Western Maryland Regional Medical Center

(210027)

FY17

Community Benefit Report - Narrative

BACKGROUND

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

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

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

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

*As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:*

- *(A) A definition of the community served by the hospital facility and a description of how the community was determined;*
- *(B) A description of the process and methods used to conduct the CHNA;*
- *(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
- *(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;*
- *(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and*
- *(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).*

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

*Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:*

With respect to each significant health need identified through the CHNA, either—

(i) Describes how the hospital facility plans to address the health need; or

(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

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
Beds- 211 Bassinets-20	Adults: 11,556 Nursery: 915 Total: 12,471	21502 21532 21562 21539	Garrett Regional Medical Center	1.3 % of WMRMC patients in FY17 are uninsured Discharge Data	17.1% of WMRMC patients are Medicaid recipients Discharge Data	57.4 % of WMRMC patients are Medicare beneficiaries Discharge Data

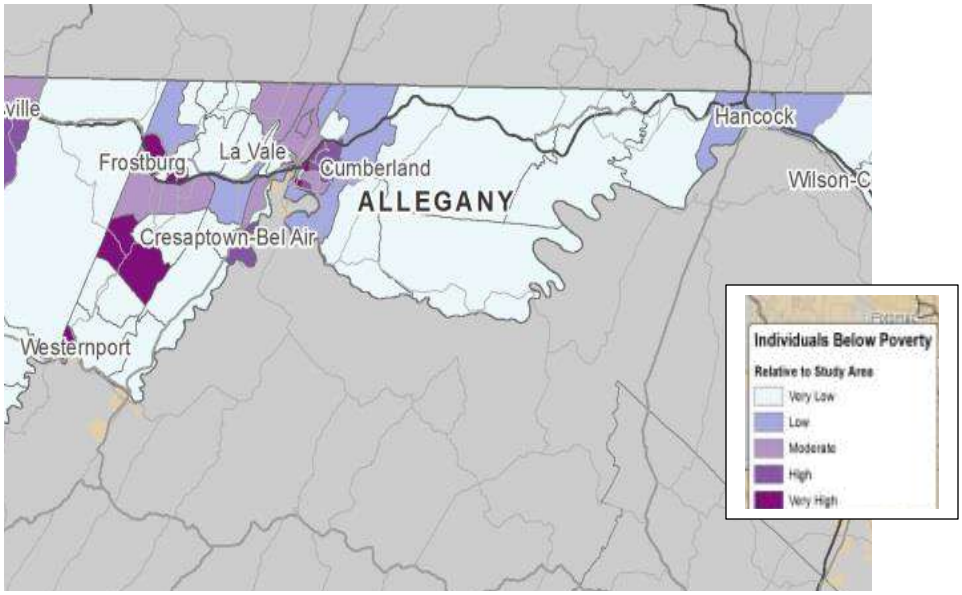
2. For purposes of reporting on your community benefit activities, please provide the following information:
   a. *Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves.*

Community Benefit Service Area (CBSA)

The Western Maryland Regional Medical Center defines its community benefit service area as Allegany County, MD. As the sole community hospital with over 70% of patients residing in Allegany County, WMRMC is accessible to all and the county population is the CBSA.

The map below shows the relative density of below poverty populations in the CBSA.

Relative Density of Below Poverty Populations (American Community Survey)



In addition to the location of poverty in the area, WMHS has examined the hot spots for high utilizers. Based on this information WMHS has begun to explore hot spot clinics in downtown Cumberland, Westernport, Lonaconing, Mount Savage and Frostburg. Table II provides demographic characteristics and social determinant data.

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.	21501, 21502, 21503, 21504, 21505, 21521, 21524, 21528, 21529, 21530, 21532, 21536, 21539, 21540, 21542, 21543, 21545, 21555, 21556, 21557, 21560, 21562, 21766 *Most vulnerable are underlined above.	Regional Planning Grant Community Needs Index
Median Household Income within the CBSA	Allegany County: $40,551 (2011-2015/ 5-year estimate)	US Census Bureau, American Community Survey (ACS)
Percentage of households in the CBSA with household income below the federal poverty guidelines	Allegany County: 17.4% (2015)	Opportunity Nation
For the counties within the CBSA, what is the percentage of uninsured for each county?	Allegany County: 8% (2017 Report)	County Health Rankings/Univ. of Wisc. US Census Bureau- Small Area Health Insurance Estimates (SAHIE)
Percentage of Medicaid recipients by County within the CBSA.	Allegany County: 27% (2016)	Maryland Medicaid eHealth Statistics (MMIS)

Demographic Characteristic	Description	Source
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	Allegany County: (2013-2015) 76.9 All Races/Ethnicities 76.6 White (Hispanic and NonHispanic) 78.5 Black (Hispanic and NonHispanic)	SHIP County Profile (DHMH Vital Statistics)
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Allegany County: Crude death rate per 100,000 population (2015 Report) 1300.2 All Races, 302.5 NonHispanicBlack, 1429.4 NonHispanic White	Maryland Vital Statistics Report
Limited Access to healthy food.	Allegany County: 16% (2017 Report) Food Environment Index 6.5	County Health Rankings –Univ. of Wisconsin
Transportation-Percentage of households without access to vehicles % of respondents missing medical appointments due to transportation	Allegany County: 10.8% (2011-2015) Allegany County: 2011- 25%, 2014-23%, 2016-16%	U.S. Census Bureau, American Community Survey (Local survey)
Illiteracy	Allegany County: 11.3% (2012 Report)	County Health Rankings/U of Wisc.
Population By Gender, Age, Race & Ethnicity	Population-72,528 • 52% Male 48% Female • Average age 41.5 years • 4.7% under age 5 • 19.4% 65 yrs. and over • 88.7% White • 8.2% Black/African Am • 0.2% Native American • 1% Asian • 1.7% Hispanic or Latino	US Census Bureau, 2015 Estimates
Pop. 25+ With Bachelor's Degree or Above %	Allegany County: 17.4% (2011-2015)	U.S. Census Bureau, American Community Survey
Children living in Single Parent Households %	Allegany County: 34% (2017 Report)	County Health Rankings –U of Wisc.
Language Other Than English spoken at home %	Allegany County: 4.8% (2011-2015)	U.S. Census Bureau, ACS
Population to Primary Care Provider Ratio	Allegany County: 1620:1 (2017 Report)	County Health Rankings –Univ. of Wisconsin
Adults who currently smoke %	Allegany County: 17% (2017 Report)	County Health Rankings –U of Wisc.

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?*

_x___Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 06/15/17

____No

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

http://www.wmhs.com/files/CHNA%20Narrative%20release%20June%202017%20corrected.pdf

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

_x__Yes Enter date approved by governing body/authorized body thereof here: 06/15/17

___No

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

http://www.alleganyhealthplanningcoalition.com/pdf/Local%20Health%20Action%20Plan%202017-2020.pdf

Though the new CHNA and implementation strategy were approved in FY17, the community benefit and local health action strategies completed in FY17 are linked to the prior Local Health Action Plan (implementation strategy). Below is a link to that document:

http://www.alleganyhealthplanningcoalition.com/lhap_pdf/FY15-17%20CHNA%20LHAP%20Final%20Report.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?*

__x_Yes

___No

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.

The data collected as part of the Community Health Needs Assessment is shared with the WMHS Administrative Team and Board of Directors. This information along with other hospital data and information was utilized to create the hospital's strategic plan. Through the Director of Community Health and Wellness connections are identified between the Implementation

Strategy and the Strategic Plan as part of the community benefit planning. The following are sections of the strategic plan that apply to community benefits.

Strategic Plan FY 2017-2020

Strategic Goal: Enhance Patient-Centered Care Delivery Model

Objective: Continue to redesign care delivery models

Strategies: Care Transitions and Process Improvements

Strategic Goal: Engage Employees, Patients and Families to Improve Health Status and Social Determinants of Health

Objective: Further Develop and strengthen relationships with community partners to address social determinants of health

Strategies: Define WMHS Role in Community, Transportation, Response to Addiction Epidemic

Objective: Strengthen the care coordination process

Strategies: Implement best practices with transitional care, including Center for Clinical Resources

Strategic Goal: Coordinate Care to Provide Population Health Management

Objective: Expand pre and post-acute services to reduce potentially avoidable utilization

Strategies: Mobile Health

Objective: Reduce variations in the treatment of patients across the care continuum

Strategies: Primary Care, Care Pathways

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)

a. Senior Leadership

1. x___CEO
2. x___CFO
3. x___Other (please specify) System Management Team

Describe the role of Senior Leadership.

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

b. Clinical Leadership

1. _x__Physician
2. _x__Nurse

3. __x_Social Worker
4. _x__Other (please specify)Allied Health

Describe the role of Clinical Leadership

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

c. Population Health Leadership and Staff

1. __x__ Population health VP or equivalent (please list)
   Jo Wilson, Vice President Population Health
   Michele Martz, Vice President Physician Enterprise

2. _x__ Other population health staff (please list staff)

   Karen Howsare, Director of Care Coordination
   Jeff O'Neal, Executive Director of Clinical Practices and Behavioral Health
   Nancy Forlifer, Director of Community Health & Wellness

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

In FY17, the focus on population health continued to increase significantly at WMHS. Through increased data analysis additional improvements have been made to the care continuum and transition points. The Population Health leaders and staff listed above participated in numerous efforts to clarify the needs of specific populations and to learn about the resources provided by partners across the continuum. This staff helped make the connections between the Strategic Plan and Implementation Strategy. They identified valuable community partnerships, best practices, and recommendations for continued population health improvement.

d. Community Benefit Operations

1. _x__the Title of Individual(s) (please specify FTE-0.068 FTE)

Nineteen individuals assisted with the tracking and documentation of community benefit activities totaling 142 hours.

- 7- Executive Secretary/Administrative Assistant-31hours
- 5-Directors/Program Coordinators-85 hours
- 7-Educators/Care Providers-26 hours

2. _x__Committee (please list members)

(Amber Ruble -Director of Finance, Nancy Forlifer- Director of Community Health & Wellness, Kathy Rogers- Director of Community Relations, and Kim Repac- CFO)

3. ___Department (please list staff)

4. ___Task Force (please list members)

5. ___Other (please describe)

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

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

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

Spreadsheet ___x__yes _____no

Narrative ___x__yes _____no

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

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

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

Spreadsheet __x___yes _____no

Narrative __x___yes _____no

If no, please explain why.

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

__x____Yes _____No

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

Many of the strategies listed under Healthcare Support Services and a few others in the community benefit spreadsheet support the Strategic Transformation Plan. Including:

- Transportation-Community Benefit investments are used to participate in Mobility Management and support a gap filling transportation service. See Table III
- Community Health Workers--Community Benefit investments are used to support outpatient Community Health Workers' efforts in the community.
- Center for Clinical Resources-Community Benefit investments are used to support comprehensive disease management including addressing social determinants of health with community partners. See Table III
- Prescription Assistance-Community Benefit investments are used to provide prescription medication upon discharge for uninsured and underinsured patients.
- Mobile Clinical Resources-Community Benefit investments are used to being clinical services to identified hot spots across the community.

Community Benefit investments allow WMHS to strengthen relationships with community partners, improve efforts to address social determinants of health, and extend evidence-based practices into the community. Through the collective efforts quality of care is improved, unnecessary ED visits and readmissions are reduced, and improvements in community health are made.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__x___Other hospital organizations

__x___Local Health Department

___x__Local health improvement coalitions (LHICs)

___x__ Schools

__x___Behavioral health organizations

__x___Faith based community organizations

__x___Social service organizations

___x__Post-acute care facilities

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
Founding Partners			
Allegany County Health Department	Jenelle Mayer	Health Officer	Co-Chair of LHIC, Assist with CHNA & LHAP
Allegany Health Right	Sandi Rowland	Executive Director	Active review of data and selection of strategies
Tri-State Community Health Center	Susan Walter	CEO	Active review of data and selection of strategies
Western MD Area Health Education Center (now AHEC West)	Susan Stewart	Executive Director	Active review of data and selection of strategies
Allegany Human Resource Development Comm.	Courtney Thomas	Executive Director	Active review of data and selection of strategies
County United Way	Mary Beth Pirolozzi	Executive Director	Active review of data and selection of strategies
Allegany Board of Education	Kim Green/ Ben Brauer	Chief Academic Officer/Central Office Supervisor Student Svs	Active review of data and selection of strategies
Advisory Board			
Media-Allegany Radio	Joe Caporale	Sales Manager	Participate in CHNA process. Assist with monitoring and evaluating progress of implementation. Promote and distribute agreed upon education.
Housing	Steve Kesner/ Jamie Thomas	Executive Director	
Business/Economic Development-Chamber of Commerce	Stu Czapski	Executive Director	
Chapman & Assoc.	Cathy Chapman	CRNP-somatic provider	
Pressley Ridge -Provider (behavioral)	Mary Beth DeMartino	Executive Director	
Case Management	Ashley Barnes	Case Manager	
Law Enforcement	Craig Robertson	Sheriff	
Affiliates			
Office of Consumer Advocate	Jennifer Glotfelty	Social Worker	Participate in the community health needs assessment process and development & implementation of the LHAP. Assist in developing and promoting health solutions to identified health problems
Salvation Army	John Bevins	Major	
YMCA	Don Enterline	Executive Director	
Western MD Food Bank	Diana Loar	Executive Director	
Local Management Board	Courtney Thomas	Chairperson	
Cumberland Area Interfaith Ministerial Association	Rebecca Vardiman	Chairperson, Pastor	
Faith Community Health Nursing Program	Lyn Strawser	Coordinator	
NAACP	Carmen Jackson	President	

University of MD Extension	Kathy Kinsman	EFNEP Educator
Maryland Physicians Care	Terry Hillegas	Marketing &Community Outreach Liaison
Priority Partners	Lisa Moran	Community Health Advocate
Allegany College of Maryland	Kathy Condor	Coordinator
Allegany Transit	Roy Cool/Libby Harper	Director
MedTrans	Abby Mensinger	Director
Friends Aware	Kathleen Breighner	Special Projects
Allegany County Dept. Social Services	Richard Paulman/ Kim Truly	Executive Director/Special Asst.
Associated Charities	Kristan Fazenbaker	Executive Director
Pharmacies	Bill McKay	Pharmacist
Drug Abuse Alcohol Council	Chris Delaney	Director
Tobacco Free Coalition	Kathy Dudley	Coordinator
Family Junction	Melanie McDonald	Executive Director
Frostburg State University	Kathy Powell	Social Worker
Sheriff's Office	Craig Robertson	Sheriff
Make Healthy Choices Easy	Jen Thomas	Health Educator
County Govt-Board of Health	Jacob Shade	County Commissioner
Park & Recreation Department	Diane Johnson	Director
Mental Health Advisory Board	Lesa Diehl	Chairperson
Workgroup on Access to Care	Nancy Forlifer	Chairperson
Transportation Advisory Board	Ryan Davis	Member
Dental Society	Diane Romaine	Chairperson
Community Wellness Coalition	Marion Leonard	Chairperson
Overdose Prevention Task Force	Becky Meyers	Director
Family Crisis Resource Center	Sarah Keiser	Executive Director
Western Maryland Food Council	Dan Fiscus	Director

The community needs data were presented at a Community Forum on December 8, 2016. Coalition partners, affiliates and members of the public participated in the forum. The presentation followed the format of the County Health Rankings Model, summarized results from 2011 and 2014, shared the community survey results, and noted the secondary data points.

After the presentation, a list of eighteen data points was distributed and those present were asked if any needs were missing. Forum participants were asked to consider the magnitude of each need in regard to the population and cost, the severity of the need, and the effect of the need on the most vulnerable

populations. Each participant was asked to identify the top three needs in priority order. The results were tabulated and then the group discussed available resources and potential strategies. With the needs prioritized based on community capacity to act, feasibility of having a measurable impact, resources already focused on the issue, and root cause connections, the Local Health Action Plan Workgroup was tasked with drafting a plan for review by the Allegany County Health Planning Coalition. Proposed strategies were identified based on evidence of effectiveness, community 'fit,' readiness, capacity, and resources.

A draft plan with key strategies and action steps was presented to the Allegany County Health Planning Coalition in January for review and feedback. During this presentation it was noted how the identified priorities fit within four focus areas (Substance Abuse, Poverty, Heart Disease, and Access to Care/Health Literacy). Based on the Coalition's feedback the LHAP workgroup updated the Local Health Action Plan including metrics, partners, and timeframes. Final edits were made and presented to the WMHS Board of Directors and Allegany County Health Planning Coalition for final input and approval by June 2017. Implementation will occur starting July 1, 2017 and extend through June 30, 2020.

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?*

___x__yes _____no

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.

Allegany County

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?*

___x__yes _____no

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.

Allegany County

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.

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify

common priority areas and alignment with other public and private organizations.

2. Please indicate how the community's need for the initiative was identified.

b. *Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.*
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

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

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

e. *Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,*

f. *Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)*

g. *Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.*

h. *Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures. Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):*

   (i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

   (ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

   (iii) The number of people served by the initiative.

   Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

i. *Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)*

j. *Continuation of Initiative:*
What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?

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

Based on feedback for Table III in last year's narrative report, we have focused on more specific initiatives that demonstrate WMHS's commitment to population health and community benefit. These initiatives are spearheaded by WMHS and involve collaboration with community partners. As noted in the tables below these initiatives support the CHNA and have documented outcomes.

Table III

<table>
<tr><td>A. 1. Identified Need:

A. 2. How was the need identified:</td><td>Through the CHNA, access to care (primary, dental, and behavioral health) was identified as a need. Poverty, transportation and other social determinants were felt to be key contributing factors. WMHS partnered with numerous community organizations to assess and implement activities to improve access to care and address the contributing factors. Transportation continued to be a priority need noted by patients and partners. It was also the most prevalent referral made by Community Health Workers.
<table>
<tr><td>Data</td><td>Baseline</td><td>Current Status</td><td>Source</td></tr>
<tr><td>% of adults who report missing appointments due to transportation</td><td>25%</td><td>16%</td><td>Community Transportation Survey,2011, 2016</td></tr>
</table></td></tr>
<tr><td>B: Name of hospital initiative</td><td>Transportation and Mobility Management</td></tr>
<tr><td>C: Total number of people within target population</td><td>Based on most recent 5 year estimate from the US Census Bureau, American Community Survey, of the 72,538 county population:

10.1% lack transportation=7,326 residents (ACS)</td></tr>
<tr><td>D: Total number of people reached by the initiative</td><td>It is difficult to obtain a total number of unduplicated people reached, since individuals access transportation through many entry points. The number of people that were reached by the WMHS supported transportation program is estimated at 362 and through Mobility Management another estimated 800 individuals were provided rides.</td></tr>
<tr><td>E: Primary objective of initiative:</td><td>Objective from Implementation Strategy: Between July 1, 2014 and June 30, 2017, the HRDC Mobility Management Program will provide low-income residents with 6,000 rides (one way) to health and human service appointments.

WMHS expanded upon the Mobility Management Program in FY17 in order to reduce no shows and their resulting costs and readmissions, especially for complex care patients.</td></tr>
<tr><td>F: Single or multi-year plan:</td><td>Multi Year
Transportation efforts began in 2012 and are anticipated to be ongoing. In FY17, the Transportation service was added to fill in the gaps when existing programs did not meet the patients' needs.</td></tr>
<tr><td>G: Key collaborators in delivery:</td><td>Western Maryland Health System (WMRMC) –Nancy Forlifer, Director Community Wellness
Human Resource Development Commission –Renee Kniseley, Director AAA
Allegany County Health Department- Jennifer Wilson, Director WIC
Tri State Community Health Center- Denise Friend, Case Manager
Mental Health Systems Office- Lesa Diehl, Director CSA
Allegany Transit –Roy Cool, Director
Tri County Council, WMD- Ryan Davis, Economic Development Planner</td></tr>
</table>

H: Impact of hospital initiative:	Though this initiative does not directly monitor improvements in health status of patients, by increasing access to needed care, it is anticipated that medically unnecessary visits to the ED and readmissions will be reduced. • Short Term- increase number of rides provided (Target- by end of FY17- 6000 rides) • Mid Term- decrease number of people missing appointments because of transportation barrier (Target for FY17 -20%) • Long Term- improved access resulting in reduced readmissions and costs (FY17 target – identify means to monitor link between transportation and utilization)
I: Evaluation of outcome	The short term and mid term targets have been met. In FY17, 14,755 rides were provided through Mobility Management to enable low-income residents to access health and human service appointments. This is more than double the number of rides in FY15. An additional 2943 rides were provided by the transportation service. Community surveys done in 2011, 2014 and 2016 show a decrease in the percent of adults who report missing appointments due to problems finding transportation from 25% to 16%. Another survey will be done in FY18. In the past, a claim was made that the transportation services contributed to the continued reduction of level 1&2 visits in ED from 17,519 in 2011 to 7746 in 2017. However, this initiative cannot independently claim the reduction of ED visits that could have been treated in primary or urgent care sites. In an attempt to distinguish the impact of transportation on complex care patients a match was made between Meditech and the transportation portal. This did not include Mobility Management or taxi vouchers. With outliers and deceased removed: 349 unique patients account for 883 unique Transport appointments 118 unique patients retuned to the hospital within 30 days of transport following 193 unique transport appointments 62 Future inpatient visits (26 Readmissions) 112 Future emergency visits 19 Future observation visits ---------- (883-193)/883 = 78.14% of Transport appointments had 0 visits to the hospital visit post 30 days (349-118)/349 = 64.19% of Transport patients had 0 visits to the hospital post 30 days Further testing of this logic is needed and then it may be linked to the associated costs.
J: Continuation of initiative:	In addition to improved data analysis of transportation and its link to utilization, there continues to be a need for more coordinated transportation in Allegany County. Based on the results from Mobility Management and the expanded transportation service and a study completed by KFH Group in FY17, WMHS and its community partners are committed to the following: • greater mobility management efforts to better meet current needs and fill gaps in transportation for health &human service clients as well as employers • address demand for transportation in the region surpassing resources, by fully utilizing wheelchair accessible vans in the community and consolidating long distance trips that travel through multiple counties in the region when possible • develop a One Call One Click (OCOC) transportation system that will bring together additional resources into a coordinated system with central point of access • Explore and advocate for innovative approaches to non-emergent transportation, including ridesharing

<table>
<tr><td>K: Expense:</td><td>A. Total Cost of Initiative
• Transportation: $110,926</td><td>B. Total Cost of Initiative provided through restricted grant or donation
• Transportation: $0</td></tr>
<tr><td>Table III

A. 1. Identified Need:

A. 2. How was the need identified:</td><td colspan="2">In both the CHNA and the WMHS strategic planning process, the need to engage individuals in self- care and behavior change was noted. According to the Community Health Status Reports (DHHS) half of all deaths can be attributed to lifestyle and behavioral risk factors.

One of the outcome measures in the CHNA is % of elementary children who are in the 95th percentile or higher for body mass index, and last year the measure began to go in the wrong direction.
<table>
<tr><th>Data</th><th>Baseline</th><th>Current Status</th><th>Target</th><th>Source</th></tr>
<tr><td>Percent of elementary children who are in the 95th percentile or higher for body mass index</td><td>20</td><td>19.3</td><td>13.6</td><td>Allegany County Public Schools School Health Program</td></tr>
</table>

As part of the Implementation Strategy/LHAP, there was a two tier approach; policy and environmental changes which would be led by the health department and affordable/accessible programs to promote behavior change and healthy lifestyles spearheaded by WMHS in collaboration with many partners.</td></tr>
<tr><td>B: Name of hospital initiative</td><td colspan="2">Make Healthy Choices Easy- multimodal, community wide campaign to promote healthy eating and physical activity by making healthy choices easier</td></tr>
<tr><td>C: Total number of people within target population</td><td colspan="2">Based on most recent 5 year estimate from the US Census Bureau, American Community Survey, of the 72,538 county population:

19.3% of elementary children are obese=<u>782</u> (actual count)
28% of adult population are physically inactive=<u>20,310</u> adult residents</td></tr>
<tr><td>D: Total number of people reached by the initiative</td><td colspan="2">The number of people that were reached through the services offered by WMHS as part of the Make Healthy Choices Easy initiative in FY17:

• 6489 people participated in over 100,000 encounters promoting healthy lifestyles and about 58% of the programs measured behavior change.</td></tr>
<tr><td>E: Primary objective of initiative:</td><td colspan="2">Objective from Implementation Strategy:
• Between July 1, 2014 and June 30, 2017, at least 6,000 residents will participate in low-cost, accessible healthy lifestyle programs.
• By June 30, 2017, at least 30% of low-cost, accessible healthy lifestyle programs will measure behavior change.
WMHS intended to offer programs in collaboration with partners that would make healthy eating and physical activity easier.</td></tr>
<tr><td>F: Single or multi-year plan:</td><td colspan="2">Multi-year. Family Fit began in 2014. Change to Win started in 2011. Coaching began in 2006. Evergreen were piloted in 2015. Farmers Market vouchers began in 2016. Services added in 2017- Wellness Wednesdays,HIIT, and Chair Yoga.

In order to maintain engagement, the content of these programs is regularly updated and as innovative best practices are identified, we evaluate their use. For example, it was decided that Family Fit will end in FY17 and be replaced by a Healthy Schools Challenge in FY18.</td></tr>
</table>

G: Key collaborators in delivery:	WMHS Make Healthy Choices Easy Coalition-Jen Thomas, Health Educator Allegany County Board of Education-Ben Brauer, Supervisor Student Services Allegany County Health Department- Bill Laferty, Chronic Disease Outreach Coor. Evergreen Heritage Center-Janice Keene, Executive Director Maryland Physicians Care –Terry Hillegas, Communications Manager Priority Partners- Lisa Moran, Outreach Coordinator University of Maryland Extension- Kathy Kinsman, EFNEP Educator Western Maryland Area Health Education Center (AHEC West)- Katie Salesky,Coor. YMCA-Mary Beth Strickler, Marketing
H: Impact of hospital initiative:	This initiative has the potential to show improvements in the health status of participants, but the emphasis has been on promotion and access so that individuals can and will engage. • Short Term-increase number of residents that participate in low-cost, accessible healthy lifestyle programs (Target by end of FY17-6,000) • Mid Term-increase % of healthy lifestyle programs that measure behavior change (Target 30%) • Long Term-decrease % of elementary children who are in the 95th percentile or higher for body mass index (Target 13.6%)
I: Evaluation of outcome	The short term and midterm targets have been met. In FY17, the number of community wide participants increased by 100 compared to the prior year, and the 3 year target was surpassed. This year WMHS offered many more programs in the schools ranging from elementary through high school and included mindfulness and stress reduction in addition to nutrition and physical activity, which seemed to increase the interest level. Lifestyle and behavior changes are challenging and take significant support and time. In FY17 the % of programs tracking behavior change remained stable at 58%. There is still a need for better tools and processes for assessing and tracking behavior change. The bullets below highlight some of the measureable results, many of which are still focused on the numbers reached. BMI data collected by school health nurses for all public elementary children had a baseline of 20% in the 95th percentile or higher, it had been declining but in the last year increased to 19.3%. This is a long term measure that will require continued focus. • Of 149 Change to Win participants, 32 lost five-nine pounds, 36 others lost 10 or more pounds and attended at least 9 of the sessions. • Family Fit and Fun Challenge had 1,567 children participate along with an adult, which is 35.1% of all county school students in grades Pre-K-5. This was a 3.9% increase from last year. • With Evergreen Heritage Center we provide fun and interactive nutrition and physical activities during Family Fun Nights and summer camp. Through pre and post surveys, there has been a documented increase in consumption of fruits and vegetables by the participants. • 232 patients with chronic disease utilized a voucher to purchase produce at the onsite farmers market. • *Wellness Wednesday* video series launched and received great feedback and including reports of behavior change as a result of the video(s). • HIIT-High Intensity Interval Training was offered at worksites, schools and in the park with 269 encounters in the year. • Chair Yoga targeting seniors ages 55-95 with limited mobility and/or

<table>
<tr><td></td><td>chronic pain or illness. Improvements noted by participants were better respiration, increased mobility and flexibility, and a calmer mind. The pilot program reached 34 individuals in 234 encounters.</td></tr>
<tr><td>J: Continuation of initiative:</td><td>WMHS will continue to collaborate with community partners on making healthy choices easy, but tracking of behavior change needs to improve. A new tool for tracking improvements in mind, body or spirit is to be tested in FY18.

Based on the success in FY17, Change to Win, Evergreen, Farmers Market vouchers, and coaching will continue. HIIT and Chair Yoga are likely to expand. Offering programs where people are, such as schools, parks, is important and provide healthy food and engage individuals in fun physical activity are keys to success.

To have a greater impact on the community, healthy lifestyle initiatives need to be connected across the care continuum.</td></tr>
<tr><td>K: Expense:</td><td>C. Total Cost of Initiative
<u>Make Healthy Choices Easy</u>
Family Fit: $8,200
Change to Win: $9,910
Evergreen: $7,461
Farmers Market: $1,253
Coaching: $4,211
HIIT:$987
Other (schools & libraries): $1,698</td><td>D. Total Cost of Initiative provided through restricted grant or donation
Family Fit: $0
Change to Win: $0
Evergreen: $0
Farmers Market-$0
Coaching: $0
HIIT: $0
Other (schools & libraries): $0</td></tr>
<tr><td>Table III

A. 1. Identified Need:

A. 2. How was the need identified:</td><td colspan="2">The CHNA identified death rates and the level of ED visits associated with chronic diseases to be a concern. Hospital data confirms that many of the highest utilizers of care are those individuals with multiple chronic conditions. Baseline data from SHIP (2010) showed the age-adjusted death rates in Allegany County for heart disease and the rate of ED visits for hypertension, diabetes, and asthma were above state levels. WMHS partnered with community organizations to provide disease management and care coordination.
<table>
<tr><th>Data</th><th>Baseline</th><th>Current Status</th><th>Source</th></tr>
<tr><td>Rate of diabetes-related ED visits per 100,000 population</td><td>379.6</td><td>241.4</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Age-adjusted death rate from heart disease per 100,000 population</td><td>256.8</td><td>253.2</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Rate of ED visits for hypertension per 100,000 population</td><td>225.1</td><td>279.1</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Rate of ED visits for asthma per 100,000 population</td><td>68.9</td><td>61.8</td><td>SHIP (HSCRC)</td></tr>
</table></td></tr>
<tr><td>B: Name of hospital initiative</td><td colspan="2">Center for Clinical Resources -Provides disease management targeting individuals with multiple conditions, in conjunction with primary care providers</td></tr>
<tr><td>C: Total number of people within target population</td><td colspan="2">To determine the number of people with multiple chronic conditions including those most prevalent, we used two formulas and project the number to be in between.

According to the US Dept. of Health and Human Services, 1 in 4 Americans are living with multiple chronic conditions, and individuals over the age of 65 or living in poverty are impacted more. Allegany County’s population is 72,528. 19.4% are over the age of 65 (14,030) and 18.5% of the population is poor (13,417). 25% (1of 4) of these two subgroups =<u>6872</u> people or the estimated number of people with multiple chronic conditions in the county.</td></tr>
</table>

D: Total number of people reached by the initiative	In FY17 the Center for Clinical Resources served 1635 new patients
E: Primary objective of initiative:	The goal of the CCR is to help patients with chronic disease manage their symptoms to live the life they want and in turn reduce potentially avoidable readmissions and ED visits. The CCR is also a supporting strategy for the Local Health Action Plan/Implementation Strategy that has the following objectives: • Between July 1, 2014 and June 30, 2017, at least 3 cross-agency disease management initiatives will be implemented. • Between July 1, 2014 and June 30, 2017, at least 200 people will participate in chronic disease self-management programs The CCR offers the Living Well self-management program and collaborates with partners on the Diabetes Prevention Program and Chronic Disease Self-Management Program.
F: Single or multi-year plan:	Multi Year- Center for Clinical Resources- opened November 2013 Though the design and processes utilized in the CCR are continually being evaluated and improved, the need for the service is ongoing. Portions of the CCR will be replicated in other venues in the future.
G: Key collaborators in delivery:	WMHS has collaborated with the Medical staff and area providers on the CCR. Allegany County Health Department – Bill Lafferty, Chronic Disease Outreach Coor. YMCA –Anne Bryant, Diabetes Prevention Program Coordinator University of Maryland Extension – Lisa McCoy, Dietitian AHEC West- Susan Stewart, Executive Director
H: Impact of hospital initiative:	Though the care team in the CCR is focused on health status improvements for each patient they serve, tracking health status changes collectively has not been the focus. • The short term measure for both the CCR specifically and as it connects to the CHNA, is to increase the number of patients engaged. A target for the community was to have 200 people participate in chronic disease self-management by June 30, 2017. • Mid Term- The no show rate for CCR is used to identify barriers and patient engagement but it is also related to readmissions. (Target 12%) • Long Term-Reducing the rate of medically unnecessary ED visits for chronic disease and readmissions is a long term measure. (Target Readmission Rate-6%) There are also SHIP measures listed above that are long term measures which relate to the CCR and are monitored with the CHNA.
I: Evaluation of outcome	The short term measure of 200 people participating in chronic disease self-management over the period was met, but in FY17 participation was only 121, the lowest in three years. There are now several partners who are involved with offering these evidence based programs but additional cross agency collaboration may be needed to improve the promotion and documentation. In FY17, the number of CCR encounters increased to 17,359 (office and phone). The no show rates were: COPD is 18.7%, CHF is 6.2%, DM is 10.3%. Except for COPD these were on target. Additional analysis of COPD was underway. There were 100 documented telephone avoided ER visits (COPD, DM, and CHF) by CCR patients in FY17. SHIP data indicates a decrease in the ED visits for diabetes and asthma in Allegany County, but we have yet to reach the target.

J: Continuation of initiative:	WMHS will continue to build on and improve the effectiveness of the CCR, and enhance linkages with community partners to provide a comprehensive continuum of care. In the next year, the CCR will be involved with a shared assessment of patient self-sufficiency and social determinants of health, as well as review and creation of consistent education pathways for chronic diseases that will extend into the community. Efforts are also underway to track changes in health status through a grant from Merck focusing on type 2 diabetes.	
K: Expense:	E. Total Cost of Initiative Center for Clinical Resources: $1,845,119	F. Total Cost of Initiative provided through restricted grant or donation Center for Clinical Resources: $0

2. *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.*

Through the Community Health Needs Assessment process, there were some community needs identified which will not be included in the Local Health Action Plan strategies. The Coalition felt that many of these community needs were already being addressed by other partnerships in the community, and therefore included them as a supporting strategy in the Local Health Action Plan or examined another aspect of the issue.

- Chronic Obstructive Pulmonary Disease: In FY16, COPD was in the top three reasons for admissions into the Western Maryland Regional Medical Center. The percent of Medicare beneficiaries in the county diagnosed with COPD is also higher than the national percent. Clinically there are several resources offered in the community, including a free clinic in the WMHS Center for Clinical Resources, Pulmonary Rehab, and Better Breathers support group. The preventive measures for COPD are also addressed through other avenues, such as tobacco cessation through the Allegany County Health Department and pneumonia immunizations at various locations in the community. It was decided that no additional action was needed to address COPD at this time.

- Sexually Transmitted Infections: The number of chlamydia cases recorded at the Allegany County Health Department in FY16 was 222 along with 37 cases of gonorrhea. Combined with an upward trend in the number of chlamydia cases per 100,000 population over the last few years (236 to 326) this need was discussed. The increased need was valid and the significant increase in substance abuse was felt to be a contributing factor. With services available through ACHD STI Clinic, Title X Family Planning, and the OB/GYN practices, it was decided that no additional action would be planned.

- Teen Use of E-Vapor Products: While the Youth Risk Behavior Surveillance System (YRBSS) has shown a decline in youth tobacco use in Allegany County, youth use of e-vapor products is higher than in Maryland. 18.4% of middle school students have ever used an e-vapor product compared to 17% in the State and 48.7% of high school students have ever used an e-vapor product compared to 37.6% in the State. It was agreed that this issue should be the focus of the existing Tobacco-Free Coalition facilitated by ACHD and their work would be included as a supporting strategy in the Local Health Action Plan.

- Substance Abuse: Without a doubt, substance abuse was identified as the top priority for Allegany County. There are also numerous groups already collaborating to address the need and

the Coalition felt it was important to support the continued collaboration with those groups, especially the Opioid and Overdose Prevention Task Force. There were components of substance abuse that the group felt were not being addressed by existing partnerships and they have been included in the Local Health Action Plan.

3. *How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)*
   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

There are many ways in which the hospitals' community benefit activities support the State's efforts to improve population health. As part of the community health needs assessment, the SHIP measures were reviewed and considered as part of the process. In the Local Health Action Plan/Implementation Strategy that ended June 30, 2017 the following SHIP measures are noted:

- Reduce percent of individuals unable to afford to see a doctor
- Reduce child maltreatment
- Increase access to healthy food
- Increase the percent of adults who are at a healthy weight
- Reduce the percent of children that are considered obese
- Reduce the percent of adults who are current smokers
- Reduce domestic violence
- Reduce diabetes-related emergency department visits
- Reduce hypertension-related emergency department visits
- Reduce emergency visits related to behavioral health

The implementation strategy that was approved in June 2017, includes the following SHIP measures from Attachment A of the narrative instructions, as well as others not on that list.

- Reduce infant mortality
- Reduce the % of children who are considered obese
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions

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

PHYSICIANS

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

Allegany County is a designated health professional shortage area (HPSA) for primary care for low-income populations, mental health care, and dental care for Medical Assistance populations. With the aging of primary care providers, and awareness that PCPs often close their practices to new patients when the provider is in mid 50s, recruitment has risen as a need again. According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 1,045 persons; Allegany County has 1 primary care provider for every 1600 individuals. WMHS is also below the US benchmark in dental and mental health providers.

The most recent analysis by the Healthcare Strategy Group in 2017, found that among WMHS's active medical staff in adult primary care, 11 physicians are currently over age 60 and that number will increase to 13 physicians in 2020, ten of whom will be over age 65 in 2020. Specialties that have physicians on WMHS Medical Staff who will be over the age of 65 in 2020 and may require succession planning include: Pulmonary/Critical Care, Endocrinology, and Gastroenterology. When the Medical Staff Development Plan was reviewed by the Executive Team additional analysis was requested prior to approval.

In FY17, WMHS recruited 2 psychiatrists, 2 primary care providers, and a gastroenterologist, as well as nurse practitioners in primary care, medical oncology, psychiatry and cardiac surgery.

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

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	Based on the community health needs assessment and Medical Staff Development Plan, Western Maryland Regional Medical Center has included physician subsidies for: hospitalists, psychiatric physician practice, obstetric physician practice, and primary care physician practice. With a growing number of area physicians electing to concentrate on their office practice and not admit their patients to the hospital, WMHS needed to expand the Hospitalist program to respond to community need. The aging of physicians has created a need for succession planning in primary care, psychiatry and obstetrics. WMHS responded by recruiting and maintaining practices in these areas. Although there are other providers addressing some of these needs there remained a gap and need for these services. As a WMHS practice these physicians align with the WMHS Financial Assistance Policy and help ensure that more patients are provided with care in the most appropriate setting.
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

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

Appendix I – Description of FAP
WMRMC FY17

Western Maryland Health System informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's Financial Assistance Policy (FAP) through the following means.

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

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

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

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

Appendix II – FAP Change since ACA Coverage Expansion
Western Maryland Health System (WMRMC) FY17

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

According to the FAP Policy:

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

WESTERN MARYLAND HEALTH SYSTEM DEPARTMENTAL Policy Manual	Department\Division: Business Office	Policy Number: 400-04
	Effective Date: November 12, 2010	Reviewed/Revised: 4/11, 12/11, 5/12, 10/12, 8/13, 6/14, 4/15, 7/15, 4/2015, 6/2016, 2/2017

FINANCIAL ASSISTANCE POLICY

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

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

In addition, WMHS is designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, each tax-exempt hospital is required to adopt and widely publicize its financial assistance policy. WMHS will post notices of its Financial Assistance Policy at patient registration sites, Admissions, Patient Accounting Department and at the Emergency Department. Notices of its Financial Assistance Policy will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information summary will be provided to inpatients as part of the Admission Handbook given to every admitted patient prior to discharge and also upon request. The WMHS web site has Financial Assistance program summary, in addition to the financial assistance application which can be downloaded and printed. Patients may also call the main Patient Accounting phone number at 240-964-8435 to request an application, patients may also request special assistance with completion of the application. Financial counselors are available to assist with the oral completion of the application.

This policy covers Western Maryland Regional Medical Center and Physician Clinics and Practices owned by WMHS. See attached listing of employed medical providers.

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

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

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

Financial Hardship: Medical Debt incurred by a family over a 12 month period that exceeds 10% of family income. Financial counselors will work closely with eligible parties taking into consideration issues such as lost wages due to health and any other financial barriers that a patient may face due to a sudden health condition. Assistance plans will be considered using a sliding scale from 3-10% of gross income. (See Medical Debt definition) Patients will also be granted an extended time period for payment, usually 2-3 years.

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

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

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

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

PROCEDURE:

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

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

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

4. Determination should be made that all forms of insurance are not available to pay the patient's bill. The patient/guarantor shall be required to provide information and verification of

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

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

6. Determination of income will be made after review of all required documents. The following supporting documents must be provided with the application:
   a. Most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
   b. A copy of the four (4) most recent pay stub (if employed) or other evidence of income of any person whose income is considered part of the family income as defined by Medicaid regulations.
   c. Proof of disability income (if applicable) or workers compensation.
   d. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, or statement from current source of financial support, etc.
   e. Bank statements or brokerage statements.

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

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

8. Presumptive Financial Assistance Eligibility: These are instances when a patient qualifies for Financial Assistance based on the enrollment in the following government programs. In these instances, the Financial Assistance application process is abbreviated in that documentation of

eligibility can be demonstrated by proof of acceptance and participation in one of the following programs:

a. Food Stamps
b. Women's, Infants and Children (WIC Program)
c. Households with children in the free and reduced lunch program
d. Energy assistance
e. Out of state medical assistance
f. Unemployment under federal poverty guidelines and applicant is sole provider in the household.
g. Patients eligible for out of state medical assistance and WMHS is not enrolled with participating provider credentials to file the claim

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

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

Presumptive financial assistance may also be determined based on eligibility algorithms and/or data analytics provided by specialty software systems.

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

9. The application, with supporting documents, should be completed by the applicant and returned to the Financial Counseling Department within 10 business days. In the event that the account(s) have been placed in collections status, all extraordinary collection action will be suspended until the application and review process are completed. If partial information is returned, WMHS will provide the applicant with written notice of that describing the missing information and the applicant will be given an additional 10 days to provide the required information and supporting documents. The request for additional information displays contact information for financial counseling support personnel. All extraordinary collection action will suspend during this period. If the applicant does not respond, the applicant's request for Financial Assistance will be considered incomplete and WMHS will provide the applicant with written notice of closed status. WMHS will accept applications up to at least 240 days after the first post-discharge bill statement to the patient.

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

their remaining financial obligation. Patients may request a copy of Accounts Receivable Collection policy, by calling Patient Accounting personnel at 240-964-8435.

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

12. If the patient's application for Financial Assistance is approved, it will be made effective for medical services furnished within the 12-month period prior to the approval date and remain effective for 12 months after approval date. The patient will be notified in writing of the approval showing the percentage of assistance granted and any amount owed by the patient.

13. If within a two year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $5.00.

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

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

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

Business Operations – Trivergent Health Alliance

Sr. Vice President, Chief Financial Officer

2016/2017 SLIDING SCALE ADJUSTMENTS
WMHS FINANCIAL ASSISTANCE PROGRAM

Patient Responsibility Percentages

Size of Family Unit	0%	10%	20%	30%	40%
1	$11,880-$23,760	$23,761-$26,611	$26,612-$29,581	$29,582-$32,551	$32,552-$35,640
2	$16,020-$32,040	$32,041-$35,885	$35,886 $39,890	$39,891-$43,895	$43,896-$48,060
3	$20,160-$40,320	$40,321-$45,158	$45,159-$50,198	$50,199-$55,238	$55,239-$60,480
4	$24,300-$48,600	$48,601-$54,432	$54,433-$60,507	$60,508-$66,582-	$66,583-$72,900
5	$28,440-$56,880	$56,881-$63,706	$63,707-$70,816	$70,817-$77,926	$77,927-$85,320
6	$32,580-$65,160	$65,161-$72,979	$72,980-$81,124	$81,125-$89,269	$89,270-$97,740
7	$36,730-$73,460	$73,461-$82,275	$82,276-$91,458	$91,459-$100,640	$100,641-$110,190
8	$40,890-$81,780	$81,781-$91,594	$91,595-$101,816	$101,817-$112,039	$112,040-$122,670
FPL Range	Thru 200%	201%-224%	225%-249%	250%-274%	265%-300%

Scale Effective 6/9/16

WESTERN MARYLAND HEALTH SYSTEM
Employed Providers
February 2017

Western Maryland Health System Corporation TIN# 52-0591531
NPI# 1609831247
12500 Willowbrook Road
Cumberland, MD 21502-6393
(***Denotes each practice location within each group)***

WMHS Behavioral Health Services IP NPI# 1285779884

WMHS Behavioral Health Services (Clinic) **OP NPI# 1306092531**

- **12502 Willowbrook Road, Suite 380**
  Cumberland, MD 21502-6592
  Telephone: (240) 964 -8585
  FAX: (240) 964- 8586

  REMIT: P.O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Alan N. Arnson, M.D.	1922083161
Edward M. Ehlers, M.D.	1104883883
Kevin H. Peterson, EdD	1053527895
Jean H. Ruiz, CRNP-PMH	1063471134
Debra N. Schaaf, PhD	1790737195
David K. Strickland, M.D.	1669578688
Gretia Zbarcea M.D.	1497860399

WMHS Specialty Services NPI# 1184769952

- **12502 Willowbrook Road, 3rd Floor, Ste. #470** *(Cardiothoracic Services)*
  Cumberland, MD 21502-6593
  Telephone: (240) 964 -8724
  FAX: (240) 964 - 8735

  REMIT: P.O. Box 1671
  Cumberland, MD 21501-0539
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

WMHS Specialty Services NPI# 1184769952

Continued

Leah Bucci, P.A.	1033469317
Peter Horneffer M.D.	1437145356
Mark G. Nelson, M.D.	1134111743
Heidi N. Race, P.A.	1154512556
Andrea Velandia, P.A.	1467478925
Mark F. Wilt, PA-C	1003975400
Tina Long, PA-C	1841747722

- **12502 Willowbrook Road, Ste. # 420** *(Cardiology Services)*
  Cumberland, MD 21502-6567
  Telephone: (240) 964 -8740
  FAX: (240) 964 -8741

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Michael J. Curran, M.D.	1609846476
Christopher Haas, D.O.	1093786436
Mark F. Wilt, PA-C	1003975400
Kenneth G. Judson, Jr D.O.	1770525891
Aje, Temiolu M.D.	1083816987

- **12502 Willowbrook Road, Ste. 360** *(Wound Care)*
  Cumberland, MD 21502-6498
  Telephone: (240) 964-8711
  Fax: (240) 964-8716

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  FAX: (240) 964-8336

Julie F. Bielec, M.D.	1891754370
Debra Dempsey, CRNP	1841298908

WMHS Specialty Services NPI# 1184769952

Continued

- **12502 Willowbrook Road, Ste. # 640** *(Gastroenterology)*
  Cumberland, MD 21502-
  Telephone: (240) 964 -8717
  FAX: (240) 964 -8720

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Nii Lamptey-Mills, M.D.	1689659997
Arya Karki, M.D.	1750532156
Vamshidhar Vootla M.D.	1144485467
Beverly Moser, CRNP	1023411683

- **12502 Willowbrook Road, Ste. #440** *(Medical Oncology/Int. Med.)*
  Cumberland, MD 21502-6567
  Telephone: (240) 964 -8680
  FAX: (240) 964 -8688

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Blanche H. Mavromatis, M.D.	1336137876
Faye Yin, M.D.	1780879742

12502 Willowbrook Road, Ste. # 280 *(Pulmonary)*
Cumberland, MD 21502-6494
Telephone: (240) 964-8750 (Drs. Sagin and Sprenkle)
(240) 964-8690 (Dr. Schmitt)
FAX: (240) 964 -8699

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Mark A. Sagin, M.D.	1750343505
Richard G. Schmitt, M.D.	1336271667
Boyd E. Sprenkle, M.D.	1306808159
Shannon R. Sprenkle CRNP	1013384072

Ailia W. Ali, MD.	1649400201

WMHS Specialty Services NPI# 1184769952

Continued

- **Western Maryland Health System**
  12500 Willowbrook Road
  Cumberland, MD 21502-6393

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Adegboyega Adejana M.D. (*OB Coverage)*	1316149909
Alex, Biju M.D. (*Gastroenterology Coverage*)	1750558342
Juan A. Arrisueno, M.D. *(General Surgery Trauma)*	1851393565
Kheder Ashker, M.D. *(Neurosurgery Trauma)*	1770561979
Robert Beer, M.D. (*Ortho Trauma Coverage)*	1821061813
Mary Ann Bishop, M.D. (*Nephrology Coverage*)	1609929801
Erin M. Bohen, M.D. *(Nephrology Coverage*)	1538263082
Roy J. Carls, M.D. *(Orthopedic Surgery Trauma)*	1326093634
Roy D. Chisholm, M.D. *(General Surgery Trauma)*	1275550279
Chintamaneni Choudari M.D. (*Gastro Coverage*)	1538148283
Augusto F. Figueroa, M.D. *(Neurosurgery Trauma)*	1740268945
Alison Grazioli M.D. (*Nephrology Coverage*)	1811214596
Tom F. Ghobrial, M.D. *(Ortho Surgery Trauma)*	1518928746
Rashid Hanif M.D. (*Gastroenterology Coverage*)	1285637116
Isabelle Hertig M.D. (*Pulmonary Coverage*)	1013127695
Elaine Kaime M.D. (*Oncology Coverage*)	1396716114
Rohit Khirbat M.D. (*Pulmonary Coverage*)	1194926063
Milton Lum, M.D. (*General Surgery Trauma*)	1740507433
Norman Martin M.D.(*Oncology Clinic* Coverage)	1811955495
Chetanna Okasi, M.D. (*OB Coverage)*	1356484083
Kevin Rossiter M.D. (*Nephrology Coverage*)	1093784332
Cynthia J. Shriver, CRNP *(Radiation Oncology)*	1831485572
Michael W. Stasko, M.D. *(General Surgery Trauma)*	1740365584
Jean Talbert M.D. (*OB Coverage*)	1407918741
William Waterfield M.D. (*Oncology Coverage*)	1871552760
Gregg Wolff, M.D. *(Orthopedic Surgery Trauma)*	1861431561

WMHS Specialty Services NPI# 1184769952

Continued

- **12502 Willowbrook Road, Ste 400** *(Infectious Diseases)*
  Cumberland, MD 21502-3775
  Telephone: (240) 964-8913
  FAX: (240) 964-8911

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Aman K. Dalal, M.D. 1750595575

- **1050 Industrial Boulevard** *(Occupational Health)*
  Cumberland, MD 21502-4331
  Telephone: (240) 964-9355
  FAX: (240) 964-9356

  REMIT: PO Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  FAX: (240) 964 -8336

  James B. Deren, M.D. 1053310078
  Vamsi Kanumuri, M.D. 1542559545

- **12502 Willowbrook Road, Suite 400** *(Nephrology)*
  Cumberland, MD 21502
  Telephone: (240) 964-8724
  FAX: (240) 964-8735

  REMIT: PO Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8910
  FAX: (240)-964-8911

  Umair Syed Ahmed M.D. 1053310078

- **12502 Willowbrook Road, Ste. 660** *(OB/GYN)*
  Cumberland, MD 21502-6579
  Telephone: (240) 964-8760
  FAX: (240) 964-8769

WMHS Specialty Services NPI# 1184769952

Continued

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
FAX: (240) 964-8336

Leah Bennett, PA	1336557370
Sherilyn Crist, RN,CNM	1174962849
Beth H. Jelinek, M.D.	1689700023
Tom Hartsuch, M.D.	1306830252
Victoria Willey, CRNP	1972695070

- **12502 Willowbrook Road, Ste. # 640** *(General Surgery)*
Cumberland, MD 21502-
Telephone: (240) 964 -8717
FAX: (240) 964 -8720

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Birat Dhungel, M.D. 1316142656

- **12502 Willowbrook Road, 3rd Floor, Ste. # 590** *(Ortho Surgery)*
Cumberland, MD 21502-6594
Telephone: (240) 964 -8631
FAX: (240) 964 -8689

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Robert Beer M.D.

- **12502 Willowbrook Road, Ste 450** *(Plastic Surgery)*
Cumberland, MD 21502-6593
Telephone: (240) 964-8931
FAX: (240) 964-8932

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671

Telephone: (240) 964-8515
Fax: (240) 964 -8336
Emme Chapman-Jackson, M.D. 1740487727

WMHS Specialty Services NPI# 1184769952

Continued

- **12500 Willowbrook Road** *(Pain and Palliative Care)*
  Cumberland, MD 21502-6393
  Telephone: (240) 964-8907
  FAX: (240) 964-8901

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

- **12502 Willowbrook Road, Ste 330** *(Endocrinology)*
  Cumberland, MD 21502
  Telephone: (240) 964-8900
  FAX: (240) 964-8901

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Smriti Manandhar M.D. 1801109095

- 12502 **Willowbrook Road, Ste. # 300** *(Heart Failure Clinic)*
  Cumberland, MD 21502-6498
  Telephone: (240) 964 -8787
  FAX: (240) 964 - 8687

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Brandi L. Clark, CRNP 1558790485
  Dawn M. Snyder, CRNP- F 1932343456

WMHS Specialty Services NPI# 1184769952

Continued

- **Center for Clinical Resources** *(Diabetes Program)*
  12502 Willowbrook Road, Suite 300 Cumberland, MD 21502-6498
  Telephone: (240) 964-8787
  FAX: (240) 964-8687

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  FAX: (240) 964-8336

Joni Brode, R.D.	1427310101
Jennifer Perrin, R.D.	1073834685
Tammy Keating, CRNP	1902104060
Allison Lutz, R.D.	1205122421
Mary Tola, CRNP	1588717367

- **12501 Willowbrook Road, 2nd Floor** *(Outpatient Nutritional Counseling)*
  Cumberland, MD, 21502-2506
  Telephone: (240) 964 -8425
  FAX: (240) 964-8415

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Meredythe Barrick, R.D.	1841611449
Melody Lindner R.D.	1205232824
Allison Lutz, R.D.	1205122421
Theresa A. Stahl, R.D.	1447520770

WMHS Primary Care Services NPI# 1902926686

- **625 Kent Avenue, Ste. 204** *(Internal Medicine)*
  Cumberland, MD, 21502-3799
  Telephone: (301) 777-7300
  FAX: (301) 777-7121

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Muhammad Naeem, M.D. 1710186291
  Autumn Painter, CRNP

- **1313 National Highway** *(Family Practice)*
  La Vale, MD 21502-7618
  Telephone: (240) 362-0288
  FAX: (240) 362-0052

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Jennifer Barlow, CRNP 1811957202
  Barbara Pyle, CRNP 1861498412
  Nancy White, CRNP 1336545466

- **12502 Willowbrook Road, Ste 330**
  Cumberland, MD 21502
  Telephone: (240) 964-8900
  FAX: (240) 964-8901

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

  Rameet Thapa, M.D.
  Cara Carpin, CRNP

WMHS Primary Care Services NPI# 1902926686

Continued

- **1050 W. Industrial Blvd, Ste. 17** *(South Cumberland Marketplace)*
  Cumberland, MD 21502-4331
  Telephone: (240) 964-9200
  Fax: (240) 964-9210

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Anupama Khandare, M.D.	1255610580
Mary Ann Riley, D.O.	1174736441

WMHS Urgent Care Services

- **Frostburg Health Center** **1952495079**
  10701 New Georges Creek Road
  Frostburg, MD 21532-1457
  Telephone: (301) 689-3229
  FAX: (301) 689-1129

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

David Carkin PA-C	1205814035
Jeremy Hunt, CRNP	1144465600
Jason Layman CRNP	1811942147
Rory Price, PA-C	1942201991
Darin Adiar PA-C	1265428569
Thomas Kidd PA-C	1265428569
Matt Hurley PA-C	1174519482
Robert Ryan PA-C	1750306049
Jamie Detrick PA-C	
Rondal Zapf, CRNP	
Lynn Metcalf, CRNP	
Jamie Batdorf, CRNP	
Wendell Lewis, PA-C	

WMHS Urgent Care Services
(Continued)

- **Hunt Club Medical Clinic** **1346341716 11**
  Hunt Club Plaza
  Ridgeley, WV 26753-5213
  Telephone: (304) 726-4501
  FAX: (304) 726-4051

  REMIT: P. O. Box 1671
  Cumberland, MD 21501-1671
  Telephone: (240) 964-8515
  Fax: (240) 964 -8336

Matt Hurley, PA-C	
Robert Ryan PA-C	1750306049
Jesssica Steward, CRNP	1336563089
Thomas Kidd PA-C	1265428569
Kristen Lopez PA-C	
Lynn Metcalfe PA-C	
Rondal Zapf, CRNP	
Jamie Batdorf, CRNP	
Wendell Lewis, PA-C	

Appendix IV – Patient Information Sheet
Western Maryland Health System FY17

Hospital Financial Assistance

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

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

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

Patients' Rights and Obligations

Patients' Rights:

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

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

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

Patients' Obligations:

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

The Western Maryland Health System makes every effort to see that patient accounts are properly billed, and patients may expect to receive a uniform summary statement within 30 days of discharge. It is your responsibility to provide correct insurance information.

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

If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment

plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:
If you have questions about your bill, please contact the hospital business office at **240-964-8435** and a hospital representative will be glad to assist you with any questions you may have.

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

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

If you wish to get more information about or apply for Maryland Medical Assistance you may contact your local Department of Social Services by phone 1-800-332-6347; TTY: 1-800-925-4434; or Internet www.dhr.state.md.us. West Virginia residents may contact 1-800-642-8589 orwww.wvdhhr.org. Pennsylvania residents may contact, 1-800-692-7462 or www.compass.state.pa.us

Important Billing Information

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

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

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

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

Appendix V: Mission, Vision & Values
Western Maryland Health System FY17

Mission Statement

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

Vision Statement

Shaping dynamic partnerships in advancing health and well-being.

Core Values – i2care

- **Integrity** – Demonstrate honesty and straightforwardness in all relationships
- **Innovation** – Pursue continuous improvement through creative new ideas, methods, and practices
- **Compassion** – Show care and kindness to all we serve and with whom we work
- **Accountability** – Ensure effective stewardship of the community's trust
- **Respect** – Demonstrate a high regard for the dignity and worth of each person
- **Excellence** – Strive for superior performance in all that we do