The MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Western Maryland Health System

FY 2018 Community Benefit Narrative Report

PART ONE: ORIGINAL NARRATIVE SUBMISSION

Q1.
Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) 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 developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. 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. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. 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.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. ## Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Western Maryland Health System.	⦿	○	
Your hospital's ID is: 210027	⦿	○	
Your hospital is part of the hospital system called N/A.	⦿	○	
Your hospital was licensed for 200 beds during FY 2018.	○	⦿	There were an additional 13 beds for rehabilitation and 20 for nursery.
Your hospital's primary service area includes the following zip codes: 21501, 21502, 21503, 21504, 21505, 21521, 21522, 21523, 21524, 21528, 21529, 21530, 21532, 21536, 21539, 21540, 21542, 21543, 21545, 21555, 21556, 21557, 21560, 21562, 21766	⦿	○	
Your hospital shares some or all of its primary service area with the following hospitals: none.	⦿	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find   these community health statistics useful in preparing your responses.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

> WMHS defines its community benefit service area as Allegany County and reviews the demographics for the county as part of the community health needs assessment every three years. Sources include Maryland Vital Statistics, US Census Bureau- American Community Survey, County Health Rankings, and MD SHIP. This data is examined in conjunction with internal metrics for use in community benefit efforts.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

needs_table.docx
19.6KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q7. ## Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

☑ Allegany County	☐ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County

☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☐ Montgomery County	☐ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

☑ 21502	☑ 21540
☑ 21521	☑ 21543
☑ 21524	☑ 21545
☑ 21529	☑ 21555
☑ 21530	☑ 21557
☑ 21532	☑ 21562
☑ 21539	☑ 21750

Q10. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

☐ Based on ZIP codes in your Financial Assistance Policy. Please describe.

☐ Based on ZIP codes in your global budget revenue agreement. Please describe.

☑ Based on patterns of utilization. Please describe.

As the sole community hospital with over 70% of patients residing in Allegany County, WMHS selected the county as the CBSA.

☐ Other. Please describe.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.wmhs.com/about/

Q37. Is your hospital an academic medical center?

○ Yes
◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Demographic_Characteristic_fy18.docx
19KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q40. ## Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

◉ Yes
○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's first-ever CHNA completed? (MM/DD/YYYY)

01/26/2012

Q44. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/15/2017

Q45. Please provide a link to your hospital's most recently completed CHNA.

https://www.wmhs.com/community/

Q46. Did you make your CHNA available in other formats, languages, or media?

◉ Yes
○ No

Q47. Please describe the other formats in which you made your CHNA available.

We distributed numerous paper copies of the CHNA and shared the content in presentations. A link to the online version was shared through many of the community partners.

Q48. ## Section II - CHNA Part 2 - Participants

Q49. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

CHNA Activities

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	Oversight and facilitate integration with strategic planning
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	Oversight and facilitate integration with strategic planning
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☐	☐	☑	☑	☑	☑	☐	☐	
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☐	☐	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Included through senior executive and clinical leadership
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Nurses are included in several of the other categories not specifically as a discipline.
Social Workers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Social workers are included in several of the other categories not specifically as a discipline
Community Benefit Task Force	☐	☐	☐	☐	☐	☑	☑	☐	☑	☐	Making connections between CHNA and Community Benefits
Hospital Advisory Board	☐	☐	☐	☐	☐	☐	☑	☑	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q50. Section II - CHNA Part 2 - Participants (continued)

Q51. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Health Department -- Please list the Local Health Departments here: Allegany County Health Department	☐	☑	☑	☑	☑	☑	☑	☑	☑	Co-chair the Coalition that facilitates the CHNA
Local Health Improvement Coalition -- Please list the LHICs here: Allegany County Health Planning Coalition	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Maryland Department of Health	☐	☐	☐	☑	☐	☐	☐	☑	☑	SHIP
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: Allegany Human Resources Development Commission	☐	☑	☐	☑	☐	☑	☑	☐	☐	
Local Govt. Organizations -- Please list the organizations here: Allegany Co. Dept of Social Services, Sheriff's Office, Allegany Transit, Cumberland Recreation & Parks	☐	☑	☐	☑	☐	☑	☑	☐	☐	
Faith-Based Organizations	☐	☑	☐	☐	☐	☑	☑	☐	☐	
School - K-12 -- Please list the schools here: Allegany County Public School	☐	☑	☐	☑	☑	☑	☑	☐	☐	
School - Colleges and/or Universities -- Please list the schools here: Allegany College of Md, Frostburg State Univ. University of MD Extension	☐	☑	☐	☑	☐	☑	☑	☐	☐	
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here: Pressley Ridge, Core Service Agency	☐	☑	☐	☑	☐	☑	☑	☐	☐	
Social Service Organizations -- Please list the organizations here: Salvation Army, YMCA, Associated Charities, Western Maryland Food Bank, Friends Aware, Family Junction, Family Crisis Resource Center, Allegany Health Right,	☐	☑	☐	☑	☑	☑	☑	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here: Office of Consumer Advocate, Local Management Board, NAACP Chapter	☐	☑	☐	☐	☑	☑	☑	☐	☐	
Other -- If any other people or organizations were involved, please list them here: TriState Community Health Center, AHEC West, County United Way, Chamber of Commerce, Private providers, Maryland Physicians Care, Priority Partners, Allegany Radio, Drug Abuse Alcohol Council, Tobacco Free Coalition, Make Healthy Choices Easy, Mental Health Advisory Board, Workgroup on Access to Care, Transportation Advisory Board, Dental Society, Community Wellness Coalition, Overdose Prevention Task Force, Western Maryland Food Council	☐	☑	☐	☐	☐	☑	☑	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q52. Section II - CHNA Part 3 - Follow-up

Q53. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

◉ Yes
○ No

Q54. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/15/2017

Q55. Please provide a link to your hospital's CHNA implementation strategy.

https://www.wmhs.com/community/

Q56. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q57. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

☑ Access to Health Services: Health Insurance
☑ Access to Health Services: Practicing PCPs
☐ Access to Health Services: Regular PCP Visits
☐ Access to Health Services: ED Wait Times
☑ Adolescent Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions
☐ Blood Disorders and Blood Safety
☐ Cancer
☐ Chronic Kidney Disease
☐ Community Unity
☐ Dementias, Including Alzheimer's Disease
☑ Diabetes
☐ Disability and Health
☑ Educational and Community-Based Programs
☐ Emergency Preparedness
☐ Environmental Health

☐ Family Planning
☐ Food Safety
☐ Genomics
☐ Global Health
☑ Health Communication and Health Information Technology
☑ Health-Related Quality of Life & Well-Being
☐ Hearing and Other Sensory or Communication Disorders
☑ Heart Disease and Stroke
☐ HIV
☐ Immunization and Infectious Diseases
☐ Injury Prevention
☐ Lesbian, Gay, Bisexual, and Transgender Health
☑ Maternal & Infant Health
☑ Mental Health and Mental Disorders
☑ Nutrition and Weight Status

☑ Older Adults
☑ Oral Health
☑ Physical Activity
☐ Preparedness
☑ Respiratory Diseases
☑ Sexually Transmitted Diseases
☐ Sleep Health
☑ Social Determinants of Health
☑ Substance Abuse
☐ Telehealth
☑ Tobacco Use
☑ Violence Prevention
☐ Vision
☐ Wound Care
Other (specify)
☑ sepsis, poverty, health literacy

Q58. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

Priorities in the most recent CHNA are: substance abuse, poverty, heart disease, and access to care/health literacy. There are many common themes when comparing them to the priorities in the prior CHNA (access & socioeconomics, healthy lifestyle & wellbeing, and disease management). After review of health status indicators and causative factors, we selected more specific foci for the current CHNA. Key progress made between 2014-2017: □ -Residents that reported missing appointments due to transportation declined from 26% to 16% □- Level 1 and 2 emergency department visits decreased from 15,501 to 8,219 □ -Behavioral health related emergency department visits decreased from 7,517.9 visits per 100,000 population to 6,216.5 per 100,000 □ - 209 patients were engaged in disease management resulting in fewer emergency department and hospital visits Continued Challenges: □ - 19.3% percent of elementary age children are in the 95th percentile or higher f or body mass index and the percentage is increasing □ -Emergency department visits for hypertension are at 279.1 per 100,000 population and the rate has increased steadily since 2010 □ -18.7 drug-induced deaths caused by illicit or prescription drugs per 100,000 population and deaths are rising Substance abuse and poverty were identified as top priorities through a survey and community partners, so more streamlined strategies were created. With the continued challenge of hypertension and obesity, the priority became heart disease this cycle versus healthy lifestyle & wellbeing. Access to Care became less about insurance coverage in this cycle and more about understanding and education. Though there was not a disease management priority in the current cycle, there were aspects of disease management covered in current priorities such as social determinants of health and education. Attached below is a file that compares the priorities over the years.

Q59. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q60. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q61. Section III - CB Administration Part 1 - Participants

Q62. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☑	Coordinated the connection of CHNA and implementation strategy with community benefits
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☐	☑	☑	☐	☑	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Oversight of these activities and approval
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)		☑									
Community Benefit staff (facility level)										☑	tracking community benefits
Community Benefit staff (system level)		☑									
Physician(s)										☑	Discipline represented through senior executives
Nurse(s)										☑	Discipline represented through senior executives
Social Workers	☑										
Community Benefit Task Force										☑	Reporting and Coordination
Hospital Advisory Board	☑										
Other (specify)											

Q63. Section III - CB Administration Part 1 - Participants (continued)

Q64. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities										Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)		Other - If you selected "Other (explain)," please type your explanation below:

Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Health Department -- Please list the Local Health Departments here: Allegany County Health Dept.	☐	☑	☑	☑	☐	☐	☑	☑	☑	shared coordination of CHNA and implementation strategy
Local Health Improvement Coalition -- Please list the LHICs here: Allegany County Health Planning Coalition	☐	☑	☑	☐	☐	☐	☑	☑	☐	
Maryland Department of Health	☐	☐	☐	☐	☑	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: Allegany Human Resource Development Commission	☐	☐	☐	☐	☐	☐	☑	☑	☑	Participate in process through the LHIC
Local Govt. Organizations -- Please list the organizations here: Allegany County Dept of Social Services, Sheriff's Office, Allegany Transit, Cumberland Rec & Parks	☐	☐	☐	☐	☐	☐	☑	☑	☑	Participate in process through the LHIC

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations							☑	☑	☑	Participate in process through the LHIC
School - K-12 -- Please list the schools here: Allegany County Public Schools			☑				☑	☑	☑	Participate in process through the LHIC
School - Colleges and/or Universities -- Please list the schools here: Allegany College of Md. Frostburg State University, UM Extension							☑		☑	Participate in process through the LHIC
School of Public Health -- Please list the schools here:	☑									
School - Medical School -- Please list the schools here:	☑									
School - Nursing School -- Please list the schools here:	☑									
School - Dental School -- Please list the schools here:	☑									
School - Pharmacy School -- Please list the schools here:	☑									
Behavioral Health Organizations -- Please list the organizations here: Pressley Ridge, Core Service Agency			☑			☑	☑	☑	☑	Participate in process through the LHIC
Social Service Organizations -- Please list the organizations here: Associated Charities, Family Crisis Resource Center, WMD Food bank, YMCA							☑	☑	☑	Participate in process through the LHIC
Post-Acute Care Facilities -- please list the facilities here:	☑									

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here: Local Management Board, Office of Consumer Advocate	☐	☐	☑	☐	☐	☐	☑	☑	☑	Participate in process through the LHIC
Other -- If any other people or organizations were involved, please list them here: AHEC West, County United Way, Chamber of Commerce, Drug and Alcohol Abuse Council, Mountain Health Alliance, Make Healthy Choices Easy, Opioid Intervention Team	☑	☐	☑	☐	☐	☑	☑	☑	☑	Participate in process through the LHIC

Q65. Section III - CB Administration Part 2 - Process & Governance

Q66. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

☑ Yes, by the hospital's staff
☐ Yes, by the hospital system's staff
☐ Yes, by a third-party auditor
☐ No

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

◉ Yes
○ No

Q68. Please describe the community benefit narrative review process.

> The internal audit consists of a series of checks and balances. There are a collection of reporters that enter occurrences into CBISA, each of their entries is reviewed and imported by the System Administrator/Director of Community 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 entered into CBISA by the System Administrator and then several reports are pulled for review by the System Administrator and Finance Director (including a three year comparison). Since the Director of Community Wellness serves as the CBISA System Administrator and is engaged with the CHNA and implementation plan, this position is responsible for compiling the draft narrative. All members of the Community Benefits Committee review the narrative to ensure its accuracy. The Chief Financial Officer has the final review and sign off before it is shared with the WMHS Board of Directors for review and action.

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

◉ Yes
○ No

Q70. Please explain:

This question was not displayed to the respondent.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

◉ Yes
○ No

Q72. Please explain:

This question was not displayed to the respondent.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

🔘 Yes

⭕ No

Q74. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

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 hospitals strategic plan. Through the Director of Community 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

Q75. (Optional) If available, please provide a link to your hospital's strategic plan.

Q76. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

During the period between community health needs assessments, the outcome metrics are reviewed and updated along with the process metrics for identified strategies in the local health action plan. These steps are completed in conjunction with the Local Health Action Plan Workgroup and Allegany County Health Planning Coalition. Adjustments to the implementation plan and link to community benefits are shared with WMHS Administration. If significant changes were desired, they would be presented to WMHS Administration and the Board for approval prior to implementation.

Q77. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q78. Based on the implementation strategy developed through the CHNA process, please describe   *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q79. Section IV - CB Initiatives Part 1 - Initiative 1

Q80. Name of initiative.

Transportation and Mobility Management

Q81. Does this initiative address a need identified in your CHNA?

🔘 Yes

⭕ No

Q82. Select the CHNA need(s) that apply.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Adolescent Health	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Maternal and Infant Health
☐ Blood Disorders and Blood Safety	☐ Mental Health and Mental Disorders
☐ Cancer	☐ Nutrition and Weight Status
☐ Chronic Kidney Disease	☐ Older Adults
☐ Community Unity	☐ Oral Health
☐ Dementias, Including Alzheimer's Disease	☐ Physical Activity
☐ Diabetes	☐ Preparedness
☐ Disability and Health	☐ Respiratory Diseases
☐ Educational and Community-Based Programs	☐ Sexually Transmitted Diseases
☐ Emergency Preparedness	☐ Sleep Health
☐ Environmental Health	☑ Social Determinants of Health
☐ Family Planning	☐ Substance Abuse
☐ Food Safety	☐ Telehealth

☐ Genomics   ☐ Tobacco Use
☐ Global Health   ☐ Violence Prevention
☐ Health Communication and Health Information Technology   ☐ Vision
☐ Health-Related Quality of Life and Well-Being   ☐ Wound Care
☐ Hearing and Other Sensory or Communication Disorders   ☐ Other. Please specify.

Q83. When did this initiative begin?

09/20/2012

Q84. Does this initiative have an anticipated end date?

○ The initiative will end on a specific end date. Please specify the date. _____

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

○ The initiative will end when external grant money to support the initiative runs out. Please explain.

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

◉ Other. Please explain. | Until an alternate source of transportation is made available to patients.

Q85. Enter the number of people in the population that this initiative targets.

7326

Q86. Describe the characteristics of the target population.

The target population includes mostly seniors, individuals with disabilities, and low income residents. The target number is based on the percentage of the total population without vehicles. This service targets patients without transportation or faced with transportation barriers when trying to access care or return home.

Q87. How many people did this initiative reach during the fiscal year?

945

Q88. What category(ies) of intervention best fits this initiative? Select all that apply.

☐ Chronic condition-based intervention: treatment intervention
☐ Chronic condition-based intervention: prevention intervention
☐ Acute condition-based intervention: treatment intervention
☐ Acute condition-based intervention: prevention intervention
☐ Condition-agnostic treatment intervention
☑ Social determinants of health intervention
☐ Community engagement intervention
☐ Other. Please specify.

Q89. Did you work with other individuals, groups, or organizations to deliver this initiative?

🔘 Yes. Please describe who was involved in this initiative.

> Human Resource Development Commission - Allegany
> County Health Department-
> Tri State Community Health Center- Behavioral Health
> Systems Office- Allegany Transit -
> Tri County Council, WMD

⚪ No.

Q90. Please describe the primary objective of the initiative.

> The primary objective of the initiative is to provide underserved residents with rides to health and human service appointments when no other resources are available thereby reducing missed appointments. Though not a direct connection, by increasing access to needed care, it is anticipated that medically unnecessary visits to the ED and readmissions will be reduced.

Q91. Please describe how the initiative is delivered.

> A contractual arrangement and partnership agreement with several community agencies, guides the transportation initiative. Identified staff at WMHS have been trained to assess a patient's need for transportation. When scheduling a patient's appointment or discharging a patient from the hospital, if transportation is needed the first step is to see if the patient qualifies for transportation from another source or if a family/friend can provide a ride. If no other source is available, a request is entered into a portal monitored by HRDC. HRDC will determine the most appropriate mode of transportation based on the request. If a patient qualifies for the Mobility Management Program or AllTrans, those services will be used. When a request does not fit the criteria for other services, HRDC will provide the On Demand transportation or arrange for a taxi. If the patient uses a wheelchair, walker, or is unsteady and needs assistance, HRDC will assist the patient to the front door or across the threshold of a provider's office or their residence.WMHS will provide walkers, wheelchairs and other needed equipment to aid the patient. This service is not advertised. WMHS also uses taxi vouchers to provide backup when HRDC cannot provide a ride. WMHS continues to work with the partners in Mobility Management and others to identify how to coordinate transportation sources better in the area. In FY18, efforts focused on developing a proposal for a One Call One Click system for transportation.

Q92. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters `# rides provided`

☑ Other process/implementation measures (e.g. number of items distributed) `number of strategies and/or partners coordinating transportation`

☑ Surveys of participants `missing appointments due to transportation`

☐ Biophysical health indicators `_____`

☐ Assessment of environmental change `_____`

☐ Impact on policy change `_____`

☐ Effects on healthcare utilization or cost `_____`

☐ Assessment of workforce development `_____`

☐ Other `_____`

Q93. Please describe the outcome(s) of the initiative.

> In FY18, 7812 rides were provided through the transportation initiative to enable low-income residents to access health and human service appointments. Encounters include:3665 rides in portal of which 24% required wheelchair transportation,73 off hour transports, 1300 taxi vouchers,1204 Mobility Management, 1550 bus passes and 20 miscellaneous ride sources. Community surveys done in 2011, 2014 and 2016 showed a decrease in the percent of adults who report missing appointments due to problems finding transportation from 25% to 16%. The next survey was delayed until July 2019. This initiative cannot directly claim the reduction of unnecessary ED visits, however,transportation services contributed to the continued reduction of level 1&2 visits in ED from 17,519 in 2011 to 6476 in FY18. Several attempts have been made to look at cost avoidance, but often there are other variables to consider. Additional research is needed to build upon the recent studies that show non-emergency medical transport pays for itself as part of a care management strategy for patients with chronic diseases. In FY19, a comparison of no shows and transportation use for select patients is being reviewed.

Q94. Please describe how the outcome(s) of the initiative addresses community health needs.

> Access to care and the barriers of poverty are community health needs addressed by the outcomes of the transportation initiative. Poverty, transportation and other social determinants were felt to be key contributing factors to the health status of our community. 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. By increasing collaboration on transportation, especially for those living in poverty, the number of adults missing appointments decreased. This initiative addresses health equity and access to care for various health needs.

Q95. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

> $151,054 hospital funds

Q96. (Optional) Supplemental information for this initiative.

Q97. Section IV - CB Initiatives Part 2 - Initiative 2

Q98. Name of initiative.

Center for Clinical Resources (CCR)

Q99. Does this initiative address a need identified in your CHNA?

◉ Yes
○ No

Q100. Select the CHNA need(s) that apply.

☐ Access to Health Services: Health Insurance	☑ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Adolescent Health	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Maternal and Infant Health
☐ Blood Disorders and Blood Safety	☐ Mental Health and Mental Disorders
☐ Cancer	☐ Nutrition and Weight Status
☐ Chronic Kidney Disease	☐ Older Adults
☐ Community Unity	☐ Oral Health
☐ Dementias, Including Alzheimer's Disease	☐ Physical Activity
☑ Diabetes	☐ Preparedness
☐ Disability and Health	☐ Respiratory Diseases
☑ Educational and Community-Based Programs	☐ Sexually Transmitted Diseases
☐ Emergency Preparedness	☐ Sleep Health
☐ Environmental Health	☑ Social Determinants of Health
☐ Family Planning	☐ Substance Abuse
☐ Food Safety	☐ Telehealth
☐ Genomics	☐ Tobacco Use
☐ Global Health	☐ Violence Prevention
☐ Health Communication and Health Information Technology	☐ Vision
☐ Health-Related Quality of Life and Well-Being	☐ Wound Care
☐ Hearing and Other Sensory or Communication Disorders	Other. Please specify. ☑ Poverty and health Literacy

Q101. When did this initiative begin?

11/01/2013

Q102. Does this initiative have an anticipated end date?

○ The initiative will end on a specific end date. Please specify the date. [_____]

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

[   ]

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

[   ]

○ The initiative will end when external grant money to support the initiative runs out. Please explain.

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

◉ Other. Please explain.

This initiative is ongoing, however, it is continually evaluated and adjusted to meet the changing needs of the population it serves. Data analysts help to identify the effective components, and when a component is found to be ineffective it will end.

Q103. Enter the number of people in the population that this initiative targets.

6872

Q104. Describe the characteristics of the target population.

The projected target is based on the percentage of individuals over the age of 65 or low income, living with multiple chronic conditions. The Center for Clinical Resources is a source of support for at risk patients managing chronic medical conditions such as diabetes, heart failure, and lung disease, or taking anticoagulation medication.

Q105. How many people did this initiative reach during the fiscal year?

1599

Q106. What category(ies) of intervention best fits this initiative? Select all that apply.

☑ Chronic condition-based intervention: treatment intervention
☑ Chronic condition-based intervention: prevention intervention
☐ Acute condition-based intervention: treatment intervention
☐ Acute condition-based intervention: prevention intervention
☐ Condition-agnostic treatment intervention
☑ Social determinants of health intervention
☐ Community engagement intervention
☐ Other. Please specify.

Q107. Did you work with other individuals, groups, or organizations to deliver this initiative?

◉ Yes. Please describe who was involved in this initiative.

WMHS has collaborated with the Medical staff and area providers who are very supportive of the CCR. Associated Charities collaborates on prescription assistance and addressing the social determinants of health. In FY18 AHEC West and ACHD were engaged in chronic disease self management.

○ No.

Q108. Please describe the primary objective of the 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 desire is to effectively co-manage at-risk patients who have a chronic disease to improve their health.

Q109. Please describe how the initiative is delivered.

The Center for Clinical Resources promotes disease management with patient education, support services, condition monitoring and medication management in the areas of Congestive Heart Failure, Diabetes, COPD, anticoagulation and medication therapy management. A referral is needed for communication to be maintained with the PCP. An interdisciplinary team is available and services are provided based on the patient's needs and risk level. Evidence based disease management programs are utilized. Community partners are engaged especially when a patient is identified at a lower risk level. An standard assessment of social determinants of health begins to be utilized. Education pathways have been established for some of the chronic diseases and are under development for other diseases. A variety of utilization and health status indicators are tracked and analyzed to continually improve the CCR.

Q110. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters `# new referrals and # total encounters`

☑ Other process/implementation measures (e.g. number of items distributed) `#Telephone calls that prevent ED visit`

☐ Surveys of participants `_____`

☐ Biophysical health indicators `_____`

☐ Assessment of environmental change `_____`

☐ Impact on policy change `_____`

☑ Effects on healthcare utilization or cost `% no shows`

☐ Assessment of workforce development `_____`

☑ Other `rate of ED visits per 100,000 population`

Q111. Please describe the outcome(s) of the initiative.

During FY18, there were 11,265 (office and phone) encounters for CHF, Diabetes and COPD. The OPAC and medication management added another 12,547 encounters. The no show rates were: COPD at 17.3%, CHF at 6.6%, DM at 14.8%. COPD was down slightly, CHF was about the same, and diabetes was up but only included dietitian visits as there is no longer a full time CRNP focused on diabetes in the CCR. COPD has been identified as an opportunity for improvement and was suggested for consideration in the strategic plan. A new grant focused on type 2 diabetes has impacted the processes for diabetes in the CCR this fiscal year, and may make the outcomes less comparable with prior years. CHF patients in the CCR had 580 documented interventions (i.e. IV Lasix). Of those 580 encounters, 96% remained out of the emergency department for at least three days post intervention, resulting in cost avoidance and improved satisfaction and quality of life for the patients. MTM assisted 77 patients in FY18 by reviewing all medications and making recommendations to their PCP to improve the efficacy and cost of their medication regimen. There were 44 documented telephone avoided ER visits (COPD, DM, and CHF) by CCR patients in FY18. SHIP data indicates a slight decrease in the ED visits for diabetes. The primary Medicaid provider for our region, Maryland Physicians Care, shared data for CCR patients in FY18 showing a $1,378,741.87 reduction in cost of care and cost avoidance of $5,892 per patient including (Reduction of Emergency encounters=191, Reduction of Observation encounters=42,Reduction of inpatient encounters=110, Reduction of readmissions =36 and Reduction of LOS total days=247). ProDiver information supports the following cost avoidance (non-diagnosis specific) for patients in the Heart Failure, Diabetes, or COPD clinics for 12 months (not all Fy18): 12 months # Patients 1873 ED Encounter Reductions 666 Observation Encounter Reductions 199 Inpatient Encounter Reductions 712 Readmission Encounter Reductions 48 Cost Avoidance $13,201,230

Q112. Please describe how the outcome(s) of the initiative addresses community health needs.

Access to care, health literacy, poverty and heart disease are all priority community health needs addressed by the CCR. In addition to providing evidence-based programs, the CCR provides the extra support needed to engage patients in self management and address the social determinants of health.

Q113. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$1,612,941 hospital funds

Q114. (Optional) Supplemental information for this initiative.

Q115. ## Section IV - CB Initiatives Part 3 - Initiative 3

Q116. Name of initiative.

Maake Healthy Choices Easy

Q117. Does this initiative address a need identified in your CHNA?

◉ Yes
○ No

Q118. Select the CHNA need(s) that apply.

☐ Access to Health Services: Health Insurance
☐ Access to Health Services: Practicing PCPs
☐ Access to Health Services: Regular PCP Visits
☐ Access to Health Services: ED Wait Times
☐ Adolescent Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions
☐ Blood Disorders and Blood Safety

☐ Heart Disease and Stroke
☐ HIV
☐ Immunization and Infectious Diseases
☐ Injury Prevention
☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Maternal and Infant Health
☐ Mental Health and Mental Disorders

☐ Cancer	☑ Nutrition and Weight Status
☐ Chronic Kidney Disease	☐ Older Adults
☐ Community Unity	☐ Oral Health
☐ Dementias, Including Alzheimer's Disease	☑ Physical Activity
☐ Diabetes	☐ Preparedness
☐ Disability and Health	☐ Respiratory Diseases
☑ Educational and Community-Based Programs	☐ Sexually Transmitted Diseases
☐ Emergency Preparedness	☐ Sleep Health
☐ Environmental Health	☐ Social Determinants of Health
☐ Family Planning	☐ Substance Abuse
☐ Food Safety	☐ Telehealth
☐ Genomics	☐ Tobacco Use
☐ Global Health	☐ Violence Prevention
☐ Health Communication and Health Information Technology	☐ Vision
☑ Health-Related Quality of Life and Well-Being	☐ Wound Care
☐ Hearing and Other Sensory or Communication Disorders	☐ Other. Please specify.

Q119. When did this initiative begin?

10/06/2010

Q120. Does this initiative have an anticipated end date?

○ The initiative will end on a specific end date. Please specify the date. [ ]

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

[ ]

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

[ ]

○ The initiative will end when external grant money to support the initiative runs out. Please explain.

[ ]

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

[ ]

◉ Other. Please explain. | This initiative will not end until a large enough portion of the population makes behavior changes due to the program, environment or policy changes.

Q121. Enter the number of people in the population that this initiative targets.

12,201

Q122. Describe the characteristics of the target population.

With 28% of the adult population physically inactive and 21.5% of elementary school children obese (95th percentile or higher), this initiative targets children and families.

Q123. How many people did this initiative reach during the fiscal year?

5818

Q124. What category(ies) of intervention best fits this initiative? Select all that apply.

☐ Chronic condition-based intervention: treatment intervention

☑ Chronic condition-based intervention: prevention intervention

☐ Acute condition-based intervention: treatment intervention

☐ Acute condition-based intervention: prevention intervention

☐ Condition-agnostic treatment intervention

☐ Social determinants of health intervention

☑ Community engagement intervention

☐ Other. Please specify.

Q125. Did you work with other individuals, groups, or organizations to deliver this initiative?

◉ Yes. Please describe who was involved in this initiative.

Make Healthy Choices Easy Coalition -Allegany County Board of Education,Allegany County Health Department, Evergreen Heritage Center, Maryland Physicians Care, Priority Partners, University of Maryland Extension, AHEC West and YMCA

○ No.

Q126. Please describe the primary objective of the initiative.

The goal of this initiative is to collaborate with partners to make health eating and physical activity easier, through accessible programs to promote behavior change and with policy and environmental changes. Related objectives in implementation plan:*Between July 1, 2017 and June 30, 2020, implement at least 5 strategies to increase engagement of elementary students in healthy eating and physical activity. *By June 30, 2020, engage 500 students in positive behavior changes related to healthy eating and physical activity.

Q127. Please describe how the initiative is delivered.

This initiative is a multimodal, community-wide campaign to promote healthy eating and physical activity by making healthy choices easier. Activities to promote healthy eating and physical activity were implemented with children and families at 5 venues (Library Summer Reading Program, Healthy School Challenge, Family Fun & Literacy Nights, Stress Buster Fair at ACM, Arts In the Outdoors-Evergreen). These activities were planned with the MHCE Coalition and often coordinated by WMHS staff. The Healthy School Challenge provided an opportunity for schools to select among evidence-based strategies including nutrition, physical activity and stress management while competing with other schools for prizes. Sixteen of the 22 public schools in Allegany County participated. Activities implemented at the schools included: a no soda for a week campaign, nutrition tips with the morning announcements, students making artwork for Halloween rather than celebrating with candy, Walking Wednesdays, teachers integrating movement in the classrooms including stretching and calming exercises, a 5 minute physical activity break, balance balls for seating, tracking students' progress with Fitnessgram, mindful breathing sessions with students and parents and more. In addition to the programs, the initiative involved development of a School Wellness & Nutrition Committee and advocacy to get the Community Eligibility Provision approved for 4 schools. Based on the objectives in the implementation plan, did not include related programs focused on nutrition and physical activity in the initiative this year. Change to Win, group fitness, Wellness Coaching, Farmers Market vouchers and others are still offered by WMHS but not included in this year's report.

Q128. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters | # of participants |

☑ Other process/implementation measures (e.g. number of items distributed) | # strategies implemented |

☐ Surveys of participants

☐ Biophysical health indicators

☐ Assessment of environmental change

☑ Impact on policy change | school wellness policies |

☐ Effects on healthcare utilization or cost

☐ Assessment of workforce development

☑ Other | behavior change |

Q129. Please describe the outcome(s) of the initiative.

There were 5818 participants in this initiative and 7 strategies were implemented. 16 of the 22 schools in the county participated in the Healthy School Challenge creating behavior change with 5500 students, ranging from reducing sugary beverages to increasing movement. Through this effort a wellness champion was identified at each school and the existing school wellness policies were assessed. Other outcomes with longer term impact include approval to establish a School Wellness & Nutrition Committee under the School Health Council and approval of the Community Eligibility Provision.

Q130. Please describe how the outcome(s) of the initiative addresses community health needs.

Heart disease, poverty, access to care & health literacy are priority community health needs addressed by this initiative. By utilizing a multimodal approach with community partners and providing accessible programs to all schools, the barriers of poverty and access are overcome. By focusing on healthy eating and physical activity the risk factors of heart disease are addressed.

Q131. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$24,391 hospital funds

Q132. (Optional) Supplemental information for this initiative.

Q133. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q134. Additional information about initiatives.

Q135. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q136. Were all the needs identified in your CHNA addressed by an initiative of your hospital?

○ Yes
◉ No

Q137. Please check all of the needs that were NOT addressed by your community benefit initiatives.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Adolescent Health	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Maternal and Infant Health
☐ Blood Disorders and Blood Safety	☐ Mental Health and Mental Disorders
☐ Cancer	☐ Nutrition and Weight Status
☐ Chronic Kidney Disease	☐ Older Adults
☐ Community Unity	☐ Oral Health
☐ Dementias, Including Alzheimer's Disease	☐ Physical Activity
☐ Diabetes	☐ Preparedness
☐ Disability and Health	☐ Respiratory Diseases
☐ Educational and Community-Based Programs	☑ Sexually Transmitted Diseases
☐ Emergency Preparedness	☐ Sleep Health
☐ Environmental Health	☐ Social Determinants of Health
☐ Family Planning	☐ Substance Abuse
☐ Food Safety	☐ Telehealth
☐ Genomics	☐ Tobacco Use
☐ Global Health	☐ Violence Prevention
☐ Health Communication and Health Information Technology	☐ Vision
☐ Health-Related Quality of Life and Well-Being	☐ Wound Care
☐ Hearing and Other Sensory or Communication Disorders	Other. Please specify. ☑ COPD, Teen use of Vapor products

Q138. How do the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? The State Health Improvement Process (SHIP) seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The SHIP measures represent what it means for Maryland to be healthy. Website: http://ship.md.networkofcare.org/ph/index.aspx. To the extent applicable, please explain how the hospital's community benefit activities align with the goal in each selected measure.

Enter details in the text box next to any SHIP goals that apply.

Reduce infant mortality	Baseline-6.8, Target- 6.5, Current-8.1 Linked to substance abuse priority
Reduce rate of sudden unexpected infant deaths (SUIDs)	
Reduce the teen birth rate (ages 15-19)	
Increase the % of pregnancies starting care in the 1st trimester	
Increase the proportion of children who receive blood lead screenings	
Increase the % of students entering kindergarten ready to learn	

Increase the %of students who graduate high school	
Increase the % of adults who are physically active	
Increase the % of adults who are at a healthy weight	
Reduce the % of children who are considered obese (high school only)	WMHS tracks Elementary School Baseline-20, Target- 13.6, Current-21.5 Linked to heart disease priority
Reduce the % of adults who are current smokers	
Reduce the % of youths using any kind of tobacco product (high school only)	
Reduce HIV infection rate (per 100,000 population)	
Reduce Chlamydia infection rate	
Increase life expectancy	
Reduce child maltreatment (per 1,000 population)	possibleBaseline-23.3, Target-19 , Current-21.1 Linked to access to care priority
Reduce suicide rate (per 100,000)	
Reduce domestic violence (per 100,000)	Baseline-719.5, Target- 500, Current-610 Linked to access to care priority possible
Reduce the % of young children with high blood lead levels	
Decrease fall-related mortality (per 100,000)	
Reduce pedestrian injuries on public roads (per 100,000 population)	
Increase the % of affordable housing options	
Increase the % of adolescents receiving an annual wellness checkup	
Increase the % of adults with a usual primary care provider	Use ratio of people per PCP
Increase the % of children receiving dental care	
Reduce % uninsured ED visits	
Reduce heart disease mortality (per 100,000)	Baseline-256.8, Target- 236.8, Current-246.7 Linked to heart disease priority
Reduce cancer mortality (per 100,000)	
Reduce diabetes-related emergency department visit rate (per 100,000)	
Reduce hypertension-related emergency department visit rate (per 100,000)	Baseline-225.1, Target-214.4 , Current-279.1 Linked to heart disease priority
Reduce drug induced mortality (per 100,000)	
Reduce mental health-related emergency department visit rate (per 100,000)	Baseline-2320.6-, Target-3500, Current-4722.9 Linked to access to care priority
Reduce addictions-related emergency department visit rate (per 100,000)	
Reduce Alzheimer's disease and other dementias-related hospitalizations (per 100,000)	
Reduce dental-related emergency department visit rate (per 100,000)	
Increase the % of children with recommended vaccinations	
Increase the % vaccinated annually for seasonal influenza	
Reduce asthma-related emergency department visit rate (per 10,000)	

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

☐ No gaps

☑ Primary care

☑ Mental health

☐ Substance abuse/detoxification

☐ Internal medicine

☐ Dermatology

☑ Dental

☑ Neurosurgery/neurology

☐ General surgery

☐ Orthopedic specialties

☐ Obstetrics

☐ Otolaryngology

☑ Other. Please specify. pulmonary and gastroenterology

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

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 hasresponded 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)	Speciality practices meeting unmet need-With community need for specialists in nephrology, infectious disease, endocrinology, pulmonary, cardiology, GI, and wound care, WMHS provides these services that would otherwise not be available and does so at a loss.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

Q146. Upload a copy of your hospital's financial assistance policy.

Financial_Assistance_Policy.pdf
322.1KB
application/pdf

Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Patient_Info_Sheet_WMHS_FY18.docx
20.2KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q148. What is your hospital's household income threshold for medically necessary free care? Please respond with ranges as a percentage of the federal poverty level (FPL).

Between 0% and 200% of Federal Poverty Level

Q149. What is your hospital's household income threshold for medically necessary reduced cost care? Please respond with ranges as a percentage of the FPL.

Between 200% and 300% of FPL

Q150. What are your hospital's criteria for reduced cost medically necessary care for cases of financial hardship? Please respond with ranges as a percentage of the FPL and household income. For example, household income between 301-500% of the FPL and a medical debt incurred over a 12-month period that exceeds 25 percent of household income.

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. Patients will also be granted an extended time period for payment, usually 2-3 years.

Q151. Provide a brief description of how your hospital's FAP has changed since the ACA Expansion became effective on January 1, 2014.

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.

Q152. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q153. (Optional) Please attach any files containing further information about your hospital's FAP.

Q154. Summary & Report Submission

Q155.

<p style="text-align:center; color:red;">Attention Hospital Staff! IMPORTANT!</p>

You have reached the end of the questions, but you are not quite finished. Once you proceed to the next screen using the right arrow button below, you cannot go backward. For that reason, we strongly recommend that you use the Table of Contents to return to the beginning and double-check your answers.

When you click the right arrow button below, you will see a page with all of your answers together. You will see a link to download a pdf document of your answers, near the top of the page. You can download your answers to share with your leadership, board, or others as required by your internal processes.

Location Data

Location: (39.599197387695, -78.844398498535)

Source: GeoIP Estimation

PART TWO: ATTACHMENTS

Community Health Needs Assessment FY17 – Needs Table
Allegany County Health Planning Coalition
November 15, 2016

Need	Allegany Co	Maryland	US or Target	Note	Source
1. Sexually Transmitted Infections Chlamydia cases / Population * 100,000	325.6	454.1	134.1 top US	AC Trend (236, 262,325.6) ACHD-FY16 cases: 222 chlamydia and 37 gonorrhea	County Health Ranking2016
2. Percentage of children (under age 18) living in poverty	23%	14%	13%	AC Trend (26, 25,23)	County Health Ranking2016
3. Substance exposed newborns	167 17% of deliveries (29 addicted/138non addicted)	--	--	SHIP Infant Death Rate for AC 6.8 to 9.1 over 5 yrs compared to MD at 6.5	WMHS 2015
4. Physically Active Adults (self report 150/75 minutes.wk)	41.2%	48%	47.9% HP2020	AC in 2011 was 52.2% headed in wrong direction	SHIP
5. Child Maltreatment rate Number of total indicated findings for physical and sexual abuse, mental injury-abuse, neglect, and mental injury-neglect among children, rate per 1000 >18yrs	23.3	9.9	8.5 HP2020	AC Trend 25.8, 23.2, 27.5, 23.3	SHIP
6. Domestic Violence- Number of domestic violence crimes per 100,000	608.6	455.8	--	AC reduced from last year at 719.5 but above 2010-2012 when below 500	SHIP
7. ED visits for diabetes primary diagnosis per 100,000 population	241.4	204	--	AC Trend 185.2 in 2010, 261.9 in 2012, 237.5 in 2013	SHIP
8. ED visits for hypertension primary diagnosis per 100,000 population	279.1	252.2	--	AC steady increase since 154.5 in 2010	SHIP
9. ED visits for mental health related diagnosis per 100,000 population	4722.9	3442.6	--	AC steady increase since 2320.6 in 2010	SHIP
10. Drug induced death rate per 100,000 population - for which illicit or prescription drugs are the underlying cause	18.7	15.2	11.3 HP2020	AC in 2007-09 was 14.2 Jan-Aug 2016 :272 overdoses, per C31 29 deaths as of 8/7/16	SHIP

11. Age-adjusted mortality rate from heart disease (per 100,000 population	253.2	169.9	152.7 HP2020	AC had reduced to 240s in last few years but back up	SHIP
12. Teen Birth rate -ages 15-19 years (per 1,000 population	23.4	17.8	--	AC was 31.8 in 2010 so decrease seen. YBRFSS shows more high school students in AC than MD report sexual intercourse but level decreased from 48.9 in 2013 to 40.9 in 2014	SHIP YBRFSS
13. % high school students reporting use of cigarettes, cigars, chew tobacco, snuff, dip in past 30 days % students ever using e-vapor products	24.9% 18.4% middle school 48.7% high school	16.4% 17% 37.6%	21% HP2020 ---	YBRFSS shows decline in tobacco use but use of e-vapor products is higher than State	YBRFSS / SHIP
14. Alcohol Impaired Driving Deaths -Percentage of driving deaths with alcohol involvement	44% (14 of 32)	34%	14%	AC Trend (29,34,44%) DUI/DWI AC-FY15-220, FY16-206, Q1FY17-66	County Health Ranking
15. Food insecurity -% population need food support –FARM, SNAP, etc	13.4%	12.7%	15.4%	Community Commons shows AC above MD & US in FARM-56.11%, SNAP-18.24% CHR-Food Environment Index AC6.4 of 10 vs MD 8.1 of 10, with 10 being best	Feeding America
16. Children & Teens Obese- ages 12 to 19 public school (BMI) above the 95th percentile for age and gender % elementary public school students with BMI at 95th percentile or above	13.6% 2013 (13.5%-YBRFSS for 2014) 19.3% (782 youth)	11% --	16.1% HP2020 --	 BMI data for elementary schools of ACPS show negative trend upward 2014-17% 2016-19.3%	SHIP- ACPS- Elementary BMI
17. Stroke Mortality- age adjusted per 100,000 population	47.8%	37.4%	37.3%		Community Commons

Demographic Characteristic	Description	Source
Median Household Income within the CBSA	$44,700 median household income vs. $78,800 Maryland; $57,617 US	(2016 SAIPE)
Percentage of households in the CBSA with household income below the federal poverty level	17.4% household income below poverty level vs. 9.9% Maryland; 15.1% U.S.	U.S. Census Bureau, American Community Survey (2012-16)
For the counties within the CBSA, what is the percentage of uninsured for each county?	6% (2018 Report) 1.4% (WMHS Patient Mix)	County Health Rankings/Univ. of Wisc.
Percentage of Medicaid recipients by County within the CBSA.	16.4%	WMHS Patient Mix
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/Home.aspx	76.4 All Races/Ethnicities 76.0 White (Hispanic and NonHispanic) 80.4 Black (Hispanic and NonHispanic)	DHMH Vital Statistics (2014-16)
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Crude death rate per 100,000 population 1300.2 All Races, 302.5 NonHispanicBlack, 1429.4 NonHispanic White	Maryland Vital Statistics Report (2015 Report)
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%	County Health Rankings –U of Wisc. (2018 Report)
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: 1650:1	County Health Rankings –Univ. of Wisconsin (2018 Report)
Adults who currently smoke %	Allegany County: 16%	County Health Rankings –U of Wisc. (2018 Report)

The table below lists the identified priorities from each cycle.

2011	2014	2017
Tobacco Cessation (especially during pregnancy)	Access and Socioeconomics (children in poverty, primary care access, adult dental access, health literacy, homelessness)	Substance Abuse
Obesity		
Access to Care and Providers		
Emotional and Mental Health (suicide rate / depression)		
Substance Abuse (alcohol and drugs)		
Screening and Prevention (diabetes, hypertension, cancer)	Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related injury and death, healthy weight)	Poverty
Heart Disease and Stroke		
Health Literacy		Heart Disease
Healthy Start (prenatal care)		
Dental	Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)	Access to Care and Health Literacy
Cancer		
Immunizations (flu)		
Chronic Respiratory Disease		

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 children residing in the same household.

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

Financial Hardship: Medical Debt incurred by a family over a 12 month period that exceeds 10% of family income. Financial counselors will work closely with eligible parties taking into consideration issues such as lost wages due to health and any other financial barriers that a patient may face due to a sudden health condition. Assistance plans will be considered using a sliding scale from 3-10% of gross income. (See Medical Debt definition) 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
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Andrea Velandia, P.A.	1467478925
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WMHS Primary Care Services   NPI#
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WMHS Urgent Care Services

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Rondal Zapf, CRNP	
Lynn Metcalf, CRNP	
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WMHS Urgent Care Services
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Hospital Financial Assistance Policy

The Western Maryland Health System provides care if you are seeking care, regardless of your ability to pay. Your ability to pay is based on a review which is done by a member of the Health System's Business Office. This review assures that if you seek emergency or urgent care, you receive those services regardless of your 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.

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.

Patient Rights and Obligations

Patient Rights
If you meet the financial assistance policy criteria described above, you may receive assistance from the Health System in paying your bill.

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

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).

Patient Obligations
If you have the ability to pay your bill, it is your obligation to pay the hospital in a timely manner.

The Western Maryland Health System makes every effort to see that your accounts are properly billed, and you 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 you are eligible for free, reduced cost care, or a payment plan, it is your 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.

Contact Us

Have Questions about your Bill?
Contact the hospital business office at **240-964-8435**. A hospital representative will be glad to assist you with any questions you may have.

Have Questions About the Financial Assistance Plan?
If you wish to get more information about or need to apply for the hospital's financial assistance plan, you may call the business office or download the uniform financial assistance application: http://www.hscrc.state.md.us/Pages/consumers_uniform.aspx or https://www.wmhs.com/wp-content/uploads/2018/04/FAP-App-REV-061715.pdf

Apply for Medical Assistance
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: Call **1-800-642-8589** or **www.wvdhhr.org**.

Pennsylvania residents: Call **1-800-692-7462** or **www.compass.state.pa.us**

Physician Services

Physician services provided during your visit will be billed separately and their services are not included on your hospital billing statement. This includes the fees for emergency department physicians, primary care physicians, surgeons, cardiologists, radiologists, and other physicians who provide care during your visit.

Insurance Hotline

If you have any questions about which WMHS diagnostic facility you should use based on your insurance coverage, please call our Insurance Hotline at **240-964-8111**.

Services for the Uninsured

WMHS is co-owner of Maryland Physicians Care (MPC), a Medicaid Managed Care Organization (MCO). MPC has provided its members free, quality health care for more than a decade. MPC offers valuable benefits and services with absolutely no copays to more than 100,000 qualifying children, pregnant women and adults 19 and over.

For more information, call **1-800-953-8854** or visit Maryland Physicians Care online at **www.MarylandPhysiciansCare.com**.

PART THREE: AMENDMENTS

Question

(Question 48)The section on CHNA participants listed activities under "other" for "Community Benefit Task Force" but did not check the "other" box. Did you intend to select the "other" box?

Answer

Yes, I intended to select "other".

Question

(Question 137) In the section related to whether all CHNA needs were addressed by initiatives of the hospital, the narrative included "Other – COPD, teen use of vapor products" as unmet needs but these are not specifically listed as CHNA needs. Did you intend to include these as CHNA needs in Question 57?

Answer

I considered COPD and Teen use of vapor products to fall under Respiratory diseases and Tobacco Use in Q57 and then listed them as other in Q137. It would be best to correct this by adding these needs to Q57.