Community Benefits Report Narrative

Fiscal Year 2017

Submitted December 15, 2016

Frederick Memorial Hospital
400 W 7th Street
Frederick, MD 21701

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
239 licensed	**18,709** *(includes IP, IP-Hospice, IP-Psych, Newborn and Neonatal, EXCLUDES OP-Observation)*	**21701** **21702** **21703** **21771** **21788** **21793**	**none**	**1.8%**	**19.41%**	**35.13%**

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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., 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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	**Northern** – 21727, 21757, 21773, 21778, 21780, 21788, 21791, 21793, 21798 **Central** – **21701***, **21702*, 21703***, 21704 **Southern** – 21710, 21716, 21718, 21754, 21755, 21758, 21769, 21770, 21771, 21774, 21777, 21790 Most vulnerable populations include the **Waverly/Hillcrest*** area within the Central zip codes and the **areas east of Frederick Memorial Hospital*** (to East and South Streets). Also have pockets of vulnerable populations in Brunswick and Thurmont.	Various
Median Household Income within the CBSA	$85,715 (Frederick Co., 2012-2016)	Census Bureau State and County Quick Facts
Percentage of households in the CBSA with household income below the federal poverty guidelines	6.9%	Census Bureau State and County Quick Facts
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	6.7%	Census Bureau State and County Quick Facts
Percentage of Medicaid recipients by County within the CBSA.	15%	http://www.mhaonline.org/docs/default-source/presentations-and-talking-points/maryland-medicaid-landscape.pdf?sfvrsn=2

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	80.8 years	SHIP
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	All rates are per 100,000: • Cancer Mortality 147.8 • Heart Disease Mortality 168.7 • Chronic Lower Resp. Disease 35.8 • Influenza/Pneumonia 18.1 • Diabetes 13.1	SHIP Maryland Vital Statistics
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://ship.md.networkofcare.org/ph/county-indicators.aspx	Frederick County has consistently ranked 3rd in Maryland for Health Factors since 2012. The overall ranking for Health Factors is a composite of the next four categories. • Frederick County has consistently ranked 4th in Maryland for Health Behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity) since 2010. • In the area of Clinical Care (access to care and quality of care), Frederick County moved up one position to #9. • Frederick County ranked 3rd for Social & Economic Factors (education, employment, income, family & social support, community safety) for the second year in a row, up from #4 in 2013. • Frederick County moved down six positions to #23 in Physical Environment (air & water quality, housing & transit), down from #17 in 2014.	http://health.frederickcountymd.gov/317/County-Health-Rankings
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	**See the following two pages from the 2016 Community Health Needs Assessment related to profile and disparities.**	

Frederick County Community Profile

The Frederick County, MD population has increased 4.4% from 2010 to 2014. The White population has decreased from 77.8% in 2010 to 75.7% in 2014. The Black population has increased from 8.6% to 9.4% and the Hispanic population has increased from 7.3% to 8.4%.

2014	Frederick County	Maryland	United States
Total Population	243,675	5,976,407	318,857,056
Gender			
Males	49.3%	48.5%	49.2%
Females	50.7%	51.5%	50.8%
Race			
White, not-Hispanic (NH)	75.7%	52.6%	62.1%
Black, NH	9.4%	30.3%	13.2%
Hispanic	8.4%	9.3%	17.4%
Asian, NH	4.5%	6.4%	5.4%
American Indian and Alaska Native, NH	0.5%	0.6%	1.2%
Two or More Races	2.7%	2.6%	2.5%
Ages			
Under 5 Years Old	6.0%	6.2%	6.2%
Under 18 Years Old	23.9%	22.6%	23.1%
65 Years and Over	12.9%	13.8%	14.5%
Household and Economic Indicators			
Median Household Income (2009-2013)	$84,570	$73,538	$53,046
Homeownership rate, 2009-2013	75.3%	67.6%	
Persons per household (2009-2013)	2.69	2.65	2.63
Language other than English spoken at home, pct age 5+ (2009-2013)	12.3%	16.7%	20.7%
High school graduate or higher, percent of persons age 25+ (2009-2013)	91.8%	88.7%	86.0%
Bachelor's degree or higher, percent of persons age 25+ (2009-2013)	38.2%	36.8%	28.8%
Persons Below Poverty Level (2009-2013)	6.1%	9.8%	15.4%
Unemployment Rate, Sept 2015*	4.4%	5.1%	5.1%

Data Source: U.S. Census Bureau: State and County Quick Facts; 2013 Population Estimates; 2013 American Community Survey 1-year Estimates; United States Department of Labor; Bureau of Labor Statistics; Maryland Department of Labor, Licensing, and Regulation Local Area Unemployment Statistics (http://www.dllr.state.md.us/lmi/laus/)

Healthcare Disparities in Frederick County

At this time, county level data is not available to allow us to examine the role of poverty, education, and other social determinates of health for health disparities. Some data is available for certain topics by gender, race and/or ethnicity. The following list shows health disparities in Frederick County. Other disparities may exist, but this list consists of topics where data was available at the county level for both genders and/or at least two races.

Topic	Core Measure	Data Source	Disparities Identified	
			Gender	Race/ Ethnicity
Cancer Mortality	All Cancers Mortality	2007-2011	≠	≠
Cancer Mortality	Lung and Bronchus Cancer Mortality	2007-2011	≠	≠
Cancer Mortality	Colorectal Cancer Mortality	2007-2011	≠	Insuff. data
Cancer Incidence	All Cancers Incidence	2007-2011	≠	≠
Cancer Incidence	Lung and Bronchus Cancer Incidence	2007-2011	≠	≠
Cancer Incidence	Colorectal Cancer Incidence	2007-2011	≠	≠
Cancer Incidence	Female Breast Cancer Incidence	2007-2011	N/A	≠
Cancer Incidence	Prostate Cancer Incidence	2007-2011	N/A	≠
Cancer Incidence	Oral Cancer Incidence	2007-2011	≠	Insuff. data
Cancer Incidence	Melanoma Cancer Incidence	2007-2011	≠	Insuff. data
Chronic	All Heart Disease Death Rates 35+ years	2011-2013	≠	≠
Chronic	Stroke Death Rates 35+ years	2011-2013	≠	≠
Chronic	Hypertension Death Rates 35+ years	2011-2013	≠	≠
Maternal, Infant, Child Health	Low Birth Weight	2014	Data not collected	≠
Maternal, Infant, Child Health	Early Prenatal Care	2014	N/A	≠
Maternal, Infant, Child Health	Cesarean Section Births	2010-2014	N/A	≠
Sexually Transmitted Diseases	HIV Adult/Adolescent Cases	2014	≠	≠

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

   Yes Provide date here: **June 2016 (also in 2013)**

   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.fmh.org/documents/PDFs/56183-Community-Health_Rev-829.pdf

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

   Yes

   Approved by the Frederick Memorial Hospital Board of Directors on 9/27/16

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

   https://www.fmh.org/documents/FMH-Community-Needs-Assessment-Implementation-Strategy-2016.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?

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

   Yes

   If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

   Community Benefits Planning, The Community Health Needs Assessment and the Community Health Needs Implementation Strategy are all presented to and reviewed by the Strategy Council of the FMH Leadership Team.

b. What stakeholders within 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

Sr. Vice President Population Health and Ambulatory Services
Strategy Council
FMH Leadership Team

Describe the role of Senior Leadership.

The Senior VP attends all Community Benefit Committee meetings and oversees strategic direction of the group to ensure that we are meeting the needs of the community as defined in the 2013 (and going forward, 2016) Community Health Needs Assessment. The Senior VP presents findings to Strategy Council for review and input as needed throughout the year.

ii. Clinical Leadership

AVP Medical Affairs
AVP Integrated Care Delivery
Director, Women's and Children's Services
Director, Nursing Resources

Describe the role of Clinical Leadership

Clinical leadership also attend all committee meetings and help to (1) determine the most appropriate community benefits and (2) ensure the clinical efficacy of each activity.

iii. Population Health Leadership and Staff

Sr. VP Population Health, Ambulatory Services

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

As described above, the Sr. VP Population Health is the executive sponsor for the Community Benefits Committee and oversees and approves its strategic direction.

iv. Community Benefit Operations

1. ___the Title of Individual(s) (please specify FTE)
2. **_X__Committee (please list members)**
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.

Please see the table below listing the members and activities of the community benefit committee.

Employee	Title/Department	Function for Community Benefits
Jim Williams	Sr. VP Population Health, Ambulatory Services	Executive sponsor, oversees and approves strategic direction.
Dr. Rachel Mandel	AVP Medical Affairs	Executive leader for overseeing clinical direction of community benefits program.
Gloria Bamforth	Director of Operations, CorpOHS	Member, provides staff and clinical expertise as needed.
Kristen Fletcher	Community Benefits Co-Chair and Director, Cardiac & Vascular Services	Co-Chairs all meetings and activities. Integral role in setting strategic direction and overseeing approval of initiatives.
Phil Giuliano	Manager, Public Safety, Security and Emergency Preparedness	Member, assists with planning, parking and public safety for larger events.
Sharon Hannaby	Director, Volunteer Services	Member, provides insight and assists with lining up volunteers as needed.
Janet Harding	Community Benefits Co-Chair and Director, Cultural Awareness and Inclusion	Co-Chairs all meetings and activities. Integral role in setting strategic direction and overseeing approval of initiatives.
Heather Kirby	AVP Integrated Care Delivery	Member, plays crucial role in determining which initiatives provide best access to care for our most vulnerable communities.
Melissa Lambdin	Director, Marketing and Communications	Member, assists in planning and working at events. Provides publicity when needed.
Mike McLane	Director, Nursing Resources	Member and clinical lead in deciding on how initiatives meet clinical needs and assists with staffing.
Katherine Murray	Director, Women's and Children's Services	Member and clinical lead in deciding how initiatives meet the needs for vulnerable women's and children's population.

Employee	Title/Department	Function for Community Benefits
Patricia Reggio	Women's Health Navigator	Member, provides insight related to reaching community needs for women.
Don Schilling	VP Ambulatory Services	Member, assists in staffing community events.
Tom Shupp	Stroke Center Coordinator	Member and clinical insight related to stroke needs and care.
Margaret Siebeneichen	Oncology Care Navigator	Member and clinical insight related to oncology needs and care.
Cookie Verdi	FMH Select! Program Coordinator	Member, also plays crucial role in tracking and reporting on 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 Yes

Narrative Yes

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

The spreadsheet is reviewed by Jim Devlin, Director of Financial Reporting and Jennifer Hulvey, Director of Reimbursement. Finance provides a supporting spreadsheet with the details of what department posted each expense, along with printouts from the General Ledger supporting each line item.

The narrative is reviewed by Jim Williams, Sr. VP Population Health and Ambulatory Services and Kristen Fletcher, Community Benefits Co-Chair and Director of Cardiac & Vascular Services.

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

Spreadsheet No

Narrative No

If no, please explain why.

The narrative and data pulled for this report are used to develop our 990 tax filing. The filing is audited by Ernst & Young. After that process, the information is presented to our Board of Directors.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

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?

Yes to the following:

Local Health Department

Local health improvement coalitions (LHICs)

Behavioral health organizations

Faith based community organizations

Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	Name of Key Collaborator	Title	Collaboration Description
Frederick County Health Department	Dr. Barbara Brookmyer	Health Officer	• Collaborated on 2016 CHNA • Collaborate with care transition team to provide community services • Key member of Ebola and other infectious disease preparation and drills • Support each other's efforts at Frederick Community Health Fair and other events • Peer Recovery Support Specialist those with substance abuse transition back into the community. • COPE Team and Behavioral Health leadership at FMH are part of the county's Overdose Fatality Review Team to identify and target trends related to SA deaths to prevent future deaths.. • Frederick Memorial is working closely with the Frederick County Health Department to ensure coordination of efforts around chronic disease management programs and engagement of high risk individuals is coordinated in a manner that reduces duplication of effort, provides a standardization of tools and resources and optimizes the reach of such programs. As an example of this effort we are working to develop a shared tool to identify high risk individuals and will actively train hospital staff using the same Certified Health Coach training as used by the health department. Additionally, we are working to engage EMS personnel in the dialogue with plans to develop a paramedicine program to further reach high risk individuals and assist in appropriate access of health, medical and social services.
Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**

Asian American Center of Frederick	Elizabeth Chung and various staff	Executive Director	• Partner on annual community health fair • In partnership, launched a Community Health Worker pilot to support patients and their families navigating and accessing community services, providing advocacy, and coaching to promote improved overall health and wellbeing. The CHW will support providers through an integrated approach to care management and community outreach. As a priority, activities will promote, maintain, and improve the health of patients and their family. Community Health Workers come from the communities they serve, working at the grassroots level building trust and vital relationships which make them effective culture brokers between their own communities and systems of care
George Washington University	Cherise B. Harrington, PhD, MPH	Assistant Professor	Worked with research students to interview 483 community residents, hold six focus groups and interviewed 20 key community leaders as part of CHNA.

Organization	Name of Key Collaborator	Title	Collaboration Description
LHIC	Jenny Morgan	Business Health Manager	The Coalition serves to improve availability and accessibility to quality health care in Frederick County. The idea to form a coalition rose from the proceedings of the Frederick Health Summit (on Barriers to Access) held May 12, 2006. More than 100 diverse representatives from across the community convened to examine and prioritize barriers to health care. Business Health Manager works to garner relationships between FMH, Frederick County Health Department, Frederick County Public Schools, the Chamber and numerous health focused businesses to create a healthy community.
Way Station (residential behavioral health organization)	Scott Rose	CEO	FMH meets regularly with the Way Station Inc. to problem solve and care plan some of the most challenging and complex shared clients. The collaboration with the Way Station has resulted in improved communication across the organization, increase partnership and collaboration on share patients and the opportunity to address process/ procedural related barriers. Additionally, bringing the teams together on a regular basis has improved a variety of workflow, handoff and process related questions – all aimed at improving patient/client outcomes and ensuring individuals are appropriately connected to needed services.

Organization	Name of Key Collaborator	Title	Collaboration Description
The Coordinating Center (integrated care management for people with complex needs)	Carol Marsiglia MS,RN,CCM	Sr. Vice President, Strategic Initiatives and Partnerships	Frederick Memorial engaged with The Coordinating Center in July 2015 to provide intensive community based care management services to the highest risk and most vulnerable patient populations, including homeless individuals, ESRD patients and individuals with chronic conditions and poor health literacy. Thru the use of a health coach/advocate model The Coordinating Center has successfully engaged an estimated 280 individuals. These health coaches meet the patient in their home, the library, homeless shelter, etc. offer services and supports to increase health literacy, access services to address social determinates of health including, housing, hunger, employment, health care, etc. The patients engaged by The Coordinating Center have readmission rate of approximately 17%.
Mission of Mercy (community-based organization providing free healthcare, free dental care and free prescription medications to the uninsured, under-insured)	David Little	CFO	The Mission of Mercy provides primary care services to low and under insured individuals via a mobile health clinic model. Frederick Memorial and the Mission of Mercy entered into an MOU which provides a mechanism for hospital patients to be scheduled for follow up care, as well as ensure a warm hand off between care providers occurs. The goal of which I to increase the likelihood patients engage in follow up care as they now have a scheduled appointment versus waiting in line on the usual first come first serve service model. An estimated 160 patients have received care thru this shared patient transition of care model.

Organization	Name of Key Collaborator	Title	Collaboration Description
Capital Coordinated Medicine (provide medical service to patients with multiple and complex health issues in private homes, independent living facilities, assisted living facilities and group homes)	Amy Schiffman, MD	President	Many patients are challenged by medical or physical situations that limit their ability to access routine primary care services, thus waiting until situation exacerbate to the point of requiring a 911 call leading to emergency room visits and or hospitalization. Frederick Memorial engaged in a partnership with Capital Coordinated Medicine to provide home based primary care to Medicare beneficiaries. Capital Coordinated Medicine receives referrals from hospital discharge planners, Department of Aging, Department of Social Services and other social and health care professions with the consent of the patient. A provider from Capital Coordinated Medicine initiates in home primary care, doing so on a short or long term basis. The provider is responsible for medical management and partners with care management or other social support agencies.
Behavioral Health	Various	Various	Frederick Memorial Hospital now actively partners with professional community providers as well as peer recovery support providers. Representatives from Alcoholics Anonymous now provide AA services inside the BHU twice weekly. On-Our-Own, a local peer recovery support group for mental illness now provides their services inside the BHU weekly, in an effort to diversify the treatment and support options available to our consumers. The Frederick County Health Department, Adult Substance Abuse Services now has an embedded peer recovery support specialist who works inside the hospital with patients at all levels of need and in any location throughout the hospital (Emergency, Inpatient Medical, and Inpatient Behavioral Health). Finally, Frederick County providers from our co-owned outpatient full service psychiatric practice, Behavioral Health Partners (BHP) provide specially groups for individuals living with bipolar-spectrum disorders weekly.

Organization	Name of Key Collaborator	Title	Collaboration Description
Elderly and Vulnerable Adult Task Force	Various	Various	FMH collaborates with local EMS, law enforcement, department of social services, department of aging, and Frederick County Health Department on the Elderly and Vulnerable Adult task force – bringing key stakeholders and human service providers together to address the challenging social and medical needs of the most vulnerable adult population in the county. Working together to address individual resident needs in an effort to address immediate safety, housing, hunger, and medical needs.
Mental Health Association	Shannon Alshire	Executive Director	FMH supplies $30,000 in support to ensure operations continue in order to provide access to a crisis counselor 7 days a week. A process has been established thru which patients discharged from the hospital can be scheduled for a follow up visit to ensure ongoing support and connectivity to mental health services. An estimated 105 patients in FY 15 and the thru the first quarter of FY 16 reported they would have sought services in the emergency room if they had not had access to walk-in clinic services.

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

Yes

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

FMH personnel served as Frederick County Health Care Coalition President, Secretary, and Treasurer.

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

Yes

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Jennifer Teeter (VP, Clinical Integration and Contracting), Gloria Bamforth (Director of Operations, CorpOHS) and Jenny Morgan (Manager, Employee Health) serve as officers of the Frederick County Health Care Coalition and regularly attend meetings.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, 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.

Table III – Initiative 1 – Care Transitions

a) 1. Identified Need	To provide intensive care management services to individuals with chronic conditions, no/limited access to care, and or those challenged to meet social determinants of health in order to reduce unnecessary hospital utilization and improve population health. Intensive community based care management provides infrastructure to support some of the most chronically ill, fragile and social complex patient populations. One of the main reasons for hospital re-admission is the fact that discharged patients have historically received little or no guidance relative to follow-up visits with physicians, filling and taking their prescribed medications, making appointments for rehabilitation, etc. Patients identified as high ED utilizers, and/or patients returning to the hospital within 30 days of discharge, meet with either an RN or Social Work case management in an effort to understand why a patient has returned after discharge and or has frequent visits to the emergency room. The results overwhelmingly supported the need to establish a plan for access to; medications, follow up physician appointments, transportation, housing, employment and other medical/social support in the community, including but not limited to state and federal entitlement programs
a. 2. Was this identified through CHNA process?	Yes
b) Hospital Initiative	Care Transitions
c) Total Number of People Within the Target Population	Seek to identify those with chronic conditions and overutilization of hospital services.
d) Total Number of People Reached by the Initiative Within the Target Population	7,445
e) Primary Objective of the Initiative	In FY 2017, 7,445 patients received home/community based interventions from our Care Transitions team, which includes registered nurses, social workers, pharmacists, dietitian, nurse practitioner and a coordinator. Through the work of our Care Transitions team patients receive more focused disease management education and intensive transition planning. The services often include financial support for medications, transportation and various other medical and social support services in the community. The team puts forth a lot of time and energy working with patients identified as high risk. A comprehensive post discharge plan is created and each is individualized to meet the specific patient's needs. The patient's caregiver is also involved in this process. Referrals to the team are received from the hospital as well as community based providers. More and more emphasis is being placed on identification of high risk individuals in the community to prevent a hospitalization from taking place. Collaborative partnerships have established with the community to

	ensure services are provided and appropriate charges covered by the Care Transitions Program	
f) Single or Multi-Year Initiative Time Period	Multi-Year	
g) Key Collaborators in Delivery of the Initiative	Walgreens, Whitesell's pharmacy, Department of Aging, Frederick County Health Department, assisted living facilities, local skilled nursing facilities, community primary care and specialty practices, FMH Immediate Care, Hospice of Frederick County, Homecare, Right at Home, DaVita Dialysis Centers, Way Station Inc., Mental Health Association, Frederick Community Action Agency, Amada,	
h) Impact/Outcome of Hospital Initiative?	FMH's HSCRC measured readmission rate stays relatively consistent between 9.5 and 10.5%, which is among the lowest in the state.	
i) Evaluation of Outcomes	The effectiveness of the interventions is evaluated through our readmission and ED recidivism rates, which year over year continue to improve.	
j) Continuation of Initiative	Care Transitions is an ongoing initiative with no end date planned.	
k) Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost In FY17 the entire cost of the program, including salaries was $2,387,142n $174,253 was spent providing post-acute services to meet individual patient needs.	B. Direct Offsetting Revenue from Restricted Grants n/a

Table III – Initiative 2 – Access to Care

a) 1. Identified Need 2. Was this identified through CHNA process?	There is an underserved population in Frederick County that is lacking in health care coverage. Up to 44% of this population does not have health care coverage and 25% are Spanish speaking. Yes	
b) Hospital Initiative	Partner with the Asian American Center of Frederick on the Frederick County Health Fair.	
c) Total Number of People Within the Target Population	8,000+	
d) Total Number of People Reached by the Initiative Within the Target Population	811	
e) Primary Objective of the Initiative	FMH partnered in 2015, 2016, and 2017 with The Asian American Center of Frederick to offer health education, vaccination, and screenings to the residents of Frederick County and surrounding areas, with emphasis on underserved and underinsured populations who may not have access to care. FMH offered flu vaccinations, glucose/cholesterol screenings, bone density screenings, women's health education, pediatric asthma and chronic disease prevention education and counseling, as well community resource access. This Care Transitions/CARE Clinic team was an integral part of the health fair. When participants were identified as having a medical concern or an abnormal screening result they were directed to the CT/CARE clinic team. The team then arranged follow up services for the patient at the CARE clinic for further evaluation and management, education, and connection to needed community resources.	
f) Single or Multi-Year Initiative Time Period	Multi-year	
g) Key Collaborators in Delivery of the Initiative	Asian American Center of Frederick, Monocacy Health Partners, CorpOHS	
h) Impact/Outcome of Hospital Initiative?	At the FY 17 health fair we provided 335 adult flu vaccines, 293 Cholesterol/Glucose screenings, 70 bone density screenings, and 480audiology screenings. Healthcare literature was given to approximately 700 participants. 190 referrals were given related to abnormal screening results.	
i) Evaluation of Outcomes	We measure our results based on the number of vaccines and screenings provided, as well as the follow up of patients who are referred for ongoing care.	
j) Continuation of Initiative	Yes, we plan to continue this 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 $ 42,837	B. Direct Offsetting Revenue from Restricted Grants n/a

Table III – Initiative 3 – Heart Failure/COPD

a) 1. Identified Need	Currently more than 1 in 3 adults (81.1 million) live with 1 or more types of cardiovascular disease. In addition to being the first and third leading causes of death, heart disease and stroke result in serious illness and disability, decreased quality of life, and hundreds of billions of dollars in economic loss every year. The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status: • Prevalence of risk factors • Access to treatment • Appropriate and timely treatment • Treatment outcomes • Mortality Heart Failure and COPD patients sometimes need assistance with the transition between their hospital stay and their follow-up with their health care provider.
2. Was this identified through CHNA process?	Yes
b) Hospital Initiative	Heart Failure/COPD
c) Total Number of People Within the Target Population	10,296
d) Total Number of People Reached by the Initiative Within the Target Population	606
e) Primary Objective of the Initiative	The FMH CARE Clinic began in February 2016 with the focus on high risk patients diagnosed with heart failure or COPD who need assistance transitioning between their hospital stay and follow-up with their health care provider. The clinic's focus has expanded to include other chronic illnesses as well in addition to individuals who lack access to care. The clinic offers a multidisciplinary team approach to patient care with a nurse practitioner, social worker, registered nurse, medical assistant, behavioral health specialist and pharmacist. The goal of this team is to help people better navigate their complex health needs, provide education and reinforce their medical treatment plan. The clinic is not a substitute for a primary care doctor or specialist. Rather, it is a resource to help transition the patient until they are able to see their provider for follow up care or provide services in addition to what their primary care or specialist provide. In September 2017 the clinic expanded its operations to five days a week. This will allow the clinic's capacity to serve the community grow in FY 18.
f) Single or Multi-Year Initiative Time	Multi-year

	Period	
g)	Key Collaborators in Delivery of the Initiative	The clinic is collaboration of many departments within the hospital as well as community providers and partners.
h)	Impact/Outcome of Hospital Initiative?	Our goal is to reduce unnecessary hospital utilization and help our patients successfully manage their health in the community.
i)	Evaluation of Outcomes	Analysis has demonstrated that patients who are high utilizers of hospital services, they are 10% less likely to readmit to the hospital if they receive post-discharge follow up at the CARE clinic.
k)	Continuation of Initiative	Yes, this is an ongoing program.

l) Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative In FY17 the entire cost of the program was $97,105 $1,685 was spent providing post-acute services to meet individual patient needs.	B. Direct Offsetting Revenue from Restricted Grants n/a

Table III – Initiative 4 – Lay Health Educators

a) 1. Identified Need	FMH established the Bridges Lay Health Educator (LHE) Program in response to feedback obtained during the 2013 Community Health Needs Assessment indicating that ethnic and cultural minorities, limited English proficient, senior citizens and people in isolated geographic areas would benefit from having locally known, trusted health advocates who could provide basic information and improve health literacy, access to resources and information, access to care. Yes. The CHNA is also used to identify the most urgent and relevant need for outreach education, target areas of the county that are more remote and in need of health education and improved health literacy.
2. Was this identified through CHNA process?	Subjects, which were selected based on the Community Health Needs Assessment, Focus Groups with target communities, clinical staff, hospital data and patient feedback pointed to these topics. They change based on the CHNA and/or the advice of our CAP and LHE's, as well as the advice of our County Health Officer, Hospital trends and public health risks: • Advanced Directives • Cancer • COPD • Dementia/Alzheimer • Depression/Mental Health/Addiction • Diabetes • EMMI Patient Education System • Heart Disease • HIV/STD's/HPV • Hospice Care/End of Life • Managing Change • Medication Management • Men's/Women's Health • Navigating the Healthcare System • Nutrition • Oral Health • Obstructive Sleep Apnea • Stroke • Talking to Your Doctor Instructors are drawn from the hospital's physicians, other professional staff, nursing educators, advocacy groups and community physicians. The exchange of learning at this level is important – what the participants talk about in class, especially about barriers to access, their experiences in doctors' offices, and their comfort level with the communication between physician and patient leave a lasting impression on everyone including the "expert." Each LHE leaves with binders, totes and electronic versions of the materials that they can edit to match the audiences culture, beliefs, language, gender or tolerance for sensitive discussions and graphic images.
b) Hospital Initiative	Bridges Lay Health Educators
c) Total Number of People Within	60,000 or more county wide

the Target Population	
d) Total Number of People Reached by the Initiative Within the Target Population	61 LHE graduates have completed the program so far, **representing 32 unique Faith Based and Community Organizations** who are now working within their specific communities, reaching an exponential number of people. Reporting by the LHE's is inconsistent and unreliable, and efforts are underway to create a better method of collecting quantitative data. Their reach has as yet been undetermined, although anecdotal efforts are noted under outcomes and impact.
e) Primary Objective of the Initiative	To connect into existing networks and build partnerships that help improve health literacy and access to care, extend the reach of educational and chronic disease programs, and increase large scale collaborations to close the gap on health disparities, decrease the incidence of chronic disease and preventable illness, and build a healthier Frederick.
f) Single or Multi-Year Initiative Time Period	Multi-year
g) Key Collaborators in Delivery of the Initiative	Frederick Memorial Hospital's Lay Health Educator (LHE) Program is designed to evolve as it prepares volunteers from multicultural communities to start or energize health programs in the places that they live, work, worship and gather. There is no charge to the organization or volunteer. Key Collaborators in the delivery of the program include: Frederick Memorial Hospital Bridges Steering Committee: • Heather Kirby, VP of Integrated Care Delivery • Rachel Mandel, AVP of Medical Affairs • Janet Harding, Director of Cultural Awareness and Inclusion • Rev. Kay Myers, Director of Pastoral Care • Sue Eyler, Bridges Program Coordinator Each Steering Committee Member also leads a subcommittee: Steering Committee, Education/Curriculum, Community Advisory Partnership **Community Advisory Partnership**: A group of community leaders, program graduates, hospital leaders, and faith group leaders from a variety of churches. Organizations represented include: • Carl Gregg, Pastor, Unitarian Universalist Congregation • David Liddle, Exec. Director, Mission of Mercy • Albert Lane, Pastor, St. Paul's Church of Utica • Eva Ellis, Parish Nurse and Health Ministry Leader, Jackson Chapel UME • Julio Menocal, M.D., Community Physician/ Underserved & LEP populations • Rev. Dr. Roger Wilmer, Pastor of AME Church and past Hospital Board Member • Cathie Duncan, LHE Grad, Health Ministry, Evangelical Reformed United Church of Christ • Kristen Fletcher, FMH Leader and Community Benefits Co-Chair • Donald Moody, Crawthall Leader, Pastor • Sylvie Mirindi, St. Catherine Drexel Catholic Church - African Congregation • Barbara Brookmyer, Frederick County Health Officer • Jessica Dayal, Asian American Center of Frederick • Dr. Randy Culpepper, Deputy Health Officer, Frederick County HD

- Faith Based Organizations and Community Groups: Participants are recommended through Faith Based Organizations or other cultural and community organizations to take the 10 week, 30 hour course. Once they have supported the LHE through the program, the organizations earn a special designation of "Partner" and receive preferred status for requests for health education support, health fair support, and guided navigation for members of the group. Through this network of partners, we are able to distribute health bulletins, updates to the CHNA, updated educational resources, selected content from various state and federal health resources such as Office of Minority Health, Frederick County's Health Officer and much more.

- Elizabeth Chung and the Asian American Center of Frederick partner with us in a variety of ways. A Minority Outreach and Technical Assistance center for Frederick County, the AACF runs programs to improve access to healthcare, affordable care for uninsured and underinsured people who need it, and most relevant, partners with the hospital to identify and prepare paid Community Health Workers who are deployed to assist with some of the Hospital's patients who are frequently readmitted or who encounter multiple social determinants that inhibit their path to wellness.

- Frederick County Deaf Seniors: Two Lay Health Educators came from this County agency, and are teachers themselves, They completed the program and now partner with us to deliver health education and support to the Deaf community at meetings and at large.

Frederick County Health Coalition and Frederick County Health Department:

- The County's Health Officer serves as a member of the CAP and suggests larger scale collaborative efforts to consider, as well as smaller, more focused efforts to reach isolated and underserved individuals.
    - One of the activities we encourage LHE's to become involved in is the Local Health Improvement Process, which starts with the CHNA. The LHE's have been very engaged in organizing focus groups, suggesting places to do surveys, and communicating the results.
- Alzheimers Foundation of Frederick County provides a facilitator to teach the module on Alzheimers and Dementia; Lay Health Educators regularly contact FRHS for resources and speakers. Additionally, we regularly receive calls about resources for families and caretakers. Because of this new relationship, we have a direct line to an organization that will provide immediate support and resources to families and patient with Alzheimers.

- RSVP (Retired Seniors Volunteer Program) provides support for LHE's over the age of 55 who register with their organization, including reimbursement of mileage and other costs associated with health outreach. Many of our LHE's registered with RSVP and the organization sends people to the course. The program is formally

	associated with the Asian American Center of Frederick, which provides them with a wealth of health and quality of life related volunteer assignments such as transportation to and from doctor appointments, grocery shopping and prescription pickup – among others. • Facilitators and subject matter experts from FMH and other organizations partnered with us to create the curriculum, including physicians, nurses, Clinical Nurse Specialists and NP's. • Frederick County Department of Aging and the Ombudsman's Office provide workshops for LHE's on Elder Abuse and Elder Support Services . This enabled LHE's and their sponsoring organizations increased ability to identify, report and act on suspected Senior Abuse or Neglect. • FMH's Forensic Nurse Examiner provides workshops on Human Trafficking and Intimate Partner Violence which provided an inroad to many of our vulnerable immigrant populations who were reportedly hesitant to report activities because of fear that they might be torn away from their families. This places additional eyes and ears around the community who are looking out for their neighbors and family members. • Frederick and Thurmont Ministeriums: These groups of faith leaders from the geographic region have served as resources and communications venues to members. As a result of their support, we have not had to work hard to identify potential students. Word of mouth and a knowledge that health literacy was important to their members has allowed us to fill and overfill classes.
h) Impact/Outcome of Hospital Initiative?	As of December 31, 2016, 61 people had completed the program and community educational sessions are growing in formal, informal, and one on one formats. Each "Boys Night Out" now features discussion on men's health issues, and the Deaf Seniors group for Frederick County now receives their health education in American Sign Language. More families are holding "The Conversation" and tackling tough topics because of a chance mention of it in the monthly bulletin. Other community partnerships have developed are or are developing with the following organizations and have been recognized as Bridges Partners through their Lay Health Educators. Special programs or relationships are noted next to their name or have been included above. • Asbury United Methodist Church: Oldest African American Church in Frederick; Two graduates actively conduct health education and wellness programs. One is leading a Senior evidence based exercise program called Stepping On at the Senior Center and is a member of the Patient Family Centered Care committee at FMH. • Beth Shalom Congregation

	• Bethel Worship Center • Braddock Lutheran Church • Catoctin Episcopal Parish - Harriet Chapel: 3 graduates in the Brunswick Area, one of the targeted areas of our county, high incidence of chronic disease, especially COPD. • Catoctin View Seventh-day Adventist • Centro Hispano: Graduate developed a weekly Spanish Speaking Seniors Program and at least twice per month, a speaker provides them with health information, resources, and technical assistance to improve access to care and health literacy, in their language. FMH instructors assist or facilitate some of the programs and physicians also participate. • Deaf Community-at-large: Deaf Programs instructor at McDaniel College has used program to start a men's meeting group. • Diamond Needles • Evangelical Lutheran Church of Frederick: Pastor took the LHE program out of concern for suffering congregants and seniors within his community, wishing to establish a health ministry or health program within the church. • Evangelical Reformed United Church of Christ: Open and affirming church welcomes all people; LHE creates displays and poster boards for service attendees and puts articles in the newsletters; conducts periodic seminars for members and families • Faith Striders: Group focused on fundraising and outreach surrounding Breast Cancer, also supports Women's Health initiatives, and is especially connected to the multiethnic communities of Frederick. • Family Service Foundation of Frederick: LHE works with the organization On Our Own of Maryland and has been able to establish networks and relationships across Frederick County because of her participation in Bridges. • First Missionary Baptist Church • Frederick Church of the Brethren: Host site for Mission of Mercy, which provides direct health services to a high number of immigrant, LEP and indigent people in Frederick. LHE interprets for Spanish Speaking patients and now connects them to FRHS and is able to explain some of the basic health information they need to make decisions using her Bridges educational content. • Frederick County Public Library: Frederick County Public Library sent their reference desk librarian to Bridges LHE Program and has since regularly scheduled workshops at the library for the general public. • Frederick Deaf Seniors Group, Deaf Seniors group for Frederick County now receives their health education in American Sign Language. More families are holding "The Conversation" and tackling tough topics because of a chance mention of it in the monthly bulletin. • Frederick Seventh-day Adventist, LHE created an education program for their school children and also began to hold health screenings at the County Fair. • Good News Presbyterian • Grace Tabernacle Church

	• Islamic Society of Frederick • Jackson Chapel United Methodist Church: Ongoing health ministry led by Parish Nurse and Bridges Graduate; has sent additional members who work with Senior Citizens and other capacities. Serves on our CAP committee. • Kingdom Gospel Mission Frederick: Former physician from Cameroon and her husband emigrated to this country and have set up ministry to other Africans in Frederick County. She is also an Interpreter and works with patients at the hospital. Husband is the Pastor and works with Developmentally Disabled and uses the information to understand more about the health challenges and needs of this population, as well as those of his congregants. • Marvin Chapel/Prospect UMC • Middletown United Methodist • Mission of Mercy • Montgomery United Methodist • Peace in Christ Lutheran • Quinn Chapel AME Church • RSVP • St. James AME Church: Pastor Debra Plummer has brought along 4 members of her congregation's health ministry to ensure they have the health literacy tools required to offer information and support to her predominantly older, African American population. • St. Paul's Lutheran: Pastor Bert Lane is focused on an aging senior population and the issues faced by families who are caretaking for loved ones with a host of age related diseases. He is an active member of the CAP and head of one of the Ministeriums. His graduates prepare articles to go in the paper newsletter that is distributed to all members, avidly read, and discussed. • Unitarian Universalist Church of Frederick: Pastor Carl Gregg has brought the youth perspective to Bridges and serves on the CAP. They have a broad cross section of members and use their website to share information. He has sent one LHE to the program – and is very focused on active engagement with the congregation so they are developing their strategy.
i) Evaluation of Outcomes	1. (Short Term) We track applications, enrollments and graduation rates an initial evaluation goal of 4.75 out of 5 has been exceeded. 2. Evaluation of each module and the facilitators are conducted each week with a goal of 4.75 out of 5 for each cohort. In all cohorts, that has been exceeded. 3. We use the CHNA to identify areas in which to focus outreach efforts and define whether or not we are successful and filling those gaps. 4. Lay Health Educators received preferred status in our Community Benefits Programs as long as it meets our criteria. One result is that the request for our experts has increased, especially in the topics of Advanced Care Planning, Diabetes and Nutrition, and Mental Health and Substance Use Disorders. 5. Mid term: We wish to see more demographic information from LHE activities as well as any changes being measured, such as BP screenings, cholesterol or other measurable item that demonstrates

	health. Some are hesitant to collect this data and the specifics needed are lacking. 6. One metric we collect is the number of LHE's that also complete the Community Health Worker certification program and then are hired for paid positions. 7. We have been able to provide at least 4 people to standing hospital committees representing the Hispanic, African American, and Senior Populations. 8. Number of LHE's who graduate from the Community Health Worker certificate program; and are hired to work with patients in the community. a. This program intersects with the Community Health Worker Program which provides a paid role to trusted members of underserved and uninsured populations, especially those who are seniors and non-English speaking. Data is being collected for that program, but not attributed to this program. b. Shared Village is being used to collect data for that program and we intend to create a link to hospital and CHW's through that portal. LHE's are considering an easier web based tracking tool for LHE's to use to document their activity. This tool is currently being used by CHW's and features an easy to use interface that collects information and details and then outputs them in aggregate reports. This is the next step for Bridges. c. This should help us to achieve a long term goal: Establish a direct correlation between exposure to a LHE action and improved health within the community. 9. Currently, keeping communication open is our best form of evaluation. The program's coordinator stays in touch with all graduates and receives updates about events, success stories and photographs of LHE's in action. Materials, electronic resources, navigation questions, and referrals also occur via the Coordinator and the Steering Committee Members. 10. To keep track of activity from which metrics will develop, the program's coordinator regularly receives updates and phone calls about new ventures or the need for hospital resources. 11. Metrics are being tested and defined, but evaluations and feedback from the LHE's and Organizations has been extremely positive. New topics are added and the curriculum is adjusted after each cohort evaluates the content. 12. We held two continuing education programs in 2017 with about 50% attendance of graduates. They expand their networks, work together on new ideas, and return for a "reunion" of sorts. Attendance is tracked and recorded.	
j) Continuation of Initiative	FMH is committed to continuing this initiative in the coming years. In 2017 and 2018, additional efforts will be made to activate and coordinate the activities of Lay Health Educators, providing specific, evidence based training and delivering programs as part of Collective Impact initiatives.	
k) Total Cost of Initiative for Current Fiscal Year and What	A. Total Cost of Initiative	B. Direct Offsetting Revenue from Restricted Grants

Amount is from Restricted Grants/Direct Offsetting Revenue	$43,000	

Table III – Initiative 5 – Stroke

a) 1. Identified Need	The Maryland Institute of Emergency Medical Service Systems, (MIEMSS) has designated FMH as a Primary Stroke Center and a multiple quality achievement award hospital since 2009. The Chest Center is a 24/7 observation unit that evaluates low-risk chest pain patients in accordance with the Society of Cardiovascular Patient Care (SCPC), American College of Cardiology (ACC), and American Heart Association (AHA) guidelines. The FMH Chest Pain Center has been recognized as an accredited Chest Pain Center with PCI since 2012 from the Society of Cardiovascular Patient Care, their highest honor. Frederick County residents no longer have to be transported to neighboring facilities to receive acute stroke care, nor to have their low-risk chest pain evaluated. A program with the highest level of preparedness and state recognition is now available in Frederick County at Frederick Memorial Hospital. The FMH Stroke Program provides stroke training to Frederick County Emergency Medical Services to ensure that first-responders are aware of stroke signs and symptoms and also the most current treatments. The cooperation between these two entities enables the patient to have the best care possible at every stage of treatment. Yes
2. Was this identified through CHNA process?	
b) Hospital Initiative	Stroke Workshops, stroke support groups
c) Total Number of People Within the Target Population	30,000
d) Total Number of People Reached by the Initiative Within the Target Population	372
e) Primary Objective of the Initiative	The FMH Stroke Program offers free stroke workshops to the citizens of Frederick County. The stroke workshops increase awareness and provide details on stroke care and prevention. Attendees are given information on risk factors and steps they can take right away to change their own risk for stroke. At the conclusion of the workshop, attendees are able to name and identify stroke signs and symptoms and know what to do in case they, or someone they know, are having a stroke. The Stroke Survivor Group is a monthly meeting to join stroke survivors and caretakers focusing on issues; Such as emotional support, social support, and practical advice of coping with daily living.
f) Single or Multi-Year Initiative Time Period	Multi Year
g) Key Collaborators in Delivery of the Initiative	Frederick County Health Department, Frederick Co. Community Action Agency. American Heart Association, Centro Hispano, Asian American Center of Frederick, Various Long term/Sub-acute facilities in Frederick, EMS, Frederick Keys

h) Impact/Outcome of Hospital Initiative?	Because the onset of coronary artery disease, vascular disease and the predilection to atherosclerosis all have a genetic component, it is difficult to ascertain what impact, if any, a focused awareness campaign about the signs and symptoms of stroke may have on a given population. An immediate evaluation tool was used to assess whether the attendees learned and retained some of the pertinent information presented in the workshops.	
i) Evaluation of Outcomes	At the conclusion of the workshops, approximately 100 percent of the attendees are able to name and identify stroke signs and symptoms and know what to do in case they, or someone they know are having a stroke	
j) Continuation of Initiative	Yes, this initiative will continue. Efforts will focus even more specifically in those underserved communities in which the incidence of cardiovascular disease is highest in Frederick County.	
k) Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1,500 ($500 donated from Genentech)	B. Direct Offsetting Revenue from Restricted Grants

Table III – Initiative 6 – Prenatal Clinic

a) 1. Identified Need 2. Was this identified through CHNA process?	The FMH Auxiliary Prenatal Center (PNC) provides prenatal care for women with no insurance - or with Medical Assistance who are unable to obtain care from private practice providers. Many of the women in the Prenatal Center are high-risk patients, and present with medical conditions for which they may be unaware, that pose significant risk to full-term healthy fetal development. Yes
b) Hospital Initiative	The FMH Prenatal Center for Frederick County residents who plan to deliver at FMH.
c) Total Number of People Within the Target Population	According to the U.S. Census Bureau, 4.8 percent of Frederick County's roughly 233,000 residents were living below the poverty level between 2006 and 2010. The exact number needing prenatal care is not known.
d) Total Number of People Reached by the Initiative Within the Target Population	276 Newly enrolled Maternity Patients and 486 Total Visits in FY17
e) Primary Objective of the Initiative	The implementation of early prenatal care in the PNC allows uninsured or underinsured patients who live in Frederick County to receive early interventions and clinical care for the pregnancy and any secondary diagnoses to avert complications and ensure the healthiest possible outcomes for the mother and baby. Patients in the FMH Auxiliary Prenatal Center are self-referred or referred by Frederick County Health Department (FCHD), Frederick County Mission of Mercy, private physicians, or other community groups. Our PNC Mother-Baby care includes Transformational Quality Improvements: ▪ 39 Week Elective Induction Hard Stop ▪ High Risk Case Reviews ▪ Hemorrhage Risk Assessment & Protocol ▪ Improved PPROM Order set ▪ Intrauterine Resuscitation Protocol ▪ Delayed Cord Clamping ▪ Skin-to-Skin in OB OR & LDR ▪ Complete Couplet Care ▪ Newborn Hypoglycemia Protocol ▪ Breastfeeding Protocol ▪ Neonatal Abstinence Syndrome ▪ Nutrition & Donor Breast Milk
f) Single or Multi-Year Initiative Time Period	Multi year
g) Key Collaborators in Delivery of the Initiative	The FMH Auxiliary Prenatal Center staff members consist of certified nurse midwives, a Spanish certified interpreter, two bilingual department assistants who serve as schedulers and registrars, and a new Clinical Nursing Assistant; who assist the providers in the evaluation and management of our patients. Our new OBGYN Hospitalists serve as our obstetricians and provide oversight of the clinical care provided under the direction of Dr Albert C. Simmonds MD.

	In addition, FMH contracts with Mid Maryland Perinatology Associates and patients are referred for Maternal-Fetal-Medicine (MFM) consults if they have high risk factors; fees for these consultants' services are paid by FMH PNC. The Range of MFM services include: ▪ Perinatal Diagnostic Ultrasound ▪ Ante-partum Testing ▪ Diabetic Consultation and Management ▪ Genetic Counseling Services ▪ Management of complex maternal and fetal co-morbidities ▪ Plan of care during initial and follow-up consultations ▪ Communicate acuity of issues affecting maternal/fetus-neonate at the time of delivery ▪ Advanced preparation to ensure the best potential outcome for mother/baby dyad
h) Impact/Outcome of Hospital Initiative?	PNC quality outcome metrics are reported to The Frederick County Office for Children and Families, Health-E Kids Program.
i) Evaluation of Outcomes	Overall for all races, Frederick County has met the Healthy People 2020 Goal & Maryland SHIP 2017 Goal. The percentage of pregnant women in Frederick County who have received early prenatal care remains consistently higher than the Maryland percentage. As a result of our prenatal care in the PNC our newborns are: ▪ 3 x Less Likely to Be Born at Low Birth Weight ▪ 5 x Less likely to Die ▪ Less Likely to be Exposed to Nicotine, Alcohol , & Illegal Drugs During Pregnancy ▪ Less Likely to be Born with Unanticipated Complications & Health Concerns Frederick County's infant mortality rate decreased from 4.8 deaths per 1,000 live births in 2013 to 3.6 in 2014, and remains consistently lower than the Maryland infant mortality rate. The percentage of preterm births in Frederick County decreased from 9.7% in 2013 to 9.2% in 2014, and remains lower than the Maryland percentage.
Please see table on next page for Outcome Criteria and Data for FY17	

Service Quantity (***Please indicate the quarter total and cumulative total in each cell, when applicable)*** ***(For the quarter =(Q) and cumulative = (C)***	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
# of pregnant women receiving prenatal care:	***Q = 111_***	***Q = 130*** ***C = 241***	***Q = 110*** ***C = 351***	***Q = 135*** ***C = 486***
# of newly enrolled pregnant women receiving prenatal care:	***Q =___70_***	***Q = 68*** ***C = 138***	***Q = 70*** ***C = 208***	***Q = 68*** ***C = 276***
# of prenatal care visits	***Q= ___567***	***Q = 601*** ***C = 1168***	***Q = 659*** ***C = 1827***	***Q = 675*** ***C = 1334***
Service Quality	**1st Quarter (Due Oct. 14th)**	**2nd Quarter (Due Jan. 13th)**	**3rd Quarter (Due April 14th)**	**4th Quarter (Due July 14th)**
# and % of pregnant women indicating satisfaction with the prenatal services they received this quarter	***15*** ***98.33%***	***13*** ***96.67 %***	***15*** ***95 %***	***44*** ***80%***
Impact	**1st Quarter (Due Oct. 14th)**	**2nd Quarter (Due Jan. 13th)**	**3rd Quarter (Due April 14th)**	**4th Quarter (Due July 14th)**
# and % of pregnant women receiving at least 8 prenatal care visits through FMH/Health-E Kids who deliver babies of healthy birth weight (2500 grams or above) this quarter.	***47*** ***96 %***	***39*** ***97.5%***	***45*** ***92%***	***38*** ***97%***

j) Continuation of Initiative	Ongoing funding for PNC will be from FMH. Identified Gap is a lack of GYN care options for this same population of female patients. This extended care option for GYN will be explored next fiscal year.

k) Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $216,899	B. Direct Offsetting Revenue from Restricted Grants $10,816 grant from Frederick County Healthy Kids, Office of Families and Children

See attachment B for a complete list of seminars and community events held in Fiscal Year 2017.

1. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

   Mental Health

   Today an estimated 22.1% of adults in America - about one in five – suffer from a diagnosable mental disorder in any given year. In addition, four of the ten leading causes of disability are mental disorders. While Frederick County's rate of emergency department visits related to behavioral health per 100,000 population is less than the Maryland Healthy Communities target of 5,028, it remains a significant – and growing - problem in the county. The Frederick County figure for 2010 was 3,725 per 100,000 population. In 2011 the figure grew to 4,422. That is an increase of 84% per 100,000 population.

   Frederick Memorial Hospital provides behavioral health care to patients who come to the hospital for help. Because we are hospital-based, we offer a full continuum of services. Our highly specialized team consists of board certified psychiatrists, clinical nurses, mental health associates, clinical nurse specialists, physical therapists, occupational therapists and clinical social workers.

   Addressing the community's behavioral health needs is an important and urgently needed facet of care that is missing in Frederick County. While FMH recognizes this issue must be addressed moving forward, the organization will not be able to respond in the near term because of facility constraints and the lack of the infrastructure necessary to sustain the kinds of programs that would make an impact in this area. Until we are given permission by the HSCRC to expand inpatient bed capacity, and the economic environment is such that funds will be available for the necessary construction, FMH will continue to participate in the County's ongoing needs assessment process, and support with in-kind services and dollars those agencies better positioned to immediately manage the near crisis conditions our community is currently experiencing.

2. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?

Our Community Health Workers, Lay Health Educations, Care Transitions team and CARE Clinic all contribute to providing better access to care and increasing health literacy, especially for the vulnerable populations.

Our work with the Frederick County Health Care Coalition includes the following initiatives:

- **Access to Care --To expand community awareness about existing mental health and substance misuse disorders treatment resources in Frederick County while in parallel reducing stigma associated with having mental health and substance misuse disorder issues. By 2018: Increase by 10% the # of lay health educators at FMH who are trained on crisis services available in Frederick County.**
- **Dental Health Home – Ensuring every adult resident of the county as an affordable dental home.**
- **Healthy Workplace – Recognize work places committed to improving employee health and well being based upon evidence-based worksite wellness guidelines derived from the CDC Worksite Health Scorecard.**
- **Low income Elderly advocacy – No elderly person in Frederick County will have an unmet health need due to lack of funding including access to: health care, transportation, housing, assisted living and nursing home care.**
- **Reduction of Deaths due to overdose and suicide – Reduce overdose death rates by 20%. Provide a seamless system of prevention, intervention, treatment and recovery services regardless of ability to pay. Decrease County suicide rates by 9.1%.**

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.

   Frederick County currently has gaps in accessibility for five specialties. Our uninsured population is impacted by the lack of Dermatologists who will accept Medicaid patients. Frederick County also has a shortage of Primary Care, Pulmonary, Neurosurgery and Adult Ear/Nose/Throat physicians, leading to limited access for all residents.

   There are numerous specialties, as well as primary care and internal medicine, where the majority of practices don't willingly accept uninsured or Medicaid HMO patients. Outside of our employed group of Orthopedic physicians, most practices do not accept uninsured patients.

   FMH bylaws state that medical staff members MUST see patients referred from the ED when they are on call.

   FMH pays for an anti-coagulation management clinic, since few Frederick county physicians provide this service.

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	FMH subsidizes Intensivists, Behavioral Health, Sleep Medicine, Laborists, Maternal Fetal Medicine, Neonatology, Interventional Radiology, Neurology and NICU providers. FMH also contractually subsidizes Pediatric Ophthalmology, Anesthesia, Emergency Physicians (both adult and peds), Interventional Cardiologists, and Observation services. There would not be enough providers for these services within the Frederick community without our contractual arrangements.
Non-Resident House Staff and Hospitalists	FMH subsidizes Hospitalists to meet the needs of our patients. There are not enough primary care providers in Frederick to accommodate all inpatient needs. Also, most community PCP physicians do not maintain their hospital privileges and therefore cannot care for their patients while in the hospital.
Coverage of Emergency Department Call	FMH contracts with the following specialties to provide coverage on a 24/7 basis. • Anesthesiology • Bariatric • Cardiology • ENT • Gastroenterology • General Dentistry • Hematology/Oncology • Interventional Cardiologists • Nephrology • Neurology • Ophthalmology • Oral/Maxillo/Facial • Orthopedics • Pediatrics • Plastic Surgery • Pulmonary Medicine • Thoracic • Urology • Vascular Surgery • Neuro Surgeon

Category of Subsidy	Explanation of Need for Service
Physician Provision of Financial Assistance	Monocacy Health Partners (MHP) is a division of Frederick Regional Health System and includes primary and specialty care providers in the community. MHP provides financial assistance to patients and FMH subsidizes the financial shortfall this creates for the practices.
Physician Recruitment to Meet Community Need	MHP has actively recruited Endocrinology, Family Medicine, Internal Medicine, Oncology, Orthopedics, Urology and General Surgery to meet the provider shortage in the community. FMH has paid for the cost of recruiting these physicians.
Dental Clinic	Due to the growing need for adult dental care, MHP has a Dental Clinic to serve under and uninsured adults in Frederick County. The Dental Clinic is partially funded by grants and the remainder of the budget is paid for by FMH.

VI. 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;
      - 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).

APPENDIX I

Description of Financial Assistance Policy

Appendix I - Description of Financial Assistance Policy

FMH reviews the Financial Assistance Policy (FAP) and the communication methodology we employ on a regular basis to make sure our patients have easy access to this information in a variety of formats and that it is culturally and linguistically sensitive.

We review the FAP to make sure the reading comprehension level is appropriate for our audience and we provide English and Spanish versions to meet the needs of our CBSA. We have services available to provide any other languages when needed.

The FAP is shown on our website (following this page) and is offered to patients as part of the intake process at time of registration in the hospital and in the emergency department. Our billing statements reference our Financial Assistance Policy and include the URL for the online version. The billing statements are being updated during FY 17 to include detailed explanation of the FAP.

FMH provides assistance to our patients who need to apply for government benefits when appropriate. Most common examples are "self-pay" Inpatients who admit through the Emergency Department and patients who come to our Prenatal Clinic. We have a Department of Social Services Representative onsite at our Prenatal Clinic to work directly with the patients.

All patients receive the Patient Information Sheet (Appendix IV), available in English and Spanish, which includes information about Financial Assistance.

The following information about Financial Assistance can be found on our website at:

http://www.fmh.org/About/Billing/Financial-Assistance.aspx

Financial Assistance

Patients' Rights

Frederick Memorial Hospital will work with their uninsured patients to gain an understanding of each patient's financial resources.

- Those patients that meet the criteria of Frederick Memorial Hospital's financial assistance policy may receive assistance from Frederick Memorial Hospital in paying their bill.
- Frederick Memorial Hospital will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have been wrongly referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

Frederick Memorial Hospital believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Pay the hospital bill in a timely manner if they have the ability to pay.
- Contact the hospital immediately if the patient cannot afford to pay the bill in full and seek assistance in resolving their outstanding balance.
- Provide complete and accurate insurance & financial information.
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us immediately at the number listed below of any changes in circumstances.

Contacts:

Call 240-566-3055 with questions concerning:

- Your hospital bill
- Your rights and obligations with regards to your hospital bill

Call 240-566-4781 with questions concerning:

- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance

Contact your local department of Social Services

1. TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

Physician charges are not included on hospitals bills and are billed separately by the physician.

Click here to download the Policy

Apply Online for Financial Assistance

Frederick Memorial Hospital has a Financial Assistance Program available for patients who find that they are unable to pay all or part of their medical bills. This program is based on the Federal Income Guidelines of the household, assets owned by the household, and household size.

You will receive a reply within two business days of the submission of your financial assistance request. If additional information and/or documentation is required, we will contact you by phone or mail within two business days.

You will be notified in writing of the decision regarding this application within 30 days of the submission of your application. If you have any questions or concerns about your application, please contact us at 240-566-4602.

Click here to download the application I Haz click aqui para descargar la aplicación

Application is shown on following pages.

http://www.fmh.org/documents/FA_327a.pdf

FREDERICK
MEMORIAL HOSPITAL

Frederick Memorial Hospital has a Financial Assistance Program available for patients who find they are unable to pay all or part of their medical bills. This program is based on the Federal Income Guidelines of the household, assets owned by the household and household size. Please complete the entire application and return it with the required documentation to:

Frederick Memorial Hospital
Attn: Patient Accounts/Financial Assistance
400 West Seventh St
Frederick, MD 21701

Helpful Hints:

- Please make sure that you include all of the required documentation with your application to avoid any delay in processing your application.
- If you have applied for Financial Assistance in the past, you must submit new and current documentation with your application. We cannot use information from your previous application.

If additional information and/or documentation are required we will contact you by phone or by mail within two (2) business days. You will be notified in writing of the decision regarding this application within 30 days of the completed application. If you have any questions or concerns regarding your application please contact a Financial Counselor at (240) 566-4214 Monday through Friday between the hours of 7:30 am and 4:00 pm.

Sincerely,

Financial Counselor
Frederick Memorial Hospital

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number ____-____-____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment?

_____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Checklist of Information that MUST be attached to this Financial Application:

Financial Documentation

Please submit the following financial documentation to assist with processing your application. **A current income tax return is the *preferred* method for determining household income.**

_____ Current Income Tax return **form 1040** for previous calendar year (if business owner, Schedule C is required). If not returned, why? _____

Or three of the following

_____ Three current pay stubs from employer for applicant and spouse. If not returned, why?
_____

_____ Bank Statement for Check/Savings account on bank letterhead. If not returned, why?
_____

_____ Social Security, Pension and/or disability

_____ Unemployment amount received

_____ Child Support

_____ Food Stamps and any government assistance

If you have no income please provide the following

_____ Signed letter of support detailing how living expenses are being met (signed by the person providing support)

Don't forget, have you:

_____ Signed the application?

_____ Completed the application?

Please use this as a checklist so you do not forget any information that would cause your application to be denied. If you have any questions about the application and its process please call (240) 566-4214.

APPENDIX II

ACA's Healthcare Expansion Option

Appendix II - ACA's Health Care Coverage Expansion Option

Our Financial Assistance Policy did not need to change after January 1, 2014 as we were already using income based-only information. We did not include any assets and we followed (and continue to follow) federal poverty level guidelines.

We work with our patients to help them find out about eligibility for assistance and application information.

APPENDIX III

Financial Assistance Policy

Frederick Memorial Healthcare System	Policy #: FN 100
POLICIES AND PROCEDURES	
TITLE: Financial Assistance Policy	
Chapter: Finance	**Effective Date:** 1/1/11
Responsible Person: Vice-President of Finance	**Reviewed Date:** 1/1/13
	Revised Date:

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:
It is the policy of Frederick Memorial Hospital to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria.

POLICY:

FMH will publish the availability of Financial Assistance on a yearly basis in the local newspaper and will post notices of availability at appropriate intake locations. Notice of availability will also be included as part of the admission packet and will be included with patient bills. A summary of the Financial Assistance policy will be posted in Admitting, the Emergency department, key registration areas and Patient Financial Services.

PROCEDURE:

1.0 Patients shall receive financial assistance if the meet any one of following three guidelines: Financial Assistance Guidelines, Financial Hardship Guidelines, and the Social Service Program Guidelines. If a patient qualifies for more than one of the guidelines, the guideline that is most favorable to the patient will be used.

2.0 Financial Assistance Guidelines - Financial eligibility criteria will be based on gross family income of the patient and/or responsible guarantor, the family size, and the monetary assets.

2.1 Gross income refers to money wages and salaries from all sources before deductions. Income also refers to social security payments, veteran's benefits, pension plans, unemployment and worker's compensation, trust payments, alimony, public assistance, union funds, income from rent, interest and dividends or other regular support from any person living the in the home or outside of the home.

2.2 Family size is determined by each person living on the gross family income.

2.3 Monetary assets are liquid and near liquid assets such as cash, savings accounts, certificates of deposit, money market accounts, stocks, bonds, mutual funds, etc. Monetary assets exclude primary residences and retirement accounts. At a minimum, the first $20,000 of monetary assets may not be considered when determining eligibility for free or reduced cost care for Financial Assistance.

2.4 Patients will receive 100% financial assistance for incomes at 200% or less of Federal Poverty Guidelines if their monetary assets are below $20,000. If the patient/guarantor's monetary assets are above $20,000, less than 100% financial assistance may be provided. The Financial Assistance Committee will review these cases and determine the financial assistance amount.

2.5 Patients will receive partial financial assistance for incomes over 200%, but less than 300% of Federal Poverty Guidelines if their monetary assets are below $20,000. The amount of partial financial assistance a patient is to receive is outlined in Attachment A – Frederick Memorial Hospital Financial Assistance Program. If the patient/guarantor's monetary assets are above $20,000, the financial assistance provided may be less than outlined in Attachment A. The Financial Assistance Committee will review these cases and determine the financial assistance amount.

2.6 All other resources will first be applied including Medicaid Medical Assistance before the Financial Assistance adjustment will be given.

2.8 FMH may use publicly available tools to estimate patients' financial status and provide presumptive charity based on established guidelines. Presumptive charity will be provided only after all other payment avenues are exhausted.

2.9 Some persons may exceed established income levels but still qualify for Financial Assistance when additional factors are considered. These will be reviewed on a case by case basis by the Financial Assistance Committee.

2.10 Patients shall remain eligible for financial assistance when seeking subsequent care at FMH during the 12-month period beginning on the date on which financial assistance was initially received.

3.0 Financial Hardship Guidelines - Financial hardship guidelines apply when medical debt incurred by a family over a 12-month period exceeds 25% of family income, and their income is less than 500% of Federal Poverty Guidelines.

3.1 Medical debt is defined as out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by the hospital. Patients meeting the financial hardship guidelines are eligible for reduced cost care.

3.2 Patients shall remain eligible for financial hardship when seeking subsequent care at FMH during the 12-month period beginning on the date on which the reduced-cost necessary care was initially received.

3.3 At a minimum, the first $20,000 of monetary assets may not be considered when determining eligibility for free or reduced cost care for Financial Hardship.

3.4 The Financial Assistance Committee will review these cases and determine the financial assistance amount.

4.0 Social Service Program Guidelines - Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of means-tested social services programs are deemed eligible for free care, provided proof of enrollment can be verified. These programs include, but are not limited to:

a. Households with children in the free or reduced lunch program
b. Supplemental Nutritional Assistance Program (SNAP)
c. Low-income-household energy assistance program
d. Primary Adult Care Program (PAC) (until such time as inpatient benefits are added to the PAC benefit package; or
e. Women, Infants and Children (WIC)
f. Frederick Community Action Agency (FCAA)

4.1 Patients shall remain eligible for Social Service financial assistance when seeking subsequent care at FMH during the 12-month period beginning on the date on which financial assistance was initially received.

4.2 A monetary asset test will not be applied to patients who meet Social Service program guidelines.

5.0 PROCEDURES AND RESPONSIBILITIES:

5.1 During the registration/intake process, patients will be provided an information sheet that describes the hospital's financial assistance policy, patients rights and obligations with regard to hospital billing and collection under the law, how to apply for free and reduced-cost care, how to apply for Medical Assistance, and information that hospital and physician billing is separate. FMH staff will be available to work with the patient, the patient's family, and the patient's authorized representative in order to explain this information.

If the patient was unable to receive the information sheet at registration, the information sheet will be provided before discharge. The information sheet will also be provided with the hospital bill and upon request.

5.3 If a patient inquires about financial assistance or we determine the patient may qualify for financial assistance, a Maryland State Uniform Financial Assistance Application will be provided to the patient (either in person or via mail if patient is not in person).

5.4 During the application process, one or more of the following specific documents must be submitted to gain sufficient information to verify income for each employed family member:

a. Copy of payroll stub to include year to date wages.
b. Letter from federal or state agency indicating the amount of assistance received.
c. Copy of most recently filed federal income tax return.
d. List and value of monetary assets

e. If the patient does not have a payroll stub, receives no federal or state assistance, and has not filed a tax return, then the patient must provide written documentation as to their financial circumstances.

5.5 Completed applications will be forwarded to the Patient Financial Services Department for review. Applications are to be scanned into the patient's account for retention. .

5.6 An approval or denial letter will be sent directly to the patient or responsible guarantor to inform of the final disposition of the request for Financial Assistance.

5.7 Probable determination for Financial Assistance will be completed within two (2) business days.

5.8 The approval process for financial assistance is as follows:

a. Financial Assistance:

Approval levels for patients who qualify for Financial Assistance:

- < $10,000: Patient Financial Services Manager or his/her designee.
- $10,000 - $50,000: Patient Financial Services Director or his/her designee
- > $50,000: Senior VP & CFO or his/her designee.

b. Financial Hardship:

A Financial Assistance Committee will be established to review/approve patients who qualify under the Financial Hardship guidelines. The committee will include, but is not limited to, the following members: VP of Finance, Patient Access Director, PFS Director, and Director of Care Management. The committee will review each case on its merits and determine the level of financial assistance.

b. Social Service Program

The Patient Financial Services Manager or his/her designee can approve all patients who qualify for assistance under the Social Service Programs Guidelines, regardless of balance.

5.9 If a financial assistance request is denied, the patient or responsible guarantor may appeal the decision. Appeals will be reviewed for final determination as follows:

- < $10,000: Patient Financial Services Director.
- $10,000 - $50,000: Senior VP & CFO
- > $50,000: Financial Assistance Committee.

5.10 Hospital contracted vendors will be required to follow this FMH policy.

5.11 Write offs of accounts meeting the criteria will be noted as financial assistance.

5.12 Refunds will be provided for amounts collected from a cooperative patient or guarantor of a patient who was found eligible for free care within two (2) years of the date of service. Patients or guarantors deemed to be uncooperative in providing required information may have their eligible timeframe reduced to 30 days after date of hospital service.

6.0 The FMH Board of Directors shall review and approve this policy every two (2) years.

7.0 QUALITY ASSESSMENT:

1.1 The Poverty Guidelines are issued each year in the Federal Register by the department of Health and Human Services (HHS). The guidelines are a simplification of the Poverty thresholds for use for administrative purposes.

1.2 The Poverty Guidelines are available on line at: *hltp:Ifaspe.hhs.gov/povertyIindex.shtml*

1.3 Poverty guidelines are updated each year by the Census Bureau whereby thresholds are used mainly for statistical purposes and weighted for the average poverty thresholds determination.

1.4 Eligible care covered under this program is all necessary medical care provided.

DEFINITIONS:

APPENDIX IV

Patient Information Sheet

FREDERICK MEMORIAL HOSPITAL
400 West 7th Street
Frederick, MD 21701
240-566-3300

PAYMENT SERVICES FOR FMH PATIENTS

Frederick Memorial Hospital (FMH) is dedicated to providing patients with the highest quality of care and service. To assist our patients, and to comply with Maryland state law, FMH offers the following information.

HOSPITAL FINANCIAL ASSISTANCE

FMH provides emergency or urgent care to all patients regardless of their ability to pay. Under the FMH financial assistance policy, you may be entitled to receive financial assistance for 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.

FMH financial assistance eligibility is based on gross family income and family size of the patient and/or responsible person. Annual income criteria used will be 200% of the most current poverty guidelines published yearly in the Federal Register. Assets and liabilities will also be considered. Financial assistance is given in increments of 20%, 40%, 60%, 80% and 100%.

If you wish to get more information about or apply for FMH Financial Assistance, please call 240-566-4214 or download the uniform financial assistance application at: http://www.hscrc.state.md.us/consumers_uniform.cfm Financial Assistance applications are also available at all FMH registration areas.

PATIENT 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 been wrongly referred to a collection agency, you have the right to contact the FMH business office at 240-566-3950 or 1-855-360-5443.

You may be eligible for Maryland Medical Assistance. Medical Assistance is a program funded jointly by the state and federal governments and it pays the full cost of health coverage for low-income individuals who meet certain criteria. In some cases, you may have to apply and be denied for this coverage prior to being eligible for FMH financial assistance.

For more information regarding the application process for Maryland Medical Assistance, please call your local Department of Social Services by phone 1-800-332-6347; TTY:1-800-925-4434; or internet www.dhr.state.md.us. We can also help you at FMH by calling 240-566-3862.

PATIENT OBLIGATIONS

For those patients with the ability to pay, it is their obligation to pay the hospital in a timely manner. FMH 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 the patient's 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 at 240-566-3950 or 1-855-360-5443.

If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. It is the obligation of the patient to assure the hospital obtains accurate and complete information. If your financial position changes, you have an obligation to contact the FMH business office to provide updated information.

PHYSICIAN SERVICES

Physicians who care for patients at FMH during an inpatient stay bill separately and their charges are not included on your hospital billing statement.

APPENDIX V

Vision, Mission & Values

Vision, Mission & Values

Vision

Superb Quality. Superb Service. All the Time.

Mission

The mission of Frederick Memorial Hospital is to contribute to the health and well-being of area residents by providing quality healthcare in a caring, cost efficient, safe and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

Values

We believe in:

- Quality
- Responsibility
- Stewardship
- Respect & Dignity
- Empowerment
- Honesty & Integrity
- Collaboration & Teamwork

Attachment A

Maryland State Health Improvement (SHIP)

Attachment A

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

Bulleted activities are listed below each measure.

Increase life expectancy

- Follow up educational phone calls made by Nurse Navigators to increase participation in the high risk breast cancer screening and prevention program

Reduce infant mortality

- Increased number of prenatal clinic visits for non-insured/underinsured community residents

Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization

- Improve post hospital and community based care/access for individuals with a PQI/chronic condition by:
  - Expanding CARE clinic operations to increase access
  - Home based tele-monitoring services
  - Improving access for diabetes education and coordination through the Center for Diabetes and Nutrition
  - Community Health Workers targeting COPD, Heart Failure and Diabetes
  - Engaging with primary care practices in the community who have high rates of PQI patients – increasing access to community based services to prevent avoidable hospital utilization

Reduce the % of adults who are current smokers

- Pediatric Asthma Observation and Inpatients receive education on Trigger avoidance, which includes information on smoking cessation for the parent if needed

Reduce the % of youth using any kind of tobacco product

- Pediatric Asthma Observation and Inpatients receive education on Trigger avoidance, which includes information on smoking cessation if needed

Reduce the % of children who are considered obese

- April 2017 Children's Festival Participation – provided education on Pediatric Health eating

Increase the % of adults who are at a healthy weight

- Multiple Diabetes/Nutrition and Weight Loss seminars held throughout the year and across the county.

Increase the % vaccinated annually for seasonal influenza

- Screen all observation and inpatients and encourage and give flu vaccination

Increase the % of children with recommended vaccinations

- Screen all Pediatric patients for vaccination compliance and provided education and potential vaccination when needed

- Provide education a Children's Festival (April 2017)

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

- Pediatric Asthma Joint Commission Certified Designation Center of Excellence for our work with Peds Asthma (ensuring we are following best-practices, providing education).
- We are in the process of utilizing Community Health Workers to provide in home follow up for our asthma patients to reduce ED visits and hospitalizations

Reduce hospital ED visits related to mental health conditions

- Integrated Behavioral Health Specialist (to help meet growing MH needs in community; divert unnecessary ED visits)
- Partnership with FCMHA walk-in clinic to help meet growing MH needs in community; divert unnecessary ED visits

Reduce hospital ED visits related to addictions

- Peer Recovery Specialist (reducing ED visits r/t substance abuse)
- Instituted protocols to administer long-acting injectable to promote wellness

Reduce Fall-related death rate

Attachment B

Complete List of Seminars and Events

Run Date: 11/29/2017

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Program: Care Coordination								
Department: Community Outreach Program (7066)								
Frederick Pride-The Frederick Center cverdi	6/24/2017	11/27/2017	12.00	0.00	565	0	565	100
Notes: Frederick Pride Event-Advance Care Planning 6,000 persons attended. Direct contact with 100								
Health Unlimited Senior Health & Fitness cverdi	5/31/2017	11/27/2017	4.00	0.00	0	0	0	25
Notes: Educational materials for information								
FMH Advance Care Planning Committee-"Managing Life's Transitions" cverdi	4/26/2017	11/27/2017	12.00	0.00	85	0	85	15
Notes: Event At Crestwood Bldg. 5 persons completed Advance Directives during this event. 2 scheduled follow-up consultations for a later date. Guest Speaker, educational materials								
Mt. Carmet UMC-Advance Care Planning cverdi	3/4/2017	11/27/2017	4.00	0.00	226	0	226	40
Notes: Event Speaker, 2 participants provided FMH with a copy of their Advance Directive								
Totals (Program): Care Coordination			**32.00**	**0.00**	**876**	**0**	**876**	**180**
Program: Center for Diabetes and Nutrition Services								
Department: FMH Center for Nutrition & Diabetes (8622)								
Asbury Methodist Church/ Community Block Party cverdi	6/24/2017	7/17/2017	4.00	0.00	0	0	0	50
Notes: 50 participants received information on Diabetes and Nutrition from a Registered Dietitian/Certified Diabetes Educator.								
Frederick Co. Health Dept./Diabetes Support Group cverdi	6/16/2017	7/14/2017	1.50	0.00	0	0	0	12

Run Date: 11/29/2017

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Notes: 12 People were educated on Hypertension by a Registered Dietitian, Certified Diabetes Educator.								
Diabetes Support Group/Frederick Co. Health Dept. cverdi	6/13/2017	7/14/2017	2.00	0.00	0	0	0	5
Notes: 5 people received education on Neuropathy from a CRNP, CDE.								
Strike Out Stroke cverdi	6/5/2017	7/14/2017	2.50	0.00	0	0	0	6
Notes: Event at Key Stadium. 6 individuals received education by a Certified Diabetes Educator on Diabetes and Pre-Diabetes.								
Ask the Expert cverdi	5/16/2017	7/14/2017	3.00	0.00	0	0	0	12
Notes: 12 Individuals received education on Diabetes and Pre-Diabetes by an RD,CDE, and an RD, CDE.								
Girls Scouts Service unit 37.1/Volunteer Diabetes Education cverdi	5/6/2017	5/31/2017	1.50	0.00	0	0	0	7
Notes: 7 Girl Scout Volunteers and Troup Leaders were educated on Diabetes, to assist Girl scouts who have Diabetes, ex. identifying high and low blood sugars, especially in overnight situations. Diabetes RD lead the discussion and education. New Hope UMC,Brunswick, Md.								
Hood College Employee Benefits Fair cverdi	5/2/2017	5/31/2017	5.25	0.00	0	0	0	12
Notes: 12 Hood College employees were provided information on Diabetes and Diabetes Prevention by an RN, CDE								
Men's Health Workshop,Quinn AME Church cverdi	3/25/2017	5/31/2017	2.00	0.00	0	0	0	15
Notes: 15 men listened to an RD, CDE discuss diabetes. RD as a speaker and educational materials provided								
Division of Rehab Services (DORS) Hagerstown, Md cverdi	3/7/2017	5/31/2017	2.75	0.00	0	0	0	21
Notes: Diabetes RD Jan Drass 21 Vocational Counselors received education on Diabetes								

Run Date: 11/29/2017

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Why Weight for a Healthier Year cverdi	3/4/2017	7/14/2017	10.00	0.00	200	0	200	19
Notes: Participants received education on the health risks, and treatment options for obesity. Educational materials, Event speaker, Give Aways.								
"How Sweet It Is" Diabetes Seminar cverdi	11/16/2016	6/1/2017	12.00	0.00	0	0	0	43
Notes: 43 persons attended-Crestwood Conference Center. A CRNP and Registered Dietitian presented information on Diaabetes and Healthy Eating. Educational materials provided.								
Child and Adult Care Food Program/Healthy Weigh Kids cverdi	11/14/2016	5/31/2017	12.00	0.00	0	0	0	39
Notes: Two Registered Dietitians provided education and interactive activities to promote health eating and exercise for children, six weeks to 12 years. Educational materials provided as well as educational speaker.								
FCC Employee Health Fair cverdi	11/10/2016	5/31/2017	5.50	0.00	0	0	0	50
Notes: Approximately 200 people attended the health fair. 50 people stopped by the information table and were provided information on Diabetes, Cholesterol, and Nutrition.								
Stroke Prevention/PMG cverdi	9/27/2016	7/14/2017	2.00	0.00	0	0	0	10
Notes: 10 persons served. A Registered Dietitian provided educational materials on heart disease, stroke, and diabetes prevention to residents of the Mt. Airy area.								
Diabetes/Carbohydrate Counting, RN Nurse Champions cverdi	8/19/2016	5/31/2017	3.00	0.00	0	0	0	15
Notes: FMH RN Champions received information on Diabetes and Carbohydrate Counting, to assist them with patient care.								
Totals (Program): Center for Diabetes and Nutrition Services			**69.00**	**0.00**	**200**	**0**	**200**	**316**
Program: Frederick Health Fair								
Department: Unknown (0)								
Frederick Health Fair-AACF cverdi	10/22/2016	6/7/2017	180.00	286.00	24,897	0	24,897	811

Run Date: 11/29/2017

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Notes: 293 Chol/Glucose screenings,335 flu shots, 70 bone density screenings, 48 audiology screennge, 81 care transitions, and 50 dental care follow-up. Spreadsheet available for detail. We participated by providing educational materials, medical screenings, sponsorship, give aways (not intended for marketing purposes).								
Totals (Program): Frederick Health Fair			**180.00**	**286.00**	**24,897**	**0**	**24,897**	**811**
Program: Stroke Survivor Group								
Department: Preventative Cardiology and Rehab (8617)								
AARP/Stroke Prevention cverdi	5/18/2017	7/14/2017	2.00	0.00	0	0	0	170
Notes: Heart Disease, Stroke Prevention; we did address some chest pain s/s questions from the audience. Stroke risk factors, etc., educational materials provided.								
Paramedic Class-Stroke Care-Public Safety Way cverdi	5/16/2017	7/14/2017	1.00	0.00	0	0	0	15
Notes: Dr. Rafiq and Tom Shupp spoke to the paramedic class on Stroke Care..with class participaton, teach back.								
Ask the Expert-Crestwood cverdi	5/16/2017	7/14/2017	4.00	0.00	0	0	0	12
Notes: Educational materials, teach back on s/s of stroke/heart attack								
Stroke Support Group/Program cverdi	5/9/2017	5/31/2017	1.00	0.00	0	0	0	4
Notes: Outcomes; Readback: Ability to recognize s/s of stroke and resources for family. Educational materials., event speaker.								
Heart Disease-FCHD/All Saints Episcopal Church cverdi	2/22/2017	7/14/2017	1.50	0.00	0	0	0	20
Notes: FCHD-participants ability to recognize signs and symptoms and what to do. Event Speaker, educational materials. All Saints Episcopal Church. Thru FCHD-Behavioral Health, CORE Program								
Heart Disease-Dept. of Aging cverdi	2/22/2017	7/14/2017	1.50	0.00	0	0	0	30
Notes: Participants ability to recognize s/s and what to do if they occur. this presentation was offered to our local Dear/Hard of Hearing population. Educational materials, Event Speaker								

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Heart Haelth & Stroke Prevention/Asbury UM Church cverdi	2/14/2017	7/19/2017	1.00	0.00	0	0	0	20
Notes: Heart Disease & Stroke Prevention 20 participants ability to recognize the signs and symptoms. Event speaker & educational materials.								
Community Seninar-Stroke and Prevention cverdi	9/27/2016	11/22/2016	3.00	0.00	0	0	0	30
Notes: Community Seminar-Stroke and Prevention -Parkview Medical Group/Mt. Airy. Evaluation post seminar and Q & A session. educational materials								
Stroke Support Group cverdi	9/13/2016	11/22/2016	1.50	0.00	0	0	0	7
Notes: Discussed eating habits/information given on better food choices, educational materials.								
Stroke Support Group cverdi	8/9/2016	11/22/2016	1.50	0.00	0	0	0	8
Notes: Shared experiences since last meeting, goal setting, educational materials								
Stroke Support Group cverdi	7/12/2016	11/22/2016	1.50	0.00	0	0	0	6
Notes: Shared experiences								
Totals (Program): Stroke Survivor Group			**19.50**	**0.00**	**0**	**0**	**0**	**322**
Program: Women's and Children's Services/Women's Services								
Department: Women's & Children Services (10)								
Asian American Center-Baby Shower cverdi	5/19/2017	7/18/2017	1.00	0.00	0	0	0	15
Notes: Women's Health/Breastfeeding Presentation as well as educational materials.								
Totals (Program): Women's and Children's Services/Women's Services			**1.00**	**0.00**	**0**	**0**	**0**	**15**

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Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs		Monetary Inputs			Outputs
			Staff	Volunteer	Expenses	Offsets	Benefit	Persons
Program: Women's Health Services								
Department: Woman's Health Services at FMH Crestwood (6986)								
Health Fair/Country Meadows of Frederick cverdi	5/31/2017	7/18/2017	3.00	0.00	13	0	13	29
Notes: 9 for bone density testing, 20 for education and answering questions. Any individuals with an abnormal T score verified that they had a phy. to follow-up with. Educational materials								
Protect The Skin You're In cverdi	5/10/2017	5/31/2017	15.00	0.00	150	0	150	51
Notes: 51 direct conversations with participants about women's health and skin cancer, evaluation on quality, effectiveness and program content. Educational materials, Give Aways (neither intended for marketing purposes).								
Employee Health Fair/ Hood Collete cverdi	5/2/2017	7/18/2017	11.00	0.00	10	0	10	10
Notes: Educational and information on Women's Health and disease related co-morbidities/prevention and wellness. Educational materials provided.								
Health Fair/ Homewood @ Crumland Farms cverdi	4/21/2017	7/18/2017	3.00	0.00	15	0	15	36
Notes: Bone Density Testing & Education. 16/bone density testing. 20/education and answering questions about bone health. Made sure all those individuals with abnormal T scores for one mass had a phy. to follow-up with Educational materials provided.								
FCPS Employee Health Fair cverdi	4/5/2017	5/10/2017	6.00	0.00	0	0	0	55
Notes: Women's Health and osteoporosis prevention, breast cancer prevention and education. Educational materials								
Blood Clots: A Pain in the Leg cverdi	3/29/2017	5/10/2017	16.00	0.00	0	0	0	46
Notes: 46 total participants and 30 had vein screening by the Center for Vein and Laser Team.								
"How Sweet It Is" Diabetes Seminar cverdi	11/16/2016	1/2/2017	2.00	21.00	70	0	70	43
Notes: NP, dietician, presented, educational materials, give aways, food demonstration. 23 evaluations rec. from attendees to determine quality and effectiveness of the program. $25.00 supplies, $45.00 associated with food/catering (non-marketing related events)								

Run Date: 11/29/2017

Frederick Memorial Hospital

Occurrences - Selected Programs

For period from 7/1/2016 through 6/30/2017

Description / User /	Date	Date Created	Time Inputs: Staff	Time Inputs: Volunteer	Monetary Inputs: Expenses	Monetary Inputs: Offsets	Monetary Inputs: Benefit	Outputs: Persons
Uncomfortable Conversations (pelvic health) cverdi	9/28/2016	1/2/2017	20.00	0.00	20	0	20	41
Notes: Dr. Lea presented with Q & A during and after presentation. Educational materials table. Rehab. (Tx Team) presented on pelvic health								
Totals (Program): Women's Health Services			**76.00**	**21.00**	**278**	**0**	**278**	**311**
Number of Programs 6		**Totals:**	**377.50**	**307.00**	**26,251**	**0**	**26,251**	**1,955**
Number of Occurrences 40								