagnosis live healthier, more active lives, and provide education and support for those in danger of developing the condition. The program also aims to reduce hospital admissions due to chronic diseases.
f. Single or Multi-Year Initiative –Time Period	This is a multi-year program that is ongoing.
g. Key Collaborators in Delivery of the Initiative	The hospital works with each patient's Primary Care Provider in creating a care plan that will keep the patient healthy, active, and at home. In addition, the program also partners with the Garrett County Health Department and the Centers for Disease Control.
h. Impact/Outcome of Hospital Initiative?	The program has tallied 1,029 visits since its inception in 2010.
i. Evaluation of Outcomes:	Program Evaluation includes: • Number of diabetic patients enrolled • Number showing improved health statistics • Number completing program • Number losing weight/displaying healthier test results • Number Primary Care Providers actively engaged in patient care plans
j. Continuation of Initiative?	GRMC will continue the program well into the foreseeable future.

Table III Initiative II – Diabetes Education Program

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $7,228	B. Direct Offsetting Revenue from Restricted Grants None

Table III Initiative III –The Well Patient Program ®

a. 1. Identified Need 2. Was this identified through the CHNA process?	Hospital utilization rates are used to track individuals with chronic medical conditions who have limited family support, limited financial resources, or poor coping mechanisms, all of which can lead to a higher level of medical services usage than necessary. This was not identified through the CHNA, but is being addressed by hospitals statewide.
b. Hospital Initiative	The Well Patient Program is a multidisciplinary collaborative approach to chronic disease management. Garrett Regional Medical Center patients identified as potentially benefitting from the service will be enrolled in the Well Patient Program. GRMC medical and Patient Care Management staff will collaborate with the patient, family, and Primary Care Physician to create a comprehensive care plan that will assist the patient in navigating the health care continuum in order to ensure a favorable health outcome.
c. Total Number of People Within the Target Population	1,189
d. Total Number of People Reached by the Initiative Within the Target Population	35
e. Primary Objective of the Initiative	• To improve care coordination for chronic disease conditions in the region as measured by referrals to the *Well Patient Program* and decreased readmissions to the facility. • To decrease the Potentially Avoidable Utilization rate at GRMC from the 10.7% rate recorded at the Program's start. • To develop a program to manage patients in the appropriate care setting for their health care needs as evidenced by decreased hospital inpatient utilization for chronic diseases
f. Single or Multi-Year Initiative –Time Period	Multi Year – project will be ongoing.
g. Key Collaborators in Delivery of the Initiative	• Garrett Regional Medical Center – Cardiac & Pulmonary Rehab, Wound Care, SubAcute, Diabetes Education, Patient Nurse Navigator • Garrett County Health Department – Home Health, Adult Evaluation Services, Behavioral Health Services • Western Maryland ACO with MedChi Support – TCM and CCM code assistance • Mountain Laurel FQHC – Case Management • Nursing Homes and Assisted Living Facilities • Hospice • Community Action – Area Agency on Aging, Transportation, Medicaid Waiver, MAP Program, Housing, Energy Assistance, Homemaker Services • Garrett County Lighthouse – Psychiatric Rehabilitation Program, Safe Harbor, Case Management
h. Impact/Outcome of Hospital Initiative?	This program began in FY 2015. When the project was implemented, the Potentially Avoidable Utilization rate at GRMC was 10.7%. By June 2016, the Potentially Avoidable Utilization Rate was 7.92%. In addition, GRMC has the lowest readmission rate in the state. In FY 2015 the unadjusted readmission rate was 6.4%, and in FY 2016 it reached 4.99%.
i. Evaluation of Outcomes:	• Metrics include ED visits per 6 months, Potentially Avoidable Utilization (PAU) Rate, Readmission Rate, percentage of high utilizer patients enrolled in the *Well Patient Program,* internal data tracking and PAU charges, and Total Health Care Cost per beneficiary. • Metrics include number of telemedicine consults, Shared Care Profile with

	percentage of patients that have shared care plans with a telemedicine provider, and patient satisfaction level with telemedicine consult. • Metrics include number of primary care providers that are interfaced into Care Plan program, Encounter Notification Alerts. • Metrics include number of referrals to community agencies for care coordination, Readmission rates, and PAU rate.	
j. Continuation of Initiative?	This program is ongoing.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $79,607	B. Direct Offsetting Revenue from Restricted Grants None

Garrett County Memorial Hospital
Community Benefits Report
Fiscal Year 2016

APPENDIX I: Describe your Financial Assistance Policy

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

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

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

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

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

Appendix II

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

Implementation of the ACA's Health Care Coverage Expansion resulted in an increase in the number of patients presenting at the hospital with insurance coverage. The increase in insurance coverage has led to a decrease in the number of patients qualifying for and needing the hospital's Caring Program.

In 2011, the percentage of the population without health insurance was 14%, according to the Robert Wood Johnson Foundation County Roadmaps and Rankings. By 2015, that percentage had dropped to 9.4%, according to the US Census.

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy:

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

- You are receiving this information sheet because under Maryland law, this hospital must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.

- This hospital meets the legal requirement by providing financial assistance based on an annual income that is up to 200% of the federal poverty level. A sliding fee scale is applied to individuals/families with an annual income that is between 201% and 300% of the federal poverty level. An individual is someone who is single and does not live with any blood relatives. A family consists of all members of the same family who are related by marriage or blood that live in the household.

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

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

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

Patients' Rights and Obligations:

Patients' Rights

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

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

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

Patients' Obligations:

- For those patients with the ability to pay their bill, it is the obligation of the patient to pay the hospital in a timely manner.
- This hospital makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. This summary statement is available on inpatient accounts only. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under the hospital's financial assistance policy, or if you cannot afford to pay the bill in full, you should contact the business office promptly at 301-533-4209 to discuss the matter.
- If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

- If you have questions about your bill, please contact the hospital business office at 301-533-4209. A hospital representative will be glad to assist you with any questions you may have.
- If you wish to get more information about or apply for the hospital's financial assistance plan, you may call 301-533-4209 or download the uniform financial assistance application from the following link:
http://www.hscrc.state.md.us/consumers uniform.cfm

GARRETT REGIONAL MEDICAL CENTER

A PROUD AFFILIATE OF WVU Medicine

GRMC MISSION STATEMENT

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

OUR VISION
Garrett Regional Medical Center:

- Will be viewed as the healthcare provider of choice in the region and be recognized for excellence in delivering safe patient care, exceeding the expectations of those we serve
- Will be recognized as a collaborative community leader, partner and resource, striving to proactively respond to the health and wellness needs of the region
- Will be the employer of choice in the region
- Will provide a high level of community service and stewardship for the resources with which we have been entrusted
- Will be dedicated to a culture of excellence and performance improvement
- Will be obvious in our expression and fulfillment of our charitable mission and community benefit

GARRETT REGIONAL MEDICAL CENTER A Proud Affiliate of WVU Medicine	Department: Patient Financial Services		Policy Title: Caring Program (Financial Assistance)	
	Original Date: 09/01/01		Policy Number: 8520.000	Page Number: 1 of 8
	Effective Date: 09/01/01	Reviewed/Revised Dates: 01/11, 02/12, 2/13	Submitted by: Angela Maule RHIA, CCS	
Approval Signature & Title: Tracy Lipscomb, Vice President Finance Date: 4/22/16	Approval Signature & Title: Angela Maule, Director Health Information Management/Billing and Collecting Date: 4/22/16		Approval Signature & Title: Lori Dixon, Senior Director Finance and Accounting Date: 4/29/16	

Policy Statement:

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

Objective:

The qualifying criteria are minimal and broad so GRMC can exercise maximum flexibility to offer financial assistance to program applicants. Eligibility to the "Caring Program" represents "free" or reduced healthcare and as such, is included as part of the hospital's outreach mission.

Guidelines:

A. GRMC will grant financial assistance for eligible applicants for medically necessary services that are urgent, emergent, or acute in nature. Services included in the program are emergency room visits, inpatient admissions, and outpatient laboratory, radiology and cardiopulmonary services. Elective surgical procedures may also be eligible for financial assistance for eligible applicants through the "Caring Program" and will require individual consideration by management.

B. Screening for Medicaid eligibility is required.

a. If Medicaid eligibility is likely, the patient must apply for Medicaid within the required timeframe of the service date or the date the patient assumes financial responsibility for the services rendered (specific to state Medicaid requirements).

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

    i. All inpatient and observation visits require Medicaid status.

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

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

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

C. The "Caring Program" application must be completed and returned via the U.S. Postal Service, delivered in person, or completed over the telephone within 60 days of date the patient becomes financially responsible for services rendered. The patient, a family member, a close friend, or associate of the patient, subject to applicable privacy laws, may make a request for financial assistance.

a. All applications require the signature of the individual who is financially responsible for the unpaid bills as well as proof of financial information used to determine program eligibility.

b. If the application is completed over the telephone for the patient by the PFS representative then the application will then be mailed to the patient for a signature. The application will then be either mailed or faxed back to the PFS Department.

c. If the applicant cannot read/write, PFS will read the policy to the applicant and assist with the form completion, requiring only a witnessed signature of an "X."

d. Any required signatures or additional information requested by a Patient Financial Services Representative must be returned to the Patient Financial Services (PFS) Department within 30 days of the request. If the information is not returned within

that time, the patient is ineligible for assistance through the "Caring Program" for those service dates that related to the application.

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

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

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

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

3. Income: Before taxes from all sources, as follows:
   a. Wages and salaries
   b. Interest or dividends
   c. Cash value of stocks, bonds, mutual funds, etc.
   d. Net self-employment income based on a tax return as calculated by GRMC. Non-cash deductions (depreciation), income tax preparation fees, expenses for use of part of a home, entertainment, and any other non-essential expense will be subtracted from the reported business expense deductions in determining financial need and program eligibility.
   e. Regular payments from Social Security, railroad retirement, unemployment compensation, veterans' payments, etc
   f. Strike benefits from union funds
   g. Workers' compensation payments for lost wages
   h. Public assistance including Aid to Families with Dependent Children

i. Supplemental Security Income

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

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

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

m. Regular insurance or annuity payments

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

o. Net gambling or lottery winnings

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

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

r. Tax refunds

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

t. One-time insurance payments or compensation for injury

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

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

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

3. Eligibility for 75% financial assistance is available for incomes at 221%-230% of the Federal Poverty Guidelines

4. Eligibility for 65% financial assistance is available for incomes at 231%-240% of the Federal Poverty Guidelines.

5. Eligibility for 55% financial assistance is available for incomes at 241%-250% of the Federal Poverty Guidelines.

6. Eligibility for 45% financial assistance is available for incomes at 251%-260% of the Federal Poverty Guidelines.

7. Eligibility for 35% financial assistance is available for incomes at 261%-270% of the Federal Poverty Guidelines.

8. Eligibility for 25% financial assistance is available for incomes at 271%-280% of the Federal Poverty Guidelines.

9. Eligibility for 15% financial assistance is available for incomes at 281%-290% of the Federal Poverty Guidelines.

10. Eligibility for 5% financial assistance is available for incomes at 291%-300% of the Federal Poverty Guidelines.

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

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

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

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

2. Discussion of the situation with the individual's state Medicaid office to obtain a preliminary determination of Medicaid eligibility

3. Research the applicant's other GRMC accounts

4. Information from the next of kin or other person able to speak about the individual's financial condition-Within HIPAA guidelines

5. Have personal knowledge of the individual's living situation

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

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

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

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

M. Financial assistance is not available for any account already referred to a collection agency or attorney for formal collection action. Excluded from this statement are accounts where an individual/family has declared bankruptcy or has deceased with no estate or has an estate too small to pay our claims. Any outsourced third party collection agencies receive a copy of the financial assistance policy on an annual basis, or when changed, which ever occurs first.

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

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

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

P. Individuals or families with an income below 500% of the federal poverty level that can prove medical hardship will be eligible for The Caring Program for a15% financial assistance or reduction in charges. In order to meet the medical hardship criteria, the patient/family must have medical debt at Garrett Regional Medical Center (excluding co-pays, co-insurance, and deductibles) that exceeds 25% of the individual's/family's annual income. Medical debt is any out-of-pocket expense (excluding co-pays, co-insurance, and deductibles) for medically necessary care that the individual/family has incurred at Garrett Regional Medical Center in a 12 month period. Medically necessary care, for the purposes of this policy, does not include elective or cosmetic procedures. If an individual/ family meets these criteria and is found eligible for The Caring Program, that eligibility will last for 12 months from the date on which the reduced-cost medically necessary care was initially received, unless there is a significant change in the individual or family's income. Once found eligible, The Caring Program covers medical bills for all members of the household. Eligible medical debt does not include any accounts which the patient chooses to opt out of insurance coverage or insurance billing.

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

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

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

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

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

V. It is recognized that Old Order Amish and Old Order Mennonite patients do not rely in any manner on any type of government programs or private insurance based upon their religious beliefs. These two Orders rely on their religious community to pull resources together to pay for healthcare bills for members of their community. These patients, who are 100% self-pay will be granted a 25% discount when paid in full within 30 days of receiving first statement.

1. A letter from the Old Order Amish Church and Old Order Mennonite Church will be presented to Garrett Regional Medical Center to be kept on file.
2. Any patient applying for this discount will be required to fill out an application form.
3. Patients requesting this assistance must present to the Patient Financial Services Department and speak to a PFS Representative.
4. Any outstanding balances prior to the implementation of this discount within this policy may be considered if account notes show that payment was attempted within 30 days of date of service.