Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically 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 the fiscal year.

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Meritus Medical Center	◉	○	
Your hospital's ID is: 210001	◉	○	
Your hospital is part of the hospital system called None	◉	○	
The primary Narrative contact at your hospital is Allen Twigg	◉	○	
The primary Narrative contact email address at your hospital is allen.twigg@meritushealth.com	◉	○	
The primary Financial contact at your hospital is David White	◉	○	
The primary Financial email at your hospital is david.white@meritushealth.com	◉	○	

Q4. The next group of questions asks 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. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [x] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [x] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [x] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

In addition to the community health statistics for Washington County checked above, we use: • Demographic and socioeconomic data obtained from Nielsen/Claritas(www.claritas.com) and the US Census Bureau (www.census.gov) • Disease and Mental Hygiene incidence and prevalence data obtained from the Maryland Department of Health and Maryland Vital Statistics Administration (http://dhmh.maryland.gov) • The Centers for Disease Control and Prevention (http://www.cdc.gov) Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Some health-related indicators included in this report include BRFSS data collected by the CDC http://www.cdc.gov/brfss/ • CDC Chronic Disease Calculator, available at http://cdc.gov/chronicdisease/resources/calculator/index.htm • The health-related indicators included in this report for Maryland are BRFSS data and benchmarks coordinated by the Maryland Department of Health and Mental Hygiene as part of the State's Health Improvement Plan (SHIP) https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx last updated May 8, 2020 • Selected inpatient and outpatient utilization data on primary care sensitive conditions that were identified as ambulatory care sensitive conditions and indicators of appropriate access to health care were obtained from the Meritus Medical Center and Brook Lane Health services quality data • Meritus Health Cancer Registry Cases 2015-2019 • County Health Rankings, A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org focus Washington County, Maryland 2022

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

- [ ] Allegany County
- [ ] Anne Arundel County
- [ ] Baltimore City
- [ ] Baltimore County
- [ ] Calvert County
- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Charles County
- [ ] Dorchester County
- [ ] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Prince George's County
- [ ] Queen Anne's County
- [ ] Somerset County
- [ ] St. Mary's County
- [ ] Talbot County
- [x] Washington County
- [ ] Wicomico County
- [ ] Worcester County

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

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

- [x] 21711
- [x] 21713
- [x] 21715
- [x] 21719
- [ ] 21720
- [ ] 21721
- [x] 21722
- [x] 21733
- [ ] 21734
- [x] 21740
- [ ] 21741
- [x] 21742
- [ ] 21746
- [x] 21750
- [ ] 21755
- [x] 21756
- [x] 21758
- [x] 21767
- [x] 21769
- [x] 21779
- [x] 21780
- [ ] 21781
- [x] 21782
- [x] 21783
- [x] 21795

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

Appendix A of the Meritus Medical Center GBR agreement identifies all Washington County zip codes as the Primary Service Area. Source: Meritus 2017 GBR agreement (effective 09/13/16)

- [ ] Based on patterns of utilization. Please describe.

- [x] Other. Please describe.

The unchecked ZIP codes are PO box locations and do not include demographic data

Q35. Provide a link to your hospital's mission statement.

https://www.meritushealth.com/about-us/mission-vision/

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

The FY19 CHNA process defined the PSA using the fact that more than 78% of Meritus Medical Center discharges reside in a zip code located within Washington County, Maryland. Both the CHNA and GBR agreement definitions of the PSA are the same; Washington County, Maryland approximately 155,000 persons. The PSA makes up a representative cross section of the county's population including those considered "medically underserved," as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured, or other access issues and disparities. Meritus Medical Center serves over 200,000 persons when SSA's of Pennsylvania and West Virginia are included.

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. 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.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

03/04/2022

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.meritushealth.com/about-us/healthy-washington-county/community-health-needs-assessment/

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

T. Brook Lane CHIP FY2023 - 2025 FINAL.pdf
2.6MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	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 exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Executive Director, Behavioral & Community Health
	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 exp below:
CB/ Community Health/ Population Health Director (system 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 exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Chief Health Officer, Chief Strategy Officer
	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 exp below:
Senior Executives (CEO, CFO, VP, etc.) (system 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 exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Board of Directors member and Full Board reviewed CHNA ap plan of action
	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 exp below:
Board of Directors or Board Committee (system 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 exp below:
Clinical Leadership (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 exp below:
Clinical Leadership (system 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 exp below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	"Community Health" team members
	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 exp below:
Population Health Staff (system 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 exp below:
Community Benefit 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 exp below:
Community Benefit staff (system 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 exp below:
Physician(s)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	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 exp below:
Nurse(s)	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
	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 exp below:
Social Workers	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
	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 exp below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	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 exp below:
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 exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your 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 initiatives	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	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 initiatives	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 (system 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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system 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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system 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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system 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 initiatives	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 (facility level)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☑	Known as "Community Health team members"

	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 initiatives	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)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit 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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system 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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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 initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2022.

	Level of Community Engagement	Recommended Practices

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Brook Lane Hospital	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Department -- Please list the Local Health Departments here: Washington County Health Department	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Healthy Washington County	☑	☑	☑	☑	☑	☐	☑	☑	☑	☑	☑	☑	☑	☑
Maryland Department of Health	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑
Other State Agencies -- Please list the agencies here: Wash.Co. Mental Health, and Local Addictions Authorities	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Local Govt. Organizations -- Please list the organizations here: Wash. Co. Health Advisory Board	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	☑

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Wash. Co. Public Schools	☑	☑	☑	☑	☐	☐	☑	☑	☐	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: John Hopkins School of Public Health	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☐	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Sheppard	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: The United Way	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: San Mar, Bester Community of Hope	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

03/28/2019 (final Community Benefits FY2022 linked to the CHNA FY2019)

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.meritushealth.com/documents/CHNA/CHNA-FY19-Appendices.pdf

Q53. Please upload your hospital's CHNA implementation strategy.

FY2019 CHNA Report FINAL.pdf
5.9MB
application/pdf

Q54. 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.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Please refer to pages 118 - 126 for full implementation plan and strategies. An evaluation of progress and completion of action items from FY2019 CHNA has been uploaded below

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

A. CHNA Meritus Action Plan - FY21 Evaluation.pdf
187.9KB
application/pdf

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q58.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

- ☐ Health Conditions - Addiction
- ☑ Health Conditions - Arthritis
- ☑ Health Conditions - Blood Disorders
- ☐ Health Conditions - Cancer
- ☑ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☑ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☑ Health Conditions - Foodborne Illness
- ☑ Health Conditions - Health Care-Associated Infections
- ☐ Health Conditions - Heart Disease and Stroke
- ☑ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☑ Health Conditions - Osteoporosis
- ☐ Health Conditions - Overweight and Obesity
- ☐ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☑ Health Conditions - Sensory or Communication Disorders
- ☐ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☐ Health Behaviors - Drug and Alcohol Use
- ☑ Health Behaviors - Emergency Preparedness
- ☑ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☑ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - Nutrition and Healthy Eating
- ☐ Health Behaviors - Physical Activity
- ☐ Health Behaviors - Preventive Care
- ☑ Health Behaviors - Safe Food Handling
- ☑ Health Behaviors - Sleep
- ☐ Health Behaviors - Tobacco Use
- ☐ Health Behaviors - Vaccination
- ☑ Health Behaviors - Violence Prevention
- ☐ Populations - Adolescents
- ☐ Populations - Children
- ☐ Populations - Infants
- ☑ Populations – LGBT
- ☑ Populations - Men
- ☐ Populations - Older Adults
- ☑ Populations - Parents or Caregivers
- ☑ Populations - People with Disabilities
- ☑ Populations - Women
- ☑ Populations - Workforce
- ☐ Other Social Determinants of Health
- ☐ Settings and Systems - Community
- ☐ Settings and Systems - Environmental Health
- ☑ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☐ Settings and Systems - Health Insurance
- ☑ Settings and Systems - Health IT
- ☑ Settings and Systems - Health Policy
- ☐ Settings and Systems - Hospital and Emergency Services
- ☐ Settings and Systems - Housing and Homes
- ☐ Settings and Systems - Public Health Infrastructure
- ☐ Settings and Systems - Schools
- ☐ Settings and Systems - Transportation
- ☐ Settings and Systems - Workplace
- ☑ Social Determinants of Health - Economic Stability
- ☐ Social Determinants of Health - Education Access and Quality
- ☐ Social Determinants of Health - Health Care Access and Quality
- ☐ Social Determinants of Health - Neighborhood and Built Environment
- ☐ Social Determinants of Health - Social and Community Context
- ☐ Other (specify)

Q59. Why were these needs unaddressed?

As a community hospital, it is the mission of Meritus Medical Center to improve the health of our community. This foundational commitment to provide the best health and health care services to our community is central to governance structures as well as strategic and operational plans. Meritus conducts a community health needs assessment every three years to identify and prioritize community health needs and gaps in service and care. An action plan of initiatives and goals are developed to address the prioritized health needs. The action plan is reviewed by the Meritus Board Strategic Planning committee and is approved by the Meritus Board of Directors. The prioritized health needs from FY2019 Meritus CHNA (governs FY22 Community Benefit) includes: #1 Substance use; to improve access to care and reduce overdose deaths. Screening for substance use disorder to identify, intervene and link patients with treatment and supportive resources. Providing an inpatient consultative team and Peer Recovery Support program which has successfully help patients establish a plan of recovery. Have continued crisis stabilization, management of withdrawal and follow up treatment for hospitalized patients, transferring directly to drug rehab when indicated. Continued participation in a Neonatal Abstinence Syndrome Collaborative to intervene with mothers of drug-affected newborns, improve inpatient treatment and partner to support our community treatment providers. Providing free support group and education services to family members of persons with addiction. We identified gaps in the crisis response continuum and created a pilot "crisis beds" for stabilization and prompt access to treatment when desired by the patient. #2 Mental health; improve access to care, earlier identification and to reduce stigma. Meritus provided targeted mental health education, and support groups to decrease stigma, increase awareness of behavioral health issues and provide practical mental health education and support at no cost. Continued integration of behavioral health professionals in primary care practices to help support depression screening, mental health evaluation, crisis stabilization and linkage. Partnered to provide case management services to help link patients at high-risk for a return to the ED with needed community resources. Provides expedited access to timely psychiatry evaluation to avoid ED visit or higher level of care when indicated. Over the past year provided virtual telehealth visits with providers to ensure timely access to care. We continue partnering with community organizations including mobile crisis, law enforcement and community rescue to expand crisis response in the community. #3 Weight status; reduce obesity by increasing physical activity and eating a healthy diet. Strategic planning in January 2020 resulted in setting a bold health goal to lose 1 million community pounds by 2030. A 10-year population health campaign was launched in October 2020. Public, private and government organizations have joined this community initiative to improve the overall health of county residents. At the end of June 2022 we had more than 50 committed community partners with over 40,00 pounds lost. Provides a bi-weekly community weight loss support group led by a registered dietitian that is open to the public and free of charge. Offered BMI screening, health and nutrition information at virtual events with a focus on diet, nutrition and exercise. #4 Wellness; promote healthy lifestyles with healthful nutrition, exercise, tobacco cessation and stress reduction. Meritus has offered non-traditional, alternative health interventions that have demonstrated positive health benefits. Expanded access to primary and behavioral health care during the Covid-19 pandemic via telehealth visits. Provided wellness checks and general health screenings to provide patients with understanding of their health status. Have partnered with local health improvement coalition to provide the community-based One for Good initiative with focus on making healthier food choices, increasing physical activity, stop smoking and taking medication as prescribed. A health website known as Healthy Washington County was developed to function as the online hub that provides education and resources with links to physical activity (Do), healthy diet and nutrition (Eat) and mindfulness and stress reduction practices (Believe). The initiatives have increased participant awareness and motivation for change necessary to make lifestyle changes. Provided wellness education for practical, applicable information to current health topics including infectious disease precautions, exercise, how to decrease sense of isolation, stress reduction, physical activity, healthy diet, etc. and trends. Provided virtual support groups that cover a wide range of health-related issues including cancer, stroke, stress and grief. Incorporating wellness into the bold health goal of lose 1 million pounds campaign under the headings "DO' increase physical activity, "EAT" health, balanced nutrition and "BELIEVE" introducing stress management techniques including mindfulness, balance, and recovery from behavioral health issues. #5 Diabetes; reduce diabetes disease burden through prevention, improved management, access to care and education. Meritus provides the National Diabetes Prevention program at multiple community sites and on-line. Attained certification of National DPP to teach lifestyle changes and reduce risk of developing Type II diabetes. We have trained 10 DPP coaches and expanded a central referral network to encompass the entire community. Meritus partners with primary care, local dept. of health and Commission on Aging to ensure that DPP services are available to anyone who screens at risk for type II diabetes. In addition, diabetes self-management (DSMT) and targeted diabetes education are provided to patients diagnosed with type II diabetes through care management support in collaboration with PCP offices to improve management of diabetes. We also provide the evidenced-based Living Well diabetes education series for disease management in the community at no cost to patients who may have previously completed other education or do not qualify for DSME. Continued partnership with a local church as a “health hub” in at risk neighborhood providing diet, nutrition counseling, health education and support groups that ensure direct communication with a physician. Currently collaborating with regional partnership to develop comprehensive response aligned with the MD Diabetes Action Plan. #6 Heart disease and hypertension; improve cardiovascular health through prevention, management of blood pressure and early identification of risk. After a pandemic pause, we resumed blood pressure screenings at health outreach events, in churches and community neighborhoods to identify persons with hypertension, provide education and refer to medical management. Continuing the community wide blood pressure awareness to change the community culture to focus on personal health status. Sponsored heart healthy activities and events that promoted heart health education. Provided telehealth support and monitoring to persons with Congestive Heart Failure to improve overall management. At the conclusion of the CHNA data assessment it was recognized that many more needs were identified and exist than can be successfully met by the hospitals alone due to limited, finite resources. The prioritization criterion helped narrow the focus to directly address the issues that would have the greatest impact for improving the health of people in our community. Whenever other community organizations have a mission aligned to meet the CHNA needs that were identified, the need was scored as a lower priority for Meritus Medical Center, avoiding the duplication of existing community services and providing an opportunity to coordinate the linkage of patients to alternative services whenever appropriate. Our community providers are using the results of the CHNA to help target these unmet needs based on strengths, expertise and resources of individual organizations, and where interests are shared, new collaborative relationships between organizations will be formed.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

We track SDOH county level updates to the CDC's Social Vulnerability Index (last updated 2020) and American Community Survey Social Determinants of Health Data by Zip Code (2016-2020), but obviously the data is significantly lagging. We have established a metric to complete SDOH screening in ambulatory practices as part of our strategic health aims. The patient population has SDOH screened and documented as unique patients with visits each month in the Epic EHR. At the end of FY2022 86% of the patient population seen at Meritus Medical Centered had been screened to determine "what matters most" to them. The data is being used to both link patients to resources in real time as well as develop new strategies for the health system to bridge gaps and help meet identified social needs in our community. Through the www.CommunitySolutionsHub.org website we have access to the 2022 SocioNeeds Index, created by Conduent Healthy Communities Institute, calculated using data from Claritas, 2022. The SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need) helping us target community neighborhoods where needs are the greatest. This additional information is being used to target neighborhoods and geographic locations with the greatest health disparities. It was used when conducting the FY22 CHNA and ensured representation for focus groups to obtain input from the persons living in these locations. We use the Chesapeake Regional Information System for our Patients (CRISP) health information exchange to identify geographic "hotspots" for disease specific communities at higher risk. Additional patient outcome data and trends are generated from specific internal reports from our EHR system.

Q61. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] None
- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

CHNA Meritus Action Plan FY22 Evaluation.xlsx
25.9KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q63. Section III - CB Administration

Q64. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor

☐ No

Q65. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

◉ Yes
○ No

Q67. Please describe the community benefit narrative audit process.

The internal audit consists of a series of checks and balances. Reporters from across the health system submit Community Benefit activities on a monthly basis. Each occurrence is reviewed and entered into CBISA by the system administrator, office of Community Health. The Community Benefit team made from members of Finance and Community Health, collaborate to review all submissions, associated expenses and works to obtain any missing information. All information is reconciled in the CBISA system and multiple reports are generated for review by the CB team (including a three-year comparison). Once the financial expenses are finalized the Executive Director of Community Health coordinates the written CB narrative. Upon completion of the draft narrative all members of the Community Benefits Committee review the narrative for comparison with the financials to ensure accuracy and completion. Upon approval by the CB team, a final version is presented to the Chief Financial Officer who completes final review and sign off. The Community Benefit report is audited as part of the HSCRC Special Audit on an annual basis.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

◉ Yes
○ No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

◉ Yes
○ No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

◉ Yes
○ No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

As a community hospital, Meritus Health purposefully incorporates our commitment to community service in our internal management, governance structures, strategic and operational plans. Meritus Health conducts a community health needs assessment every three years to identify and prioritize community health needs and service gaps. An action plan of initiatives and measurable goals are developed to address the prioritized health needs. The Community Health Needs Assessment data, prioritized health needs and recommendations are shared with the Senior Executive Team and Board of Directors. The action plan is reviewed by the Meritus Board Strategic Planning committee and approved by the Meritus Board of Directors. This information along with other hospital data and information was used to develop the health system's 10 year strategic plan, 2030 Bold Goals. Using the quadruple aim framework, the 2030 Bold Goals were created to improve the health of people in our community, improve health care, have joy at work, provide affordable medical care, and develop a world class medical school. The Bold Goal to Improve Health was determined to be Lose 1 Million Pounds by 2030. Three-year strategies include 1) increase physical activity, 2) improve access to care for all residents, and 3) reduce and manage stress. Strategic planning occurred with the Board of Directors from October 2019 to January 2020. Through the office of Community Health, the Director aligns priorities between the CHNA Implementation Strategy and the Strategic Plan as a component of community benefit planning. Priority actions for 2020 – 2022 included: Blood pressure screening and education, Social Determinants of Health screening, Improved mental health with mindfulnes and stress reduction, Reduce ED wait times, Increase telehealth visits, Engage 60 community partners pledged to achieve1 million pound goal, Lose a total of 40,000 pounds, Collaborate with community providers to offer services and events that increase physical activity, and prevent and manage diabetes. Community benefit strategies will help support these initiatives through the implementation of community and population health programs over the next year.

Q74. If available, please provide a link to your hospital's strategic plan.

N/A

Q75. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

☑

Diabetes - Reduce the mean BMI for Maryland residents

Do, Eat, Believe in a Healthy Washington County by losing 1 million pounds by 2030. Diabetes risk screening with referrals for Diabetes Prevention Program or Diabetes Self-management Training for persons diagnosed with type II diabetes. Meritus is participating as a regional partner in the state's 5 year diabetes action plan.

- [x] Opioid Use Disorder - Improve overdose mortality

Use of peer support in the medical center, SBIRT screening, initiation of MAT in the ED, pilot crisis intervention with warm hand-off to residential treatment or IOP; outcomes demonstrate 80% confirmed follow-up with next provider of care.

- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17
- [ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Increase physical activity, eat healthy diet, decrease suicide and overdose fatality rates, reduce cancer mortality, reduce ED visits for diabetes, hypertension, and mental health, and reduce rate of adults who smoke (all described in CHNA action plan and initiatives).

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (•) Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	(•)	
Anesthesiology	( )	(•)	
Cardiology	( )	(•)	
Dermatology	( )	(•)	
Emergency Medicine	(•)	( )	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	( )	(•)	
Family Practice/General Practice	( )	(•)	
Geriatrics	( )	(•)	
Internal Medicine	( )	(•)	
Medical Genetics	( )	(•)	
Neurological Surgery	( )	(•)	
Neurology	( )	(•)	
Obstetrics & Gynecology	( )	(•)	

Oncology-Cancer	○	◉	
Ophthalmology	○	◉	
Orthopedics	○	◉	
Otolaryngology	○	◉	
Pathology	○	◉	
Pediatrics	○	◉	
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	○	◉	
Surgery	○	◉	
Urology	○	◉	
Other. (Describe) Hospitalists	◉	○	Non-resident house staff and hospitalists

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Meritus Medical Center subsidizes the Hospitalist program in response to a community need for this service. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured population necessitated the need for a Hospitalist program subsidized by the Hospital. Meritus Medical Center subsidizes the Emergency On-call program in response to a community need for timely access and response to emergent care. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with higher volumes of uninsured/underinsured population in the Emergency Department has necessitated the need for an Emergency On-call program subsidized by the Hospital. Supporting data includes increased Charity Care expense for FY2022.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Meritus Health Physician Gap Assessment FINAL 09-11-19.pptx
2.7MB
application/vnd.openxmlformats-officedocument.presentationml.presentation

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

MMC 210001_Financial Assistance Policy.pdf
145.3KB
application/pdf

Q84. Provide the link to your hospital's financial assistance policy.

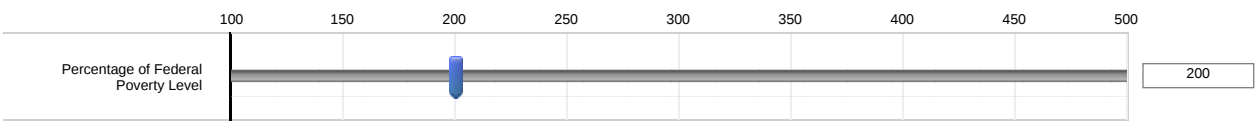
https://www.meritushealth.com/patients-visitors/financial-assistance-asistencia-financiera/

Q85. Has your FAP changed within the last year? If so, please describe the change.

◉ No, the FAP has not changed.
○ Yes, the FAP has changed. Please describe:

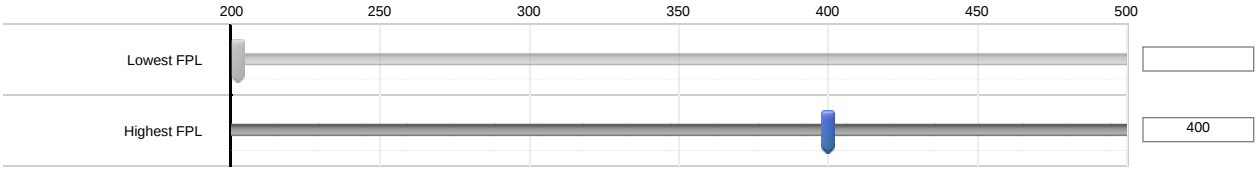
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



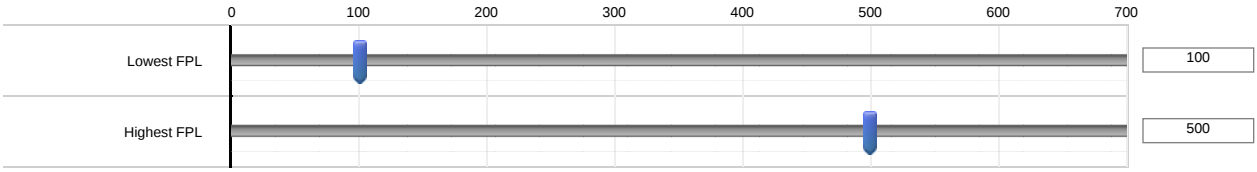
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

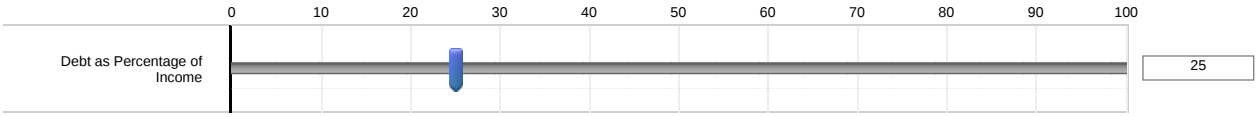


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (39.6343, -77.7337)

Source: GeoIP Estimation

FY2022 Community Health Needs Assessment

Healthy
WASHINGTON COUNTY

Table of Contents

This document has been produced to benefit the community. Healthy Washington County encourages use of this report for planning purposes and is interested in learning of its utilization. Comments, questions and suggestions are welcome and can be submitted to:

Meritus Health
Allen Twigg, Executive Director of Behavioral and Community Health Services
Allen.Twigg@MeritusHealth.com

The FY2022 Community Health Needs Assessment for Washington County, Maryland is available for review at:

- Brook Lane www.brooklane.org
- Healthy Washington County www.healthywashingtoncounty.com
- Meritus Health www.meritushealth.com
- Washington County Health Department www.washcohealth.org

A printed copy of the report may be obtained upon request to any of the following individuals:

Meritus Health
Allen Twigg, Executive Director of Behavioral and Community Health Services
Allen.Twigg@MeritusHealth.com

Brook Lane
Curt Miller, Director of Public Relations
curt.miller@brooklane.org

Washington County Health Department
Danielle Stahl, Public Information Officer
danielle.stahl@maryland.gov

Acknowledgements

The Executive Steering Committee would like to thank the countless individuals who have contributed to the success of this community assessment including all the survey participants and all those who contributed directly to writing and editing the final report

I. INTRODUCTION

Message to the Community

Healthy Washington County is proud to present the FY2022 Community Health Needs Assessment report for Washington County, MD. This report includes a comprehensive review and analysis of the data regarding health issues and needs of people living in the Washington County region.

This study was conducted to identify the health strengths, challenges and opportunities unique to our community and to provide useful information to health care providers, policy makers, collaborative groups, social service agencies, community groups and organizations, churches, businesses, and consumers who are interested in improving the health status of the general population. The results enable our health systems and other providers to strategically establish priorities, develop interventions and commit resources to improve the health status of our service region.

Improving the health of the community is foundational to the missions of Meritus Health and Brook Lane and should be an important concern for everyone in the county, individually and collectively. In addition to the education, patient care and program interventions provided through our health systems, we hope the information in this study will encourage additional activities and collaborative efforts to improve the health status of the community over time.

To demonstrate our strong community collaboration, this Community Health Needs Assessment was developed and promoted by Healthy Washington County (HWC). Healthy Washington County is a coalition of public and private organizations working to improve the health of people living in this community. The coalition strives to achieve this through raising awareness around personal health status and healthier behaviors. By bringing people and organizations together around health issues that affect quality of life in the region, we raise awareness, create opportunities to work collaboratively, and support finding new solutions. Ultimately, Healthy Washington County aims to provide the means by which all persons can achieve their healthiest potential.

Purpose

A Community Health Needs Assessment (CHNA) is a report based on epidemiological, qualitative and comparative methods that assess the existence of health issues within a defined community and the health services, gaps and disparities that people may encounter related to those health issues. This CHNA report includes findings, survey results, conclusions and an implementation plan that have been made widely available to the public via Meritus Health, Brook Lane, and Washington County Health Department websites.

The express purpose of the FY2022 CHNA was to complete a comprehensive assessment of the health status and healthcare access needs of residents living in the Washington County healthcare region. The objectives include:

- Review the FY2019 health needs and determine what progress has been made
- Identify the current health status of community residents to include data for benchmarking and trends
- Identify the availability of treatment services, strengths, gaps, barriers and opportunities
- Determine unmet community health needs and target priorities
- Develop a plan to direct community benefit and allocation of resources to meet targeted needs
- Enhance strategic planning for future services
- Meet the CHNA requirements for Meritus Health and Brook Lane as not-for-profit hospitals

Meritus Health

Meritus Health is the flagship facility of the health system, Meritus Health, the largest health care provider in the region and 2021 Large Business of the Year winner by the Washington County Chamber of Commerce. The state-of-the-art, Joint Commission accredited and Magnet® Recognized hospital opened in 2010. Not-for-profit in nature, the current census can offer more than 300 single-patient beds within the hospital's walls. With nearly 3,000 employees, 500 medical staff members and 240 volunteers, Meritus Health serves about 200,000 residents of western Maryland, southern Pennsylvania and eastern West Virginia – a tristate area. Comprehensive, quality care and service is provided at Meritus Health in the following areas of health and wellness:

- Bariatric surgery
- General surgery
- Behavioral health
- Cancer - Accredited with commendation by the Commission on Cancer
- Cardiovascular – Cardiac cath lab named by the American Heart Association as a Mission Lifeline® Gold Receiving facility for STEMI patients
- Critical care - AACN Silver Beacon Award for Excellence
- Emergency - Level III trauma center and EMS Base Station as designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and American College of Emergency Physicians Bronze Level 3 Geriatric Emergency Department Accreditation
- Joint replacement
- Labor and delivery - A Maryland Patient Safety Center Circle of Honor winner for Mothers as Medicine: An Innovative Approach to Care for Neonatal Abstinence Syndrome, Gold Certified Safe Sleep Champion department and Top Maternity Hospital by Newsweek in partnership with The Leapfrog Group
- Palliative Care
- Rehabilitation – A CARF-accredited inpatient rehabilitation unit

- Stroke care – A certified primary stroke center and the recipient of the Get With The Guidelines-Stroke Gold Plus; Target Stroke ELITE Honor Roll; Target Type 2 Diabetes Honor Roll from the American Heart Association
- Wound care

Meritus Health has officially become a teaching hospital, serving as a clinical training site for the Meritus Family Medicine Residency Program, the only residency program of its kind in the tristate region, as well as for more than 1,000 nursing and allied health students annually. Meritus Health was built with a direct link to Robinwood Professional Center, creating a campus where health care providers, outpatients, visitors and families can move easily from one service area to another. With the addition of the hospital, the one-million-square-foot combined campus represents the largest health services footprint in the state of Maryland. Meritus Medical Group, a network of 20 medical practices including primary and specialty care with more than 100 providers:

- Family Medicine
- Internal Medicine
- Endocrinology
- Hematology and Oncology
- Infectious Disease
- OB/GYN
- Orthopedics
- Pain Specialists
- Pediatrics
- Pulmonary
- Surgical Specialists
- Women's Health
- Meritus Home Health
- Equipped for Life, a medical equipment company
- Urgent Care

With a long-standing history of caring for the community, Meritus Health relentlessly pursues excellence to improve the health status of the region. Meritus Health is committed to caring for the community and has done so for more than a century.

Brook Lane

Brook Lane is a private, non-profit mental health facility with a 115-acre main campus near Leitersburg, Maryland and three satellite campuses in Hagerstown and Frederick. The 57-bed hospital provides treatment focused on crisis intervention and stabilization. Day treatment programs for children and adults provide a structured, therapeutic program yet allow the client to return home each evening. Outpatient therapy for all ages is available at three locations. Laurel Hall School provides education and therapy for students with emotional and behavioral challenges. The THRIVE Program assists children in building relationships and developing positive coping and communication skills. InSTEP, a substance use treatment program, addresses the increasing need for the treatment and support of addiction in our community. Brook Lane also provides School Based Mental Health Services, free of charge, in all middle and high schools in Washington County, Maryland.

Executive Steering Committee

An executive steering committee served as an advisory group to the CHNA process. Members are composed of organizations and community leaders who represent the core of healthcare infrastructure in the Washington County region. These individuals provided immeasurable guidance throughout the assessment process and have demonstrated their commitment to participate in collaborative community strategies to improve the health needs identified in the assessment.

Diana Gavaria	Washington County Health Department, Deputy Health Officer
Brooke Grossman	Horizon Goodwill Industries, Chief Mission Officer
Nicole Houser	Community Free Clinic, CEO
Jocelyn Hauer	United Way of Washington County, Director of Engagement
Shaheen Iqbal	Meritus Health Board of Directors, Physician
Brooke Kerbs	Washington County Mental Health Authority, Director Child and Adolescent Services
David Lehr	Meritus Health, Chief Strategy Officer
Curt Miller	Brook Lane, Director Public Relations
Amy Olack	Commission on Aging, CEO
Douglas Spotts	Meritus Health, Chief Health Officer
Danielle Stahl	Washington County Health Department,
Christie Staubs	Maryland Physicians Care MCO, Community Engagement Representative
Earl Stoner	Washington County Health Department, Health Officer
Allen Twigg	Meritus Health, Executive Director Behavioral and Community Health
Susan Walter	Tristate Community Health Center (FQHC), CEO
Laura Wilson	Family Healthcare of Hagerstown (FQHC), Grants and Marketing

II. EXECUTIVE SUMMARY

The FY2022 Community Health Needs Assessment (CHNA) was conducted to identify primary health issues, status and needs and to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results will enable healthcare providers and organizations in our region to strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community.

In January 2021, in an effort to improve the health of Washington County residents and to align their process with the Maryland State Health Improvement process, the Washington County Health Improvement Coalition (WCHIC) known as "Healthy Washington County" with leadership from Meritus Health and Brook Lane determined that a Community Health Needs Assessment would be completed during 2021 to 2022. The WCHIC commissioned an executive steering committee of key stakeholders to oversee the process. Representatives from Meritus Health, Brook Lane, Washington County Health Department, the George W. Comstock Center, the United Way, the Federally Qualified Health Clinics, and other community organizations were included. The steering committee developed the goals, objectives and timeline to conduct a community health needs assessment and recommend a plan of action to address prioritized health needs.

The research and data analysis of this effort began in spring 2021. The primary service area was defined as Washington County, Maryland. The steering committee began a review of the most recent CHNA (2019), the community health initiatives, and progress made towards improvement. Next, secondary health data from national, state and local sources were compiled and reviewed.

A subcommittee was then appointed to develop a Key-Informant questionnaire for the purpose of obtaining direct input from key community stakeholders who have knowledge regarding the health needs of people living in the primary service area. The questionnaire consisted of fifteen (15) content knowledge questions related to health, status, and behaviors and seven (7) demographic questions. In addition, a health needs and social determinants ranking survey accompanied the questions. Whenever possible the Key Informants were interviewed by a member of the steering committee, or alternatively submitted written answers to the questions and completed the ranking exercise. Twenty-two (22) key community stakeholders completed the interview questionnaire and provided input between August 6, 2021 and September 10, 2021.

Upon review of data, the steering committee coordinated eleven (11) public focus groups to help drill-down specific information on topics including nutrition and physical activity, mental health and substance abuse specific to children, adults and seniors' health needs. Two focus groups were conducted to obtain specific information about minority healthcare needs, focusing on black or African-Americans and Hispanic and Latino community members. Total group participants included 121 diverse representatives of the Washington County community.

Summary of Findings

Health needs and priorities are largely unchanged from the FY2019 CHNA findings.

Improvement

- Improving Washington County trends include fewer uninsured persons, increased supply of dentists, and lower rates of air pollution
- The majority of Washington County residents have health insurance 93%; approximately 7% of adults are not insured
- The mortality rate for heart disease and cancer both decreased 2% since last measurement period in 2018
- Diabetes mortality rate is decreasing
- Alcohol binge drinking rates of 16% are lower than the state average
- Drunk driving fatalities are trending down and are better than the state and HP targets
- Fewer opioid prescriptions are being prescribed by providers
- ED visits for behavioral health crisis declined
- Mammography screening trend is improving
- Lung and colon cancers are being diagnosed at earlier stages
- The survival rate for colon, and head and neck cancers are improving

Wrong direction

- Life expectancy has declined over ten years in Washington County, largely attributed to overdose fatalities and an increased rate of suicide
- Washington County slipped to 18th out of 24 Maryland counties in the County Health Rankings
- Cautious trends include increases in physical inactivity, preventable hospital stays, unemployment, and crime
- Concerning trends include premature death rate, increased adult obesity rates, a lack of available primary care physicians, and more children living in poverty
- Overweight adults (BMI $\geq$ 25) increased by 3.3% since last CHNA
- Adults who are physically inactive increased 2% since last CHNA
- While diabetes prevalence at 10.3% is similar to the rest of the state, Washington County has the second highest rate of diabetes mortality, 32
- Given the higher than average rates for physical inactivity, and being overweight and obese in our community, residents are at higher risk for pre-diabetes and developing diabetes in the future
- Washington County is an outlier for 9-1-1 calls for behavioral health resulting in more Emergency Department visits for mental health and crisis assessment than the state of Maryland average
- The rate of suicide at 14.7 per 100,000 lives has increased in Washington County while the state average has slightly decreased over the past six years
- There is a steady increase of drug overdose fatalities over the past ten years, at a rate that is higher than the state of Maryland average
- The trend of drug overdose deaths has increased significantly since 2014 and are primarily attributed to fentanyl

Objective findings

- The leading causes of death among adults in Washington County are heart disease 22% and cancer 19%
- Only 20% of health outcomes are attributed to the quality of clinical care provided (70% is accounted for by health behaviors 30%, social and economic determinants 40%)
- The most frequent health concerns reported include behavioral health issues including anxiety and depression, ADHD, autism and bipolar disorder, being overweight, having type II diabetes, high blood pressure, cancer, asthma, addiction, allergies, arthritis, back pain, high cholesterol and heart disease
- Other health concerns include dental, smoking, and Chronic Obstructive Pulmonary Disease (COPD)
- Community informants view the health status of people living in Washington County as "unhealthy" 57%, "average" or similar to most other communities 29%, "healthy" 10%
- The primary barriers to accessing health care include the cost of care, including inability to afford co-pays and health insurance deductibles, and inability to see a provider when needed
- More than 68% of the adult population is overweight or obese (BMI > 25)
- There was no change in the percentage of persons who maintained a healthy weight over the past three years, 31.5% (BMI < 25)
- The report of high blood pressure 32.7% is similar to the state and national averages
- There is a clear correlation between health, wellness and the rate of poverty which is higher in Washington County (12.2%) than is found in the state of Maryland (9.2%)
- Transportation to outpatient medical services is a barrier for patients who do not have independent transport

Health Disparities

- There is a health disparity among the Black or African Americans observed in a higher rate of Emergency Department visits for poorly managed health issues including diabetes and hypertension
- Black or African Americans have a higher age-adjusted death rate of 45.9 for lung cancer compared to Whites, 42.3
- The colorectal cancer rate for Black or African Americans is 50.9, more than 25% higher compared to Whites at 37.8
- The prostate cancer incidence rate among Black or African American men in Washington County is 194.4, nearly twice the rate of White men 94.8

Identified Health Service Gaps

- Over-weight and obesity is a primary health concern and people desire information regarding diet, nutrition, weight loss, and help making healthy lifestyle changes
- There are delays stretching an average of more than three weeks for a new patient to be seen by a psychiatrist
- There is a shortage of primary care and specialty providers available in Washington County

- There are no mental health crisis beds in the county
- There is a delay to timely access for substance abuse treatment when a person desires help; specifically the lack of detoxification or crisis services or ability to be admitted for inpatient/residential treatment levels of care
- There are significant health disparities with Black or African Americans, and Hispanics or Latinx

Conclusions

Overall lifespan In Washington County is on a downward-sloping trend, similar to the state and nation, but more significant.

The ongoing impact of Covid-19 on potential future costs associated with postponed treatment and reduced preventive care (screenings for behavioral, cognitive, social, and chronic medical conditions) is unknown at this time.

The occurrence of telehealth services is reshaping delivery of health care. Health integration to treat the whole person is rapidly becoming "virtual integration" providing virtual telemedicine and education services with real-time patient exchange via EHR as the foundation. The transformation is shifting the locus of health and human services from professional offices to consumer homes. New barriers in access to and use of digital devices observed when technology is not available. Access to high-speed internet access is an issue in some rural parts of the county.

Health disparities and inequities exposed during the pandemic must redirect our actions and decision-making across the health system and community to ensure equitable care for all persons.

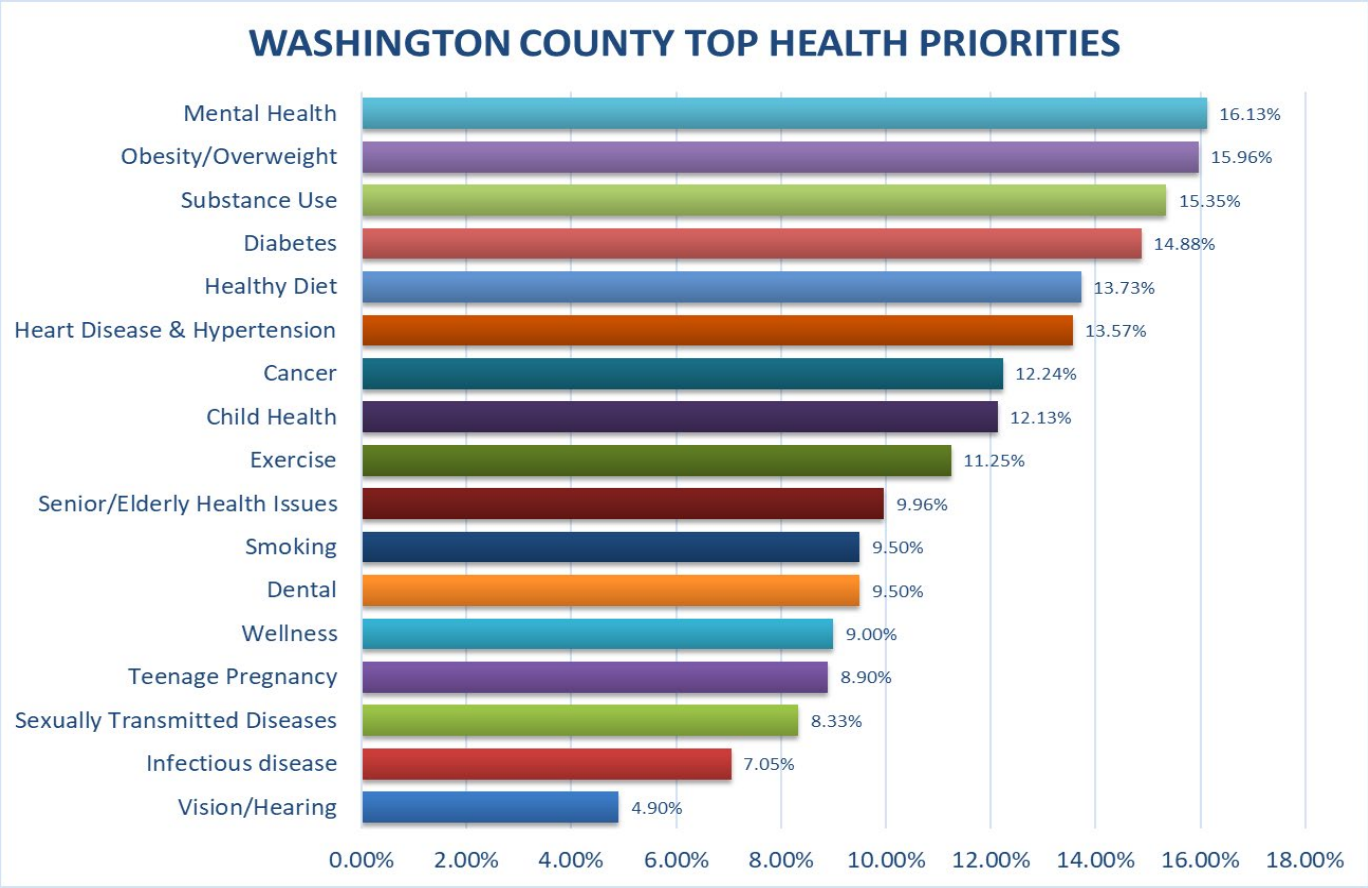
These conditions represent an excellent opportunity and potential to improve access and engagement towards our purpose of improving health for all people.

Despite the pandemic and changes to health care delivery over the past two years, the health needs and priorities for Washington County are largely unchanged from three years ago.

As summarized by Dr. Maulik Joshi, Meritus Health CEO "It's time to move from assessment to improvement."[1]

[1] http://www.modernhealthcare.com/opinion-editorial/community-health-its-time-move-assessment-improvement Accessed: 8/10/21

On November 2, 2021, Healthy Washington County conducted a public meeting to review the data, findings, needs and issues identified from the Community Health Needs Assessment process. Upon reviewing all the key data and findings, attendees endorsed the prioritized ranking of health needs and social determinants of health.



A full list of the health priorities identified for Washington County in ranked order include:

1. Mental Health
2. Obesity / weight loss
3. Substance Use
4. Diabetes
5. Healthy diet
6. Heart Disease and Hypertension
7. Cancer
8. Child health
9. Exercise
10. Senior health
11. Smoking
12. Dental
13. Wellness
14. Teenage Pregnancy
15. Sexually transmitted disease

16. Infectious disease
17. Vision/ hearing

The top ranked health priorities for the Washington County community include:

#1 Mental health
#2 Obesity / weight loss
#3 Addiction
#4 Diabetes
#5 Heart disease and hypertension

The top ranked community health priorities for Meritus Health implementation plan includes:

1. **Obesity;** lose 1 million community pounds by promoting increased **physical activity (DO)**, eating a **healthy diet (EAT),** and achieve **emotional balance (BELIEVE)**

2. Improve **behavioral health** by ensuring timely access to appropriate, quality **mental health treatment** and support, and reduce **addiction** and **overdose fatalities** to protect the health, safety and quality of life for all

3. Improve prevention and the management of type II **diabetes** and reduce mortality

4. Prevent **heart disease,** reduce **mortality** and manage **hypertension**

5. Increase **healthy equity** by helping all people **attain the highest level of health**

6. Engage and empower people to **choose healthy behaviors** and make changes to **reduce risks**

The top ranked community health priorities for Brook Lane implementation plan includes:

1. Improve **mental health** through prevention, early intervention and education

2. Lessen **substance abuse** to safeguard the health, safety and welfare of all

The Community Health Needs Assessment provides a framework for community action, engagement, and accountability in addressing the health needs of our county's citizens. Its significance as a resource to community organizations is paramount as it prioritizes our health needs and initiatives. The steering committee developed a draft implementation plan of action based on the identified health needs, community strengths, resources, and new initiatives. On November 2, 2021 the top health priorities were reviewed by Healthy Washington County, the identified community body responsible for the coordination of resources to help address the identified needs and to measure outcomes.

Based on the findings of the CHNA and the prioritization exercise, the Healthy Washington County coalition submitted an outline of priority health needs and goal direction to Meritus Health and Brook Lane. The respective hospitals developed an implementation strategy, outlining objectives, action steps and draft goals that will address the prioritized community health needs and identified resources to commit towards improvement. The Meritus Health Community Health Improvement Plan (CHIP) FY23-25 was approved and adopted by the Meritus Health Board of Directors on February 24, 2022 (see **Appendix R**). The Brook Lane Community Health Improvement Plan (CHIP) FY23-25 was approved and adopted by the Brook Lane Board of Directors on January 28, 2022 (see **Appendix T**).

On March 1, 2022 the Healthy Washington County coalition formally recommended adoption of the joint implementation strategy and action plans as received from the respective hospital Boards of Directors. The hospital plans were incorporated in a comprehensive strategy to address the top health priorities of people living in our community.

Following the approval of the Action Plans, the FY2022 CHNA report was published May 4, 2022 and was made widely available to the public as posted on the following websites:

www.brooklane.org
www.meritushealth.com
www.healthywashingtoncounty.com
www.washcohealth.org

Printed copies of the FY2022 CHNA are available onsite at Brook Lane, Meritus Health, and the Washington County Health Department. In addition, a print copy will be made available upon request.

III. Evaluation of Progress CHNA FY2019

To begin, the Healthy Washington County Steering Committee reviewed the FY2019 CHNA Action Plan and identified progress towards accomplishing goals and barriers over three years through June 30, 2021. The detailed FY21 CHNA Action Plan with outcomes is included as **Appendix A.**

The primary goal to establish a public dashboard to assess local health needs and track population health data was met through the Community Solutions Hub website: www.communitysolutionshub.com The website is "open-source" and allows organizations to upload data to provide real-time monitoring and access to information. The community has not taken advantage of the full capabilities of this tool.

Goals met:

- Lose 10,000 community pounds – MET loss 11,200 lbs.
- 25 Go for Bold! partners – MET 41 partners
- Decrease number of opioid prescriptions by 25% - MET decreased by 37%
- Decrease ED addictions visits by 5% - MET decreased by 41%
- Decrease ED mental health visits by 7% - MET decreased by 18%
- Decrease diabetes mortality by 2% - MET decreased 15%
- Decrease heart disease mortality by 1% - MET decreased 5%
- Blood pressure screening > 6,000 (3 yrs.) - MET
- Reduce Stage III & IV dx lung cancer by 5% - MET 8%
- Increase 5 yr. survival head & neck cancer by 5% - MET 13%
- Reduce Stage III & IV dx colon cancer by 10% - MET 17%
- Increase 5 yr. survival rates colon cancer by 5% - MET 9%

Goal not met:

- Decrease overdose fatalities – NOT MET 26% increase
- Decrease behavioral health 30 day readmissions by 15% - NOT MET reduced 2%
- Decrease percent of overweight adults by 2% over three years – NOT MET +3.3%
- Decrease percent of pop. identified as "food insecure" by 5% - NOT MET
- Decrease percent of adults who are physically inactive by 2% - NOT MET +2%
- Decrease percent of adults who are obese by 2% - NOT MET +3%
- Decrease percent of adult smokers by 6% - NOT MET decreased 2.6%
- Decrease rate of new diabetes diagnosis by 2% - NOT MET reduced by 0.3%
- Reduce # of ED visits for diabetes by 5% - NOT MET +6.3%
- 90% of adult pts with diabetes will have hA1c below 9% - NOT MET 79.4%

IV. METHODOLOGY

Community Health Needs Assessment Requirements

The Patient Protection and Affordable Care Act (ACA), enacted March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements of the Internal Revenue Code 501(r) set forth by the ACA.

The steering committee reviewed and followed the requirements for the FY2022 CHNA from 26 CFR Parts 1, 53 and 602, as published by the Treasury Department ("Treasury") and the Internal Revenue Service (IRS) in the Federal Register Vol. 79 No. 250 (December 31, 2014). This CHNA report includes the following:

- The identification of all organizations and persons with which the hospitals collaborated, including their title;
- A description of the community served;
- A description of the process and methods used to conduct the CHNA, including:
    - A description of the sources and dates of the data and the other information used in the assessment; and,
    - The analytical methods used to assess the community's health needs;
- A description of how the hospitals took into account input from persons who represented the broad interests of the community served, including those with special knowledge of or expertise in public health and individuals providing input who as a leader or representative of the community served by the hospitals;
- A description of information and service gaps that impact the ability to assess the health needs of the community served;
- A prioritized description of the community health needs identified through the CHNA and a description of the process and criteria used in prioritizing those needs;
- A description of the existing health care facilities and other resources within the community available to help meet the community health needs identified through the CHNA; and,
- A description of the strategic plan of action developed to address prioritized community health needs.

Community Health Needs Assessment and Planning Approach

In March 2021, the Washington County Local Health Improvement Coalition (LHIC) known as Healthy Washington County announced the intention to conduct a CHNA. A full list of the 2021 LHIC membership is included in **Appendix B**. As the local not-for-profit hospitals, Meritus Health and Brook Lane worked collaboratively with Healthy Washington County coalition to conduct the CHNA. The general guidance for conducting a CHNA was obtained from Community Health Rankings and Roadmaps as diagramed below.

Community Needs Assessment Cycle

Take Action Cycle | County Health Rankings & Roadmaps

Community Health Needs Assessment Timeline

Healthy Washington County invited community stakeholders to be involved in the Community Health Needs Assessment Steering Committee. The process began in March 2021 until publishing the final FY2022 CHNA report in May 2022 (see **Appendix C** for timeline).

Data Collection

To collect the most relevant information to assess the health needs of our community, the steering committee used qualitative and quantitative methods for data collection and analysis. Qualitative methods asked exploratory questions used in conducting interviews and focus groups. Quantitative data is information that can be displayed numerically. Both primary and secondary data sources were collected during the process.

The steering committee determined that the data collected would be defined by hypothesized needs within the following general categories: alcohol & drug use, cancer, children & adolescent health, diabetes, heart disease, health care access, health equity and disparities, immunizations & infectious disease, maternal, fetal & infant health, mental health, obesity and weight status, senior health, social determinants of health, respiratory disease, smoking, wellness & prevention.

Secondary Data

Collection and review of secondary data began in May 2021, and continued through August 2021. As information was obtained it was reviewed, summarized and analyzed by members of the steering committee. Principal secondary data sources included use of the Community Solutions Hub, Maryland Department of Health (MDOH), State Health Improvement Plan (SHIP) data and resources, the Centers for Disease Control (CDC), and Maryland Vital Statistics. The secondary data collection process focused on information specific to Washington County when available. Secondary data includes geographic, population, socio-economic, disease prevalence, health status, and environmental factors:

- Community Solutions Hub www.communitysolutionshub.org
- Demographic and socioeconomic data obtained from the US Census Bureau www.census.gov
- Disease and Mental Health incidence and prevalence data obtained from the Maryland Department of Health and Maryland Vital Statistics Administration www.health.maryland.gov and the Maryland Opioid Operational Command Center www.beforeitstoolate.maryland.gov/oocc-data-dashboard/
- The Centers for Disease Control and Prevention (CDC) www.cdc.gov conducts an extensive Behavioral Risk Factor Surveillance Survey (BRFSS) each year. The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The health related indicators included in this report include BRFSS city and county data collected by the CDC www.cdc.gov/brfss/smart/Smart_data.htm
- The health related indicators included in this report for Maryland in 2020 are BRFSS data and benchmarks coordinated by the Maryland Department of Health as part of the State's Health Improvement Process (SHIP) www.health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx
- In 1979, the Surgeon General began a program to set goals for a healthier nation. Since then, Healthy People have set 10 year science-based objectives for the purpose of moving the nation toward better health. When applicable, the available Healthy People 2030 goals are included in this report as related to Washington County health needs Healthy People 2030 | health.gov
- Meritus John R. Marsh Cancer Registry 2006-2021
- Meritus Health 2019 Physician Needs Assessment
- Maryland Health Connection www.marylandhealthconnection.gov
- The Healthy Washington County FY2016 and FY2019 Community Health Needs Assessments
- 2021 County Health Rankings, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org

The steering committee members reviewed and summarized the existing secondary data, highlighting the key health drivers, conditions with significant variance from benchmarks and averages, and health disparities.

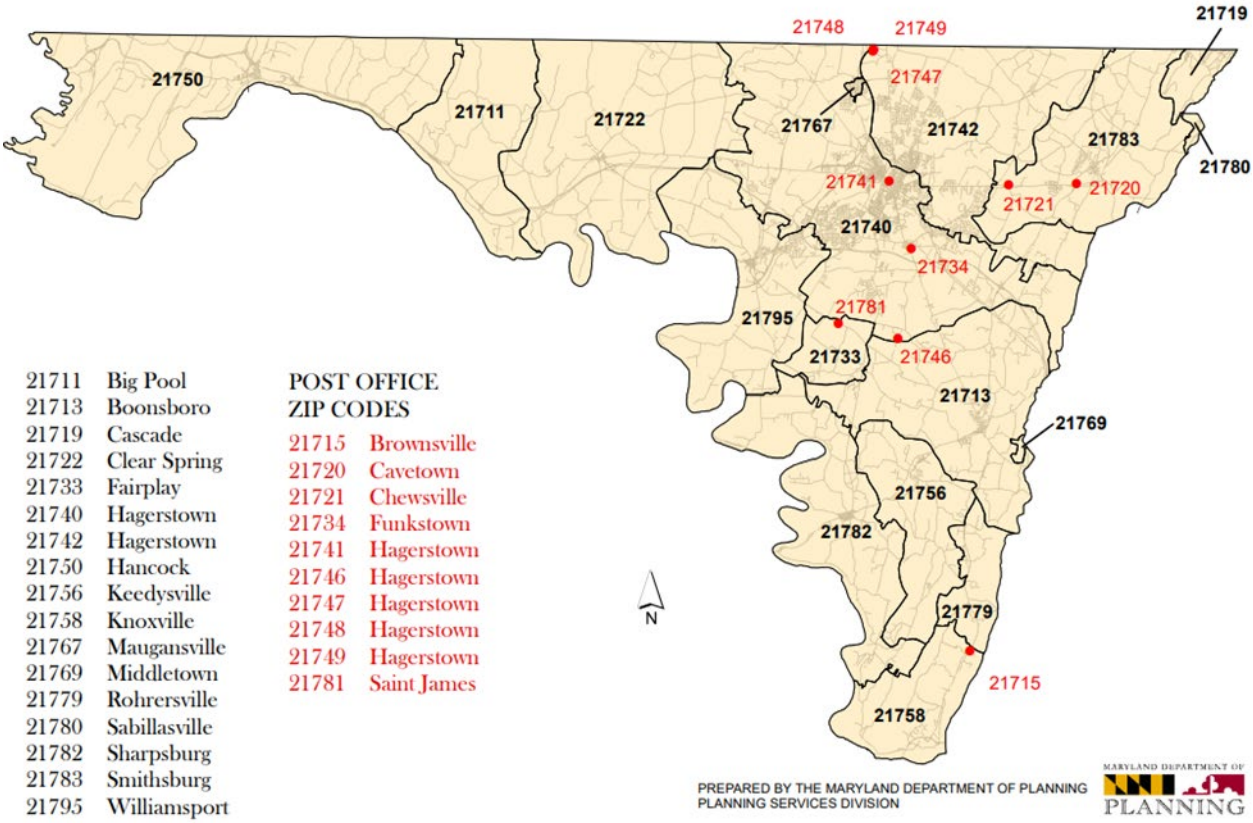
V. COMMUNITY ASSESSMENT

A. Service Area Definition

At the time that this Community Health Needs Assessment process was conducted, more than 76% of Meritus Health discharges and 60% of Brook Lane patients resided in a zip code within Washington County, Maryland. While both organizations provide services to people living throughout a 60 mile radius of the quad-state region, the geographic boundaries of Washington County was designated as the Primary Service Area (PSA) for the purposes of the CHNA. Washington County residents served by these health systems make up a representative cross section of the county's population including those considered ''medically underserved'' as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

The majority of patients served by our health systems live in Washington County, MD, which includes the following zip codes outlined in **Primary Service Area** map below**.**

Primary Service Area



B. Demographics of the Community We Serve

At the time of this CHNA report the 2020 Census had released only the *apportionment results* and *redistricting data* providing the most up to date demographic information. In 2020, the population of Washington County is 154,705. The growth rate has remained positive, increasing by 4.7% since the last U.S. Census in 2010, same as the Maryland state growth rate of 4.7%.

Washington County has become more diverse since 2010 with a diversity index of 42.5% (rank 16 / 24 Maryland counties). The racial demographics of Washington County includes White 75.9% (7.6% decrease), Black or African American 11.4% (no change), Asian 2% (+0.1%), American Indian 0.3% (no change), some other race 3% (new), two or more races 7.3%. Persons with Hispanic or Latin ethnicity 6.7% (increase from 4.7% in 2021).

The remainder of demographic information is taken from MARYLAND: 2020 Census. The current median age of persons in Washington County is 41, slightly older than the U.S. median age of 37.7 years. Our community is growing older with a projected 25% increase in persons age 65 and older between 2015 to 2025. The county percentage of adults over age 65 is slightly higher than the state while the population under age 18 is comparable.

There has been a 0.5% increase in languages other than English being spoken at home. High School graduate rates have gained 1% at 85.6% and are now only slightly lower than the Maryland average 86.3%. Washington County continues to have significantly fewer bachelor's degree college graduates at 21.9% compared to the rest of the state, 39% with a 0.5% increase over the past three years. Average travel time to work is comparable with the state average. Households in Washington County consist of an average 2.52 persons per household, similar to the state, 2.68. Housing is more affordable in Washington County with a median value of owner-occupied housing units averaging $210,300 compared to the state average of $296,500. The median household income of $60,860 rose slightly but remains less than the state average, $78,916. A higher percentage of persons live in poverty in Washington County declined 0.5% to 12.3%, 3% higher than the state average (9.3%).

Unemployment improved by decreasing -0.4% during 2019. For years 2015-2019 the rate of unemployment continued to be slightly higher than the state of Maryland.

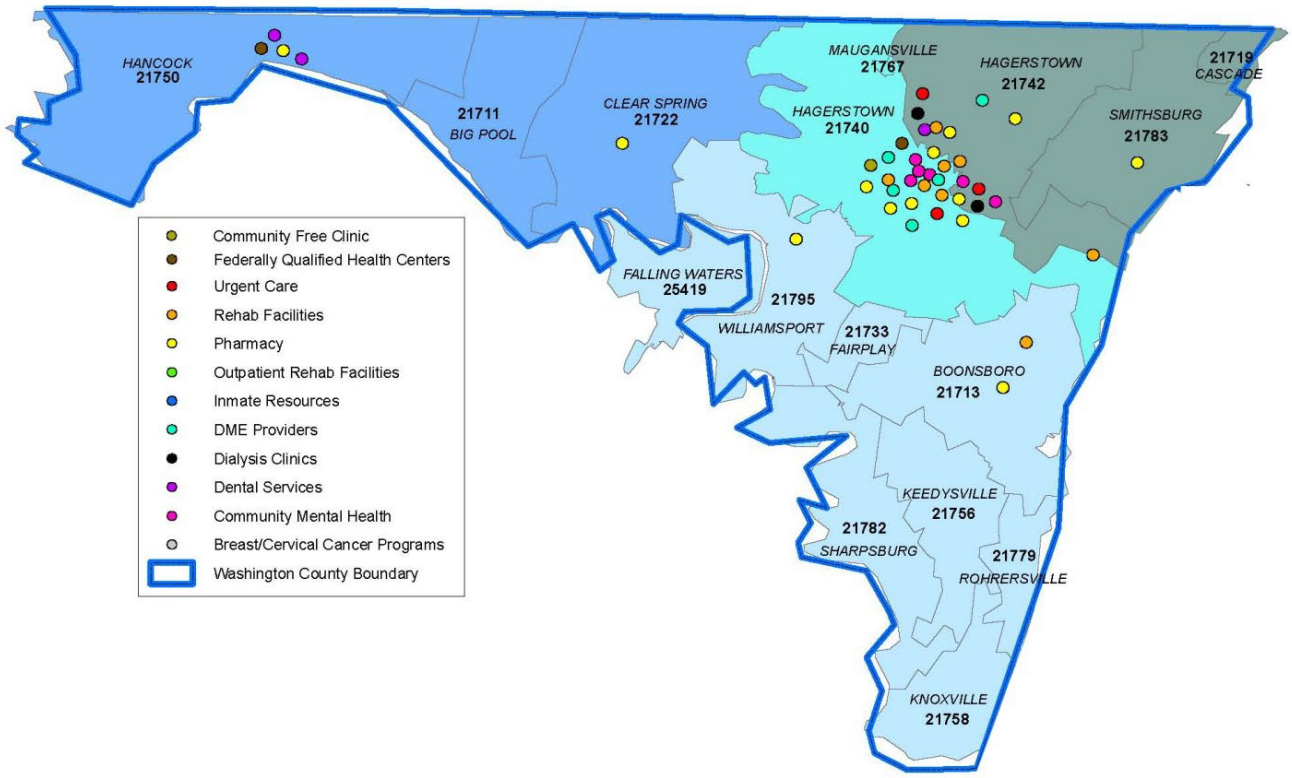
Complete demographics for Washington County as published through July 2021 can be viewed in **Appendix D**.

C. Community Asset Inventory

In order to outline the existing health care facilities and resources within the community that are available to respond to the health needs of the community, the Washington County Health Coalition completed an inventory of community assets and resources in and around Washington County, MD.

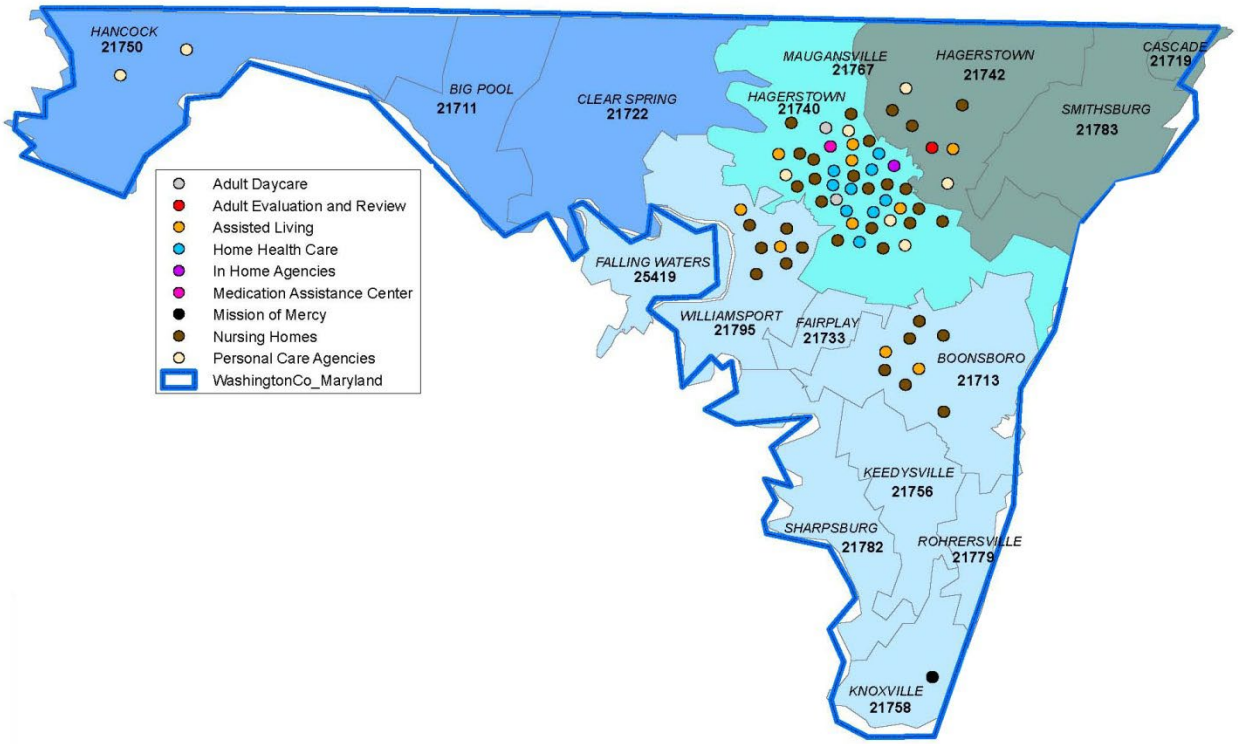
Community resources are categorized into two major areas: Medical Care Services and Senior Services. Medical Services includes, but are not limited to, Urgent Care facilities, Cancer treatment programs, Dental Services, Dialysis Centers, Durable Medical Equipment (DME) providers, Pharmacies, Outpatient Rehab Centers, Rehab Facilities, and Community Mental Health providers. The geographic locations of the Medical Service assets by category are illustrated below**.**

Washington County Community Assets: Medical Services



Senior Services include, but are not limited to, Adult Day Care, Assisted Living facilities, Commission on Aging, Evaluation and Review services, Home Health services, Hospice, In-Home Support services, Ambulance, Nursing Facilities, Personal Care Homes, and Medication Assistance. The geographic locations of the Senior Service assets are illustrated below.

Washington County Community Assets: Senior Services



Asset Inventory

A list of Washington County community resources and contact information is included as **Appendix E.**

Health Services Gaps

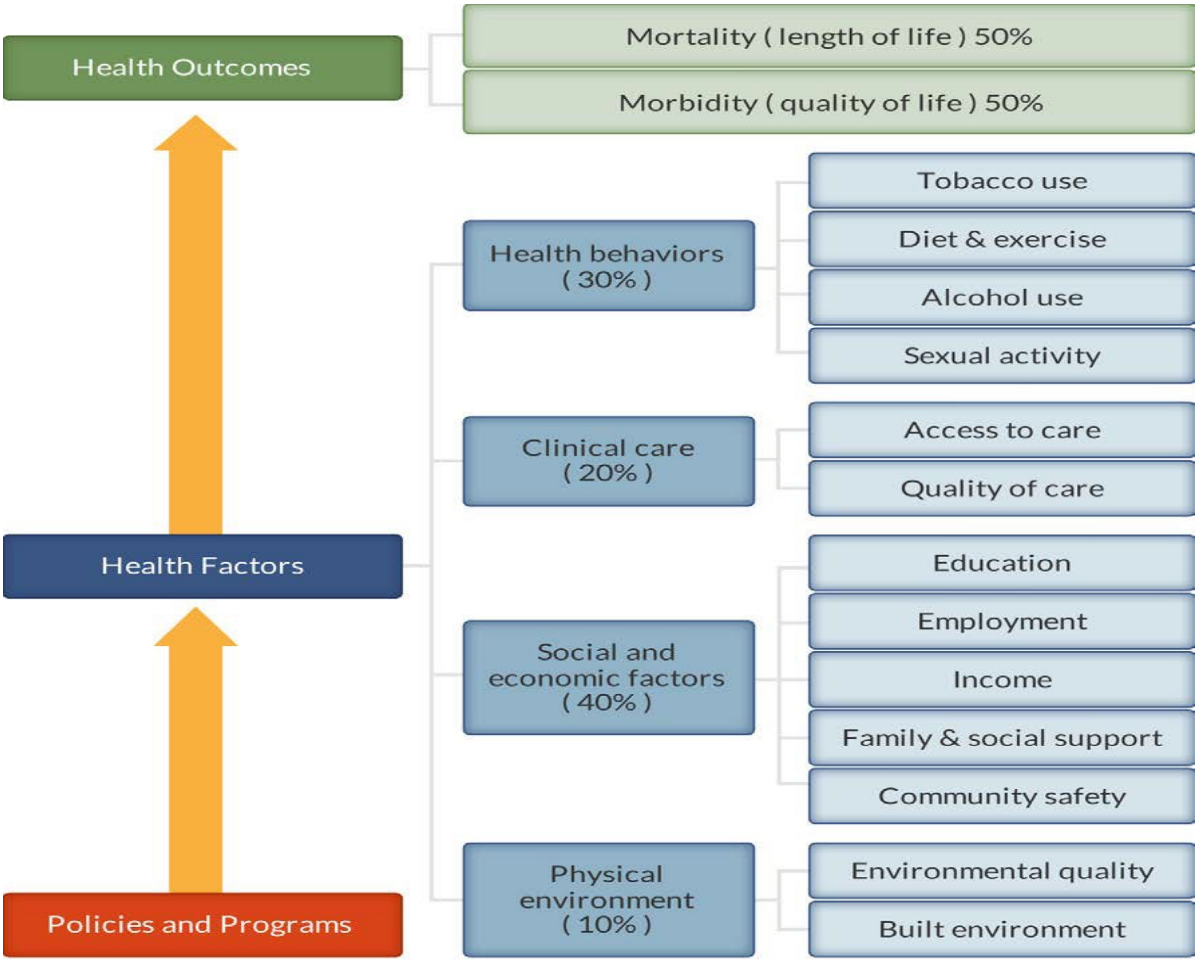
- Timely access to substance abuse treatment when a person desires help; specifically the lack of detoxification, inpatient treatment levels of care, and medication assisted treatment
- Availability of diet and nutrition consultation believed to be lacking due to poor reimbursement by health insurance
- Timely access to outpatient psychiatry services and lack of mental health crisis beds
- Adequate transportation to all medical services that can reach all parts of the county

Secondary Data Analysis

D. County Health Rankings

The County Health Rankings & Roadmaps program is based on collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings is based on a model of population health that emphasizes the many factors that can help make communities healthier places to live, learn, work and play.

County Health Rankings model



County Health Rankings model ©2012 UWPHI

The County Health Rankings measure the health of nearly all counties in the nation and rank them within states. The Rankings use county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights to provide a good snapshot of how health is influenced by where we live, learn and work. The standings also provide an excellent overview of a community's health status and are the starting point for the FY2022 CHNA assessment. The overall ranking for Washington County was 18th out of 24 among counties in the state of Maryland.

County Health Rankings Maryland 2018 vs. 2021

Rank	Health Outcomes		Rank	Health Factors	
	2018	2021		2018	2021
1	Montgomery	Montgomery	1	Howard	Howard
2	Howard	Howard	2	Montgomery	Montgomery
3	Carroll	Frederick	3	Carroll	Frederick
4	Calvert	Carroll	4	Frederick	Calvert
5	Frederick	Calvert	5	Calvert	Harford
6	St. Mary's	Queen Anne's	6	Queen Anne's	Carroll
7	Anne Arundel	Anne Arundel	7	Talbot	Anne Arundel
8	Harford	St. Mary's	8	Harford	Talbot
9	Queen Anne's	Talbot	9	Anne Arundel	Queen Anne's
10	Talbot	Harford	10	St Mary's	Baltimore
11	Charles	Worcester	11	Baltimore	Kent
12	Worcester	Charles	12	Charles	Charles
13	Baltimore	Prince George's	13	Kent	St. Mary's
14	Prince George's	Kent	14	Garrett	Garrett
15	Garrett	Garrett	15	Worcester	Cecil
16	Kent	Baltimore	16	Prince George's	Prince George's
17	Cecil	Caroline	17	**Washington**	Worcester
18	**Washington**	**Washington**	**18**	Allegany	**Washington**
19	Wicomico	Wicomico	19	Wicomico	Allegany
20	Allegany	Cecil	20	Cecil	Wicomico
21	Dorchester	Allegany	21	Caroline	Caroline
22	Caroline	Somerset	22	Dorchester	Dorchester
23	Somerset	Dorchester	23	Somerset	Baltimore City
24	Baltimore City	Baltimore City	24	Baltimore City	Somerset

Source: Robert Wood Johnson Foundation County Health Rankings 2021

When comparing 2018 to 2021 standings, Washington County dropped one ranked position, from 17th to 18th due to a decline in **Health Outcomes**. Health Outcomes includes a decreased length of life (premature death) and poorer quality of life (poor or fair health, poor physical health, poor mental health and low birth weight). The **Health Factors** ranking for Washington County remained unchanged at 18th. Health Factors include clinical care 20%, health behaviors 10%, social, and economic determinants 30% and the physical environment 10%. The overall ranking for Washington County has slipped six positions since 2012 when the county was ranked 12th / 24.

Improving Washington County trends include fewer uninsured persons, supply of dentists, and lower rates of air pollution. Cautious trends include increases in physical inactivity, preventable hospital stays, unemployment, and crime. Concerning trends include premature death rate, increased adult obesity rates, a lack of available primary care physicians, low rates of mammography screening and more children living in poverty.

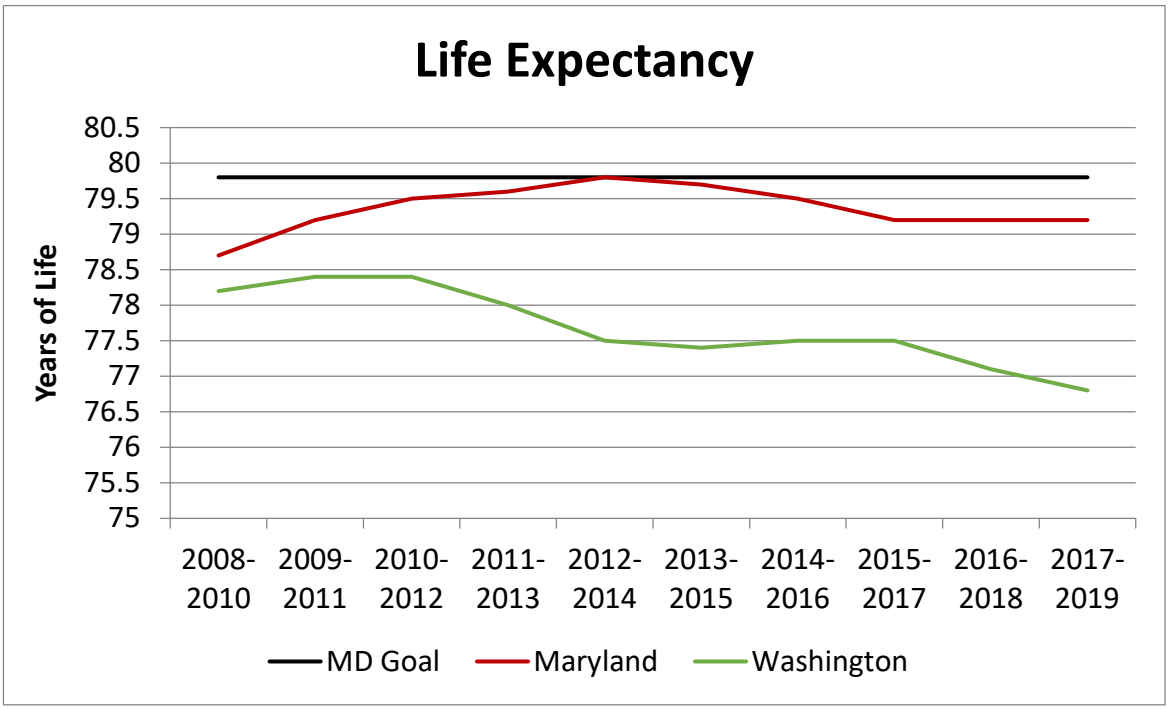
The full Washington County Health Rankings summary and data is included in **Appendix F.**

Life Expectancy

Previously, life expectancy along with infant mortality and causes of death are a sufficient basis for assessment of population health status.[2] While the quality of life has gained increased importance, overall life expectancy remains an important general indicator. In Washington Co. the most current life expectancy is 76.8 years, a decrease of 1.6 years from a trend beginning in 2010-2012 and continues to the present (see below). The overall decline is attributed to an increase in the rate of premature death that includes drug overdose fatalities among primarily younger people and a higher age-adjusted rate of suicide per 100,000 persons. The decreasing trend seen in Washington County is consistent with the national trend, attributed to increased rates of overdose deaths and suicide[3] but is declining more than the state average.

The years of potential life lost in Washington County is calculated as 8,100 years with an 11% higher rate noted among Black or African American (9,100 years).[4] Men have a shorter life expectancy than women. Black or African American males living in Washington Co. have an average life expectancy of 4.6 years less than the average.

Life Expectancy in Maryland and Washington County



Source: Maryland State Vital Statistics, 2008 – 2019

The data and rate is pre-Covid-19 and does not include any pandemic impact.

[2] World Health Organization, *Health Expectancy Indicators*, http://www.who.int/bulletin/archives/77(2)181.pdf (Aug. 9, 2015)
[3] Centers for Disease Control and Prevention, *CDC Director's Media Statement on U.S. Life Expectancy,* https://www.cdc.gov/media/releases/2018/s1129-US-life-expectancy.html (Jan. 11, 2019)
[4] County Health Rankings and Roadmaps, http://www.countyhealthrankings.org/app/maryland/2021/rankings/washington/county/outcomes/overall/snapshot (Jan.9, 2022)

The leading causes of age-adjusted mortality in Washington County include heart disease and cancer. In addition, death rates are also higher than the state average for diabetes, respiratory disease and suicide.

CRUDE DEATH RATES* FOR SELECTED CAUSES BY REGION AND POLITICAL SUBDIVISION, MARYLAND, 2019.**

REGION AND POLITICAL SUBDIVISION	ALL CAUSES	DISEASES OF THE HEART	MALIGNANT NEOPLASMS	CEREBROVASCULAR DISEASE	ACCIDENTS	CHRONIC LOWER RESP DISEASE	DIABETES MELLITUS	ALZHEIMERS	INFLUENZA AND PNEUMONIA	SEPTICEMIA	NEPHRITIS, NEPHROTIC SYNDROME, NEPHROSIS	ASSAULT, HOMICIDE	INTENTIONAL SELF-HARM (SUICIDE)	HIV
MARYLAND	841.5	194.9	177.9	50.5	40.3	35.6	25.0	16.8	13.7	13.8	12.2	9.6	10.9	3.1
NORTHWEST AREA	965.4	228.2	186.5	59.6	43.7	62.7	32.0	22.5	13.7	16.3	10.4	***	14.7	***
GARRETT	1244.2	382.6	203.4	68.9	***	***	***	100.0	***	***	***	***	***	***
ALLEGANY	1298.0	349.4	227.2	86.6	36.9	86.6	***	45.4	***	34.1	***	***	***	***
WASHINGTON	1120.8	240.3	223.8	63.6	65.5	92.7	45.7	14.6	13.9	16.6	***	***	17.9	***
FREDERICK	753.6	171.1	151.8	48.9	33.1	40.5	23.9	12.3	10.0	11.6	***	***	13.1	***

AGE-ADJUSTED** DEATH RATES* FOR SELECTED CAUSES** BY POLITICAL SUBDIVISION, MARYLAND, 2017-2019.**

REGION AND POLITICAL SUBDIVISION	ALL CAUSES	DISEASES OF THE HEART	MALIGNANT NEOPLASMS	CEREBROVASCULAR DISEASE	ACCIDENTS	CHRONIC LOWER RESP DISEASE	DIABETES MELLITUS	ALZHEIMERS	INFLUENZA AND PNEUMONIA	SEPTICEMIA	NEPHRITIS, NEPHROTIC SYNDROME, NEPHROSIS	ASSAULT, HOMICIDE	INTENTIONAL SELF-HARM (SUICIDE)	HIV
MARYLAND	713.0	161.9	148.6	40.7	36.4	30.0	20.1	15.5	13.0	12.1	11.3	9.9	10.1	2.7
NORTHWEST AREA	756.4	174.1	147.3	39.7	38.4	43.5	24.1	20.5	13.9	12.4	9.3	***	14.3	***
GARRETT	779.9	222.7	134.1	***	***	42.7	***	51.1	***	***	***	***	***	***
ALLEGANY	866.7	208.3	154.6	50.2	38.0	48.9	***	31.3	20.3	18.5	***	***	***	
WASHINGTON	843.4	184.6	162.8	41.8	51.4	55.9	32.0	16.2	13.4	13.5	***	***	14.4	***
FREDERICK	662.0	148.6	136.6	35.2	31.2	33.0	20.6	14.3	11.5	9.5	8.0	***	12.4	***

Source: Maryland Vital Statistics, 2019

The Maryland Vital Statistics 2019 were finalized and published in 2021 (see **Appendix G**). A summary for Maryland Vital Statistics is included in **Appendix H.**

Community Solutions Hub

Conduent Healthy Communities Institute (HCI) provides demographic and secondary data on health, health determinants, and quality of life topics for Washington County, Maryland. The data is easily searchable in a centralized website www.communitysolutionshub.com, funded by Meritus Health and San Mar. Local data is primarily derived from state and national public health sources. Washington Co. data is compared to available data from other counties, state average, national average, or target values. Through the Community Solutions Hub everyone has easy access to critical information about our community. Reference the Community Solutions Hub Description in **Appendix I** for a complete overview of details.

E. Health Status Indicators and Data

Health indicators are quantifiable characteristics used as supporting evidence to describe and define the health of a given population. The World Health Organization (WHO) defines health needs as "objectively determined deficiencies in health that require health care, from promotion to palliation."[5] Whenever possible, standardized health indicators for Washington County were used to provide us with comparison of data over time.

The health indicator topics with additional detail include: alcohol and drugs, cancer, diabetes, heart disease and stroke, immunization and infectious disease, maternal, fetal and infant health, teen birth, mental health, obesity, oral health, respiratory, senior health and tobacco use.

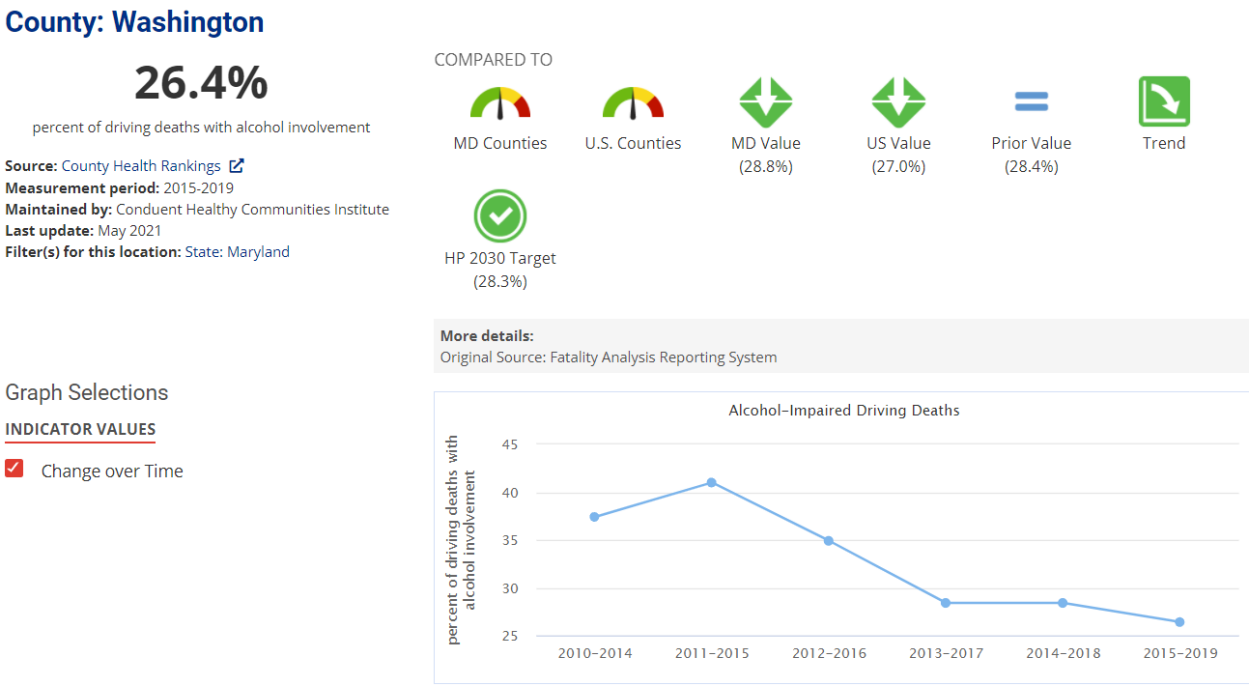
[5] *Expert Committee on Health Statistics. Fourteenth Report.* Geneva, World Health Organization, 1971. WHO Technical Report Series No. 472, pp 21-22.

Alcohol & Drug

Alcohol abuse is associated with a variety of negative health and safety outcomes including alcohol-related traffic accidents and other injuries, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems.

Driving deaths with alcohol Involvement

According to the National Highway Traffic Safety Administration, motor vehicle crashes that involve an alcohol-impaired driver kill 28 people in the United States every day, which amount to one death every 53 minutes. The Healthy People 2030 national health target is to reduce the proportion of motor vehicle crash deaths that involve a drunk driver to 28.3%. Washington County rate of 26.4% is an improved trend downwards and is better than the Healthy People 2030 target.



Adults who Binge Drink

The prevalence of binge drinking among men is twice that of women. In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers. This indicator shows the percentage of adults who reported binge drinking at least once during the 30 days prior to the survey. Male binge drinking is defined as five or more drinks on one occasion, and female binge drinking is four or more drinks on one occasion.

Washington County demonstrates a binge drinking rate of 11.3%, which is more than 50% below the Healthy People 2030 Target.

County: Washington

11.3%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (14.8%)	US Value (16.8%)	Prior Value (12.9%)	Trend	HP 2020 Target (24.2%)

Graph Selections

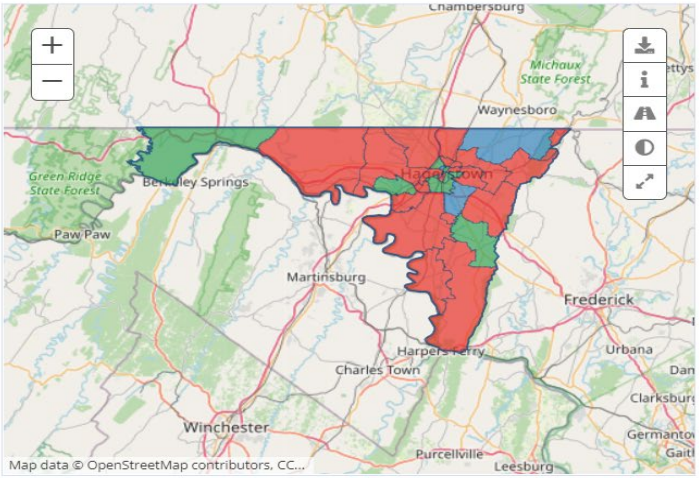
INDICATOR VALUES

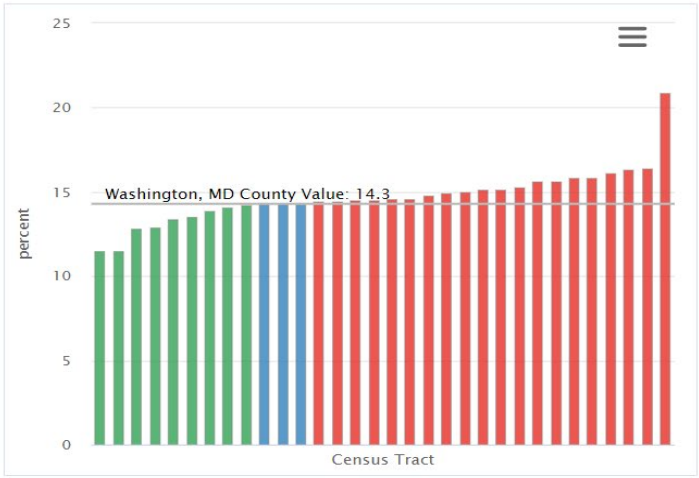
- [x] Change over Time

VIEW BY SUBGROUP

- [x] Gender

Nearly all of Washington County binge drinking rate is low with the exception of census tract 24043011000 at 20.9%. The demographics for this area include 62% Black or African American, 27% White, and 6% Hispanic or Latinx.



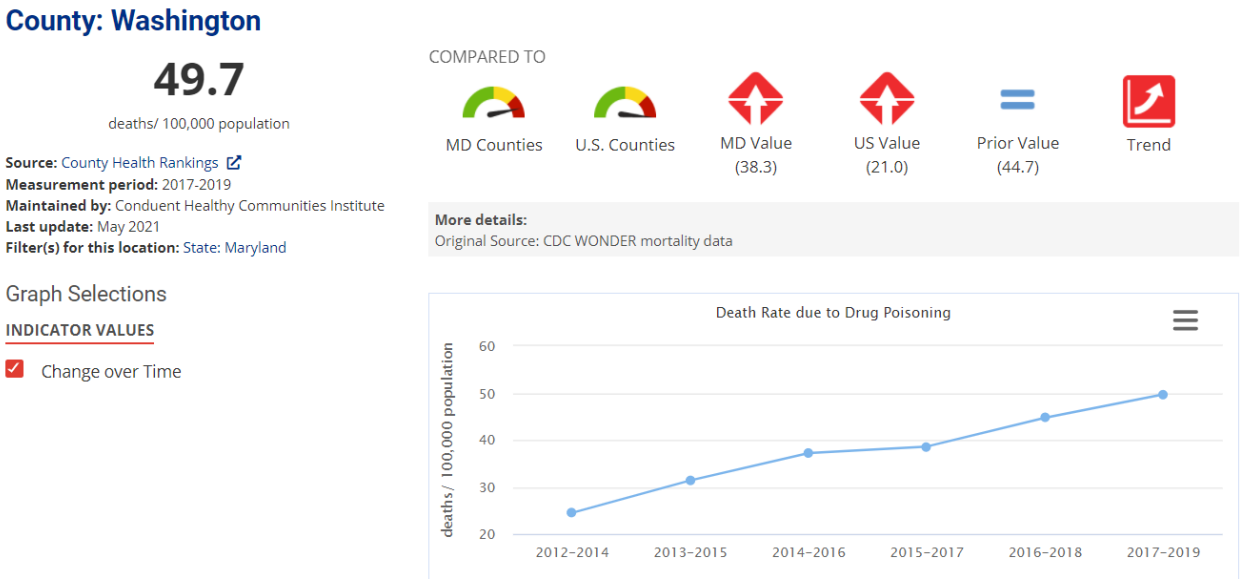


< 14.3% = 14.3% > 14.3% N/A

Age-Adjusted Drug and Opioid-Involved Overdose Death Rate

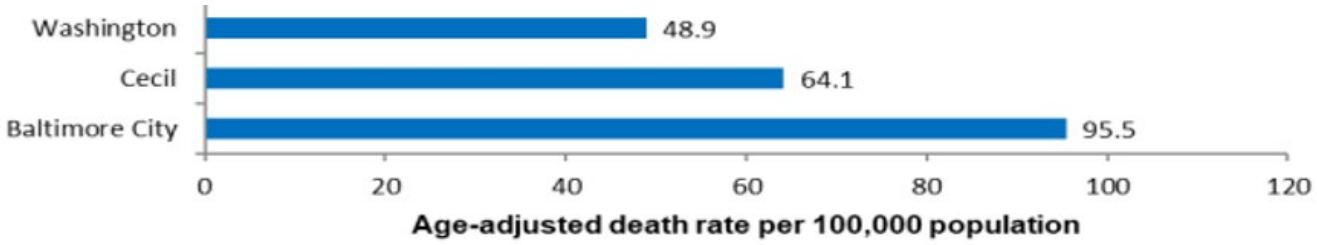
This indicator shows the death rate per 100,000 population due to drug poisoning.

Drug overdose deaths are the leading cause of injury death in the United States, with over 100 drug overdose deaths occurring every day. The death rate due to drug overdose has been increasing over the last few decades.



Those who die from drug overdose are more likely to be male, Caucasian, or between the ages of 45 and 49. The current Washington Co. rate per 100,000 persons is 49.7, an increasing trend, more than 30% above the state of Maryland average. Washington County has the third highest rate in the state, following Baltimore City and Cecil County.

Age-adjusted mortality rates for Total Unintentional Intoxication Deaths by Place of Residence, Maryland. 2017- 2019.



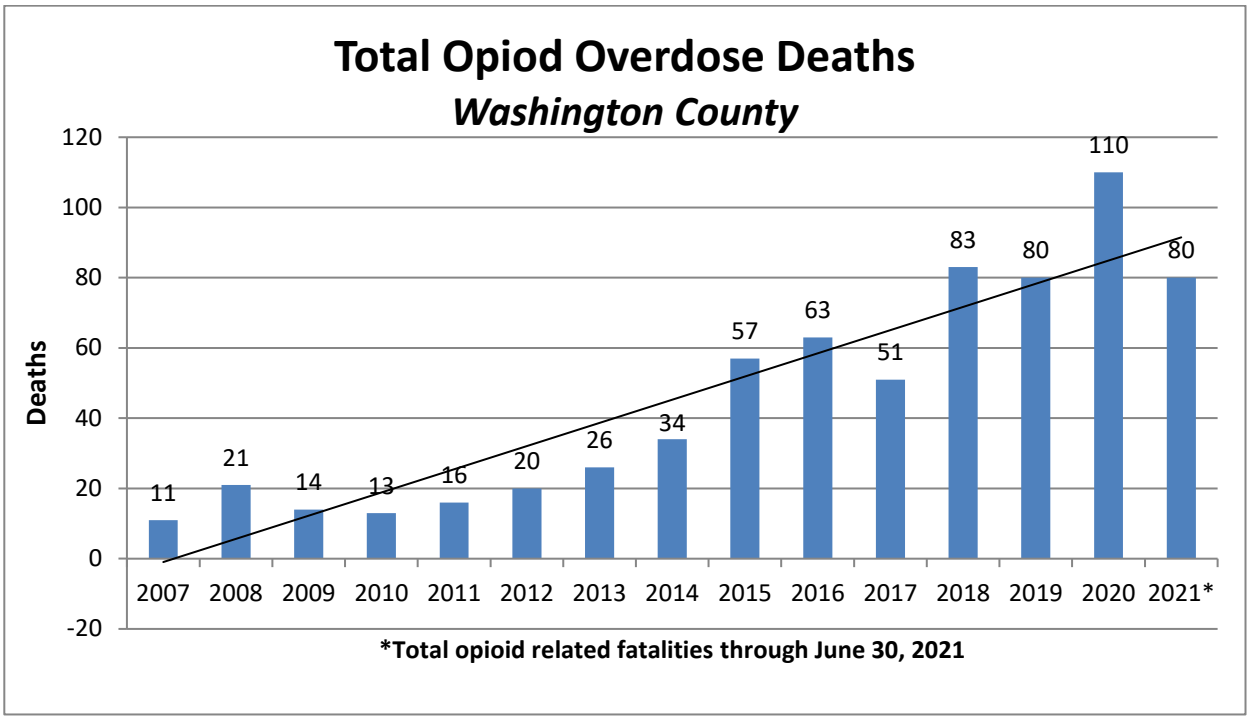
Source: www.health.maryland.gov/vsa/Documents/Overdose/Annual_2020_Drug_Intox_Report.pdf accessed 11/02/2021

Fatal overdose data include deaths that were the result of recent ingestion or exposure to prescription and illicit opioids. Includes only deaths for which the manner of death was classified as accidental or undetermined. Since 2015, the majority of fatal overdoses in Washington County are attributed to opioids, primarily identified as Fentanyl, heroin and prescription analgesics.

Substance	2013	2014	2015	2016	2017	2018	2019	2020
Alcohol	6	11	10	17	14	15	20	17
Cocaine	6	6	10	9	10	31	24	31
Heroin	14	21	38	39	22	23	25	20
Fentanyl	4	1	14	31	39	70	70	95
Prescription	11	16	20	23	8	19	17	18
Total Deaths	**28**	**40**	**64**	**66**	**59**	**91**	**88**	**110**

Source: Maryland Depart of Health, 2021

Despite intervention and harm reduction efforts the most current Washington County data demonstrates a continued increasing trend for fatal opioid overdose deaths. The fatality rate increased significantly during the pandemic, a trend that continues to the present.



Source: Washington County Comparative Overdose Data

Number of Opioid-Related Intoxication Deaths by Place of Occurrence, Maryland, 2007-2020 and YTD 2021 Through June															
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
Washington County	11	21	14	13	16	20	26	34	57	63	51	83	80	110	80

Cancer

The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. According to the NCI there are over 100 different types of cancer, but breast, colon, lung, pancreatic, prostate, and rectal cancer lead to the greatest number of annual deaths. Risk factors of cancer include but are not limited to age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure. Although some of these risk factors cannot be avoided (such as age) limiting exposure to avoidable risk factors may lower risk of developing certain cancers. The overall age-adjusted death rate for cancer in Washington Co. is 162.3, higher than state average and the HP 2030 Target, although with an improving trend. Cancer remains the second leading cause of death in Washington Co.

Health / Cancer

Age-Adjusted Death Rate due to Cancer

VALUE

162.3

Deaths per 100,000 population

(2015-2019)

COMPARED TO:

MD Counties

U.S. Counties

MD Value (151.5)

US Value (152.4)

Prior Value (169.8)

Trend

Maryland SHIP 2017 (147.4)

HP 2020 Target (161.4)

HP 2030 Target (122.7)

Approximately 8% of Washington County adults aged 18 and over have ever been told by a health professional that they have any type of cancer, except skin cancer.

County: Washington

7.7%

Source: CDC - PLACES
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: January 2021
Filter(s) for this location: State: Maryland

COMPARED TO

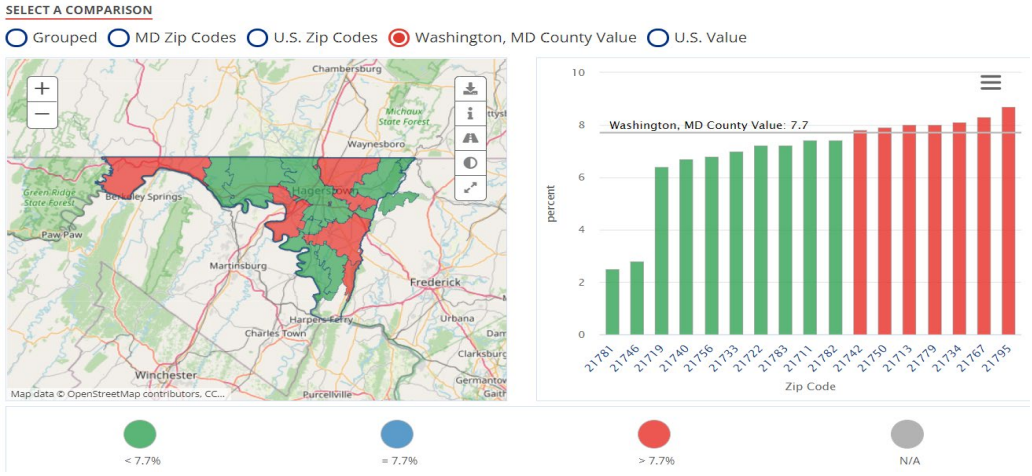
MD Counties

U.S. Counties

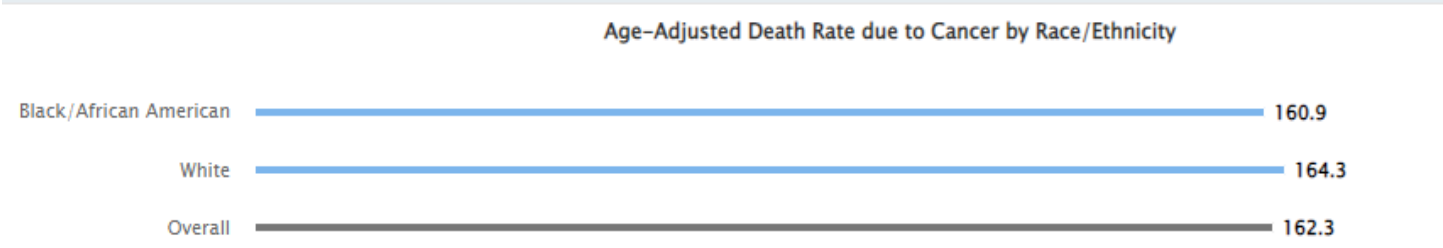
US Value (6.9%)

Technical note: Sub-county small area model-based estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.

The highest rates are 8.7% Williamsport, followed by Maugansville 8.3%, and Funkstown 8.1%

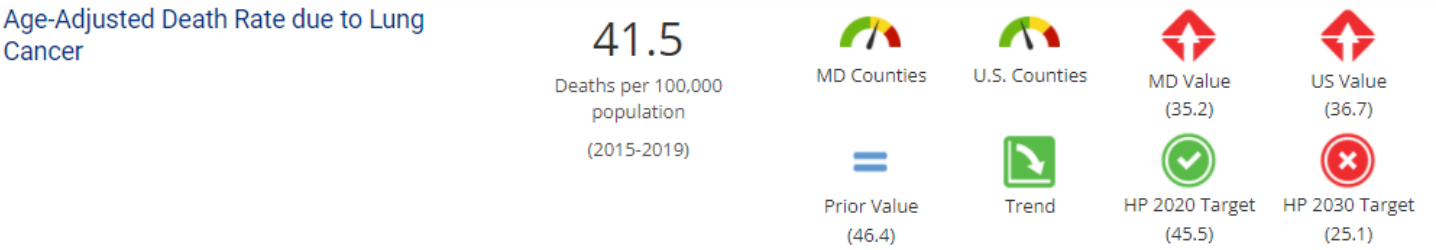


Examining overall age-adjusted cancer deaths by race and ethnicity reveal no significant differences.

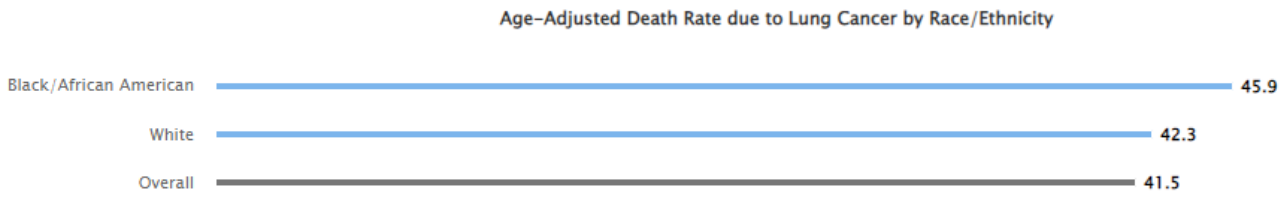


According to the American Lung Association, more people die from **lung cancer** annually than any other type of cancer, exceeding the total deaths caused by breast cancer, colorectal cancer, and prostate cancer combined. The greatest risk factor for lung cancer is duration and quantity of smoking. While the mortality rate due to lung cancer among men has reached a plateau, the mortality rate due to lung cancer among women continues to increase. Black or African Americans have the highest risk of developing lung cancer.

The Washington Co. lung cancer rate is 41.5, higher than the state and national average. However, the rate has been reduced by more than 10% over the past six years. The HP 2030 target is to reduce the lung cancer death rate to 25.1 deaths per 100,000 population.



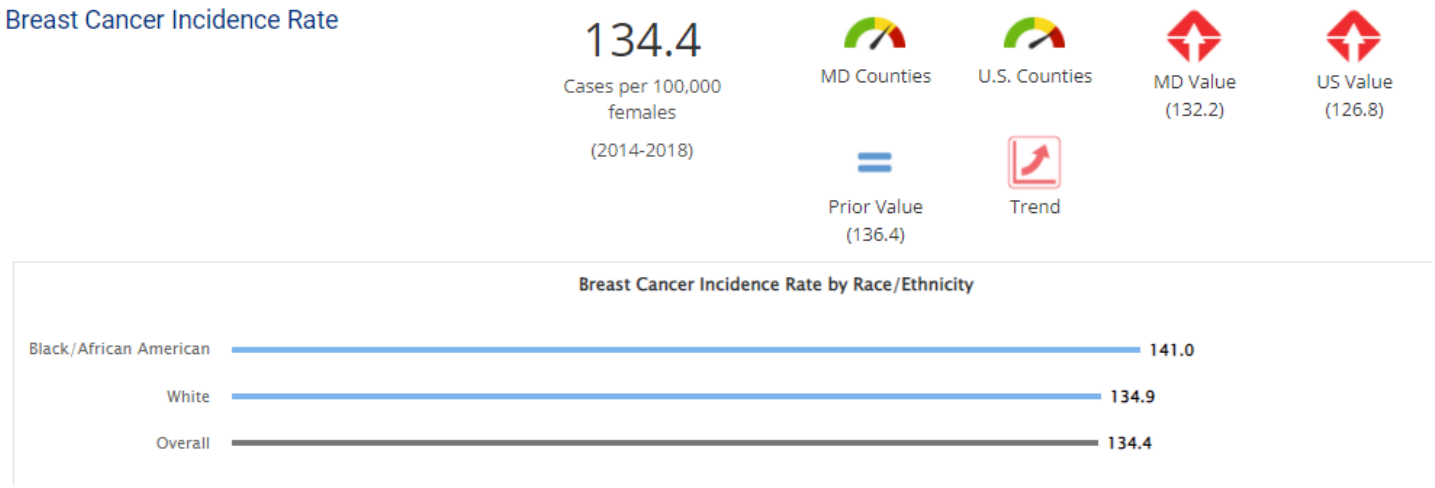
The data suggests a health disparity for lung cancer among Black or African Americans in Washington Co. at an age-adjusted death rate of 45.9 compared to a 42.3 rate among Whites.



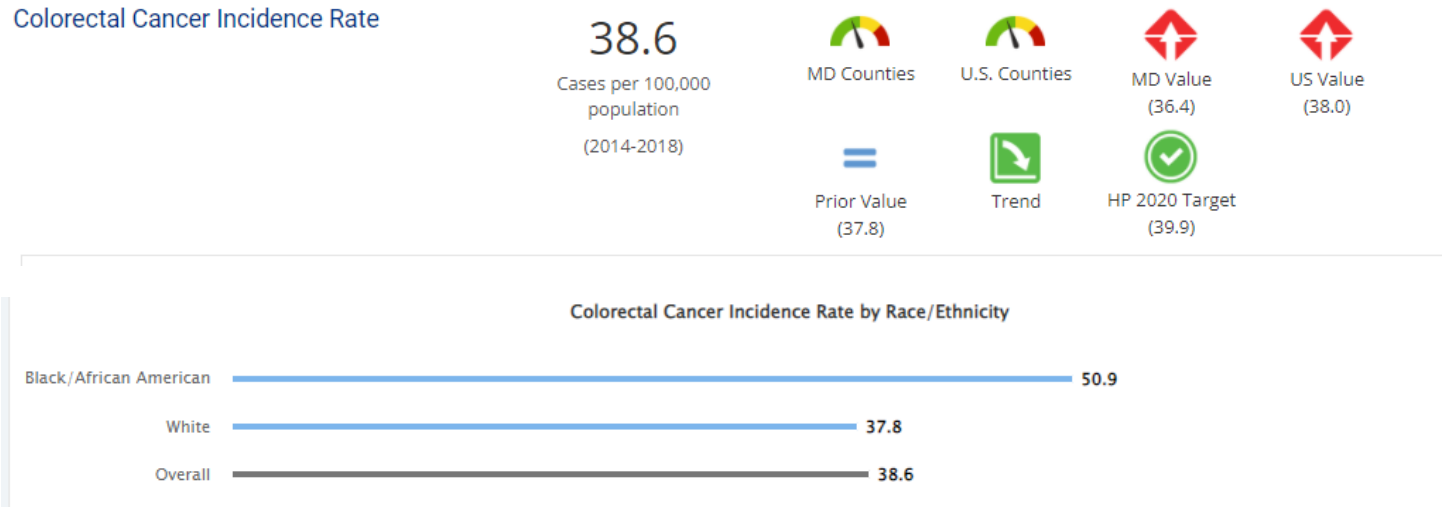
Breast cancer is a leading cause of cancer death among women in the United States. According to the American Cancer Society, about 1 in 8 women will develop breast cancer and about 1 in 36 women will die from breast cancer. Breast cancer is associated with increased age, hereditary factors, obesity, and alcohol use.

Breast cancer death rates have declined progressively due to advancements in treatment and detection since 1990. The Washington Co. rate is 134.4 per 100,000 females, a slight decrease over six years, but slightly

higher compared to the state average. There is a possible health disparity among Black or African American females in Washington Co. with a rate of 141, more than 4% higher than the rate among White females.

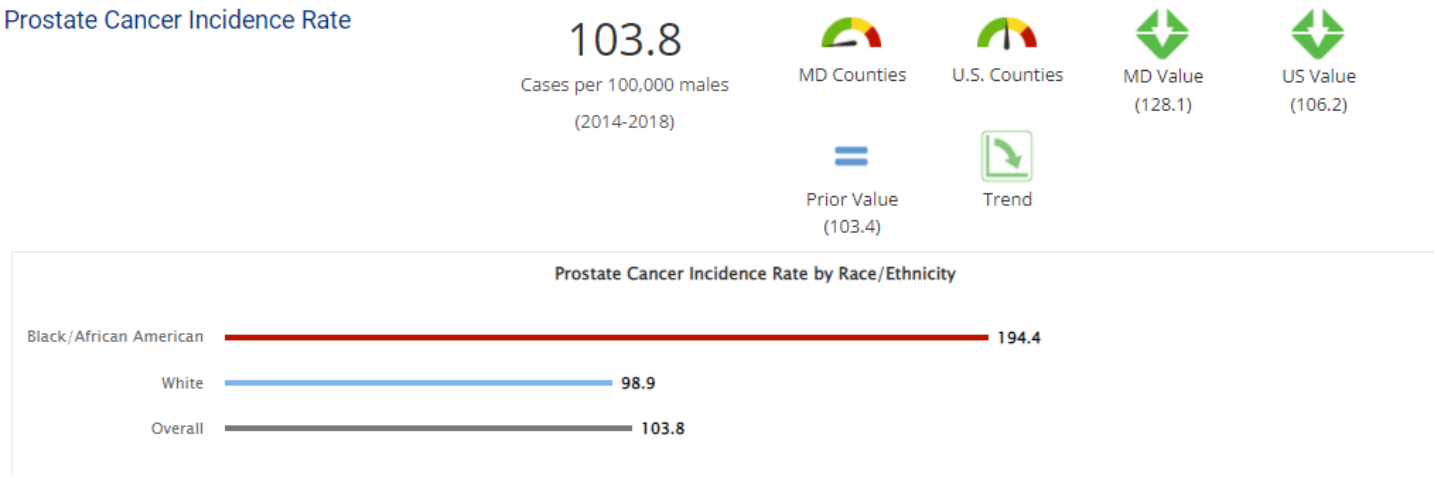


According to the CDC, **colorectal cancer** is one of the most commonly diagnosed cancers and is the second leading cancer killer in the United States. The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented. The Washington Co. colorectal cancer incidence rate of 38.6 per 100,000 is similar to the state and national averages. The current rate was better than the HP 2020 target. However the rate for Black or African Americans is 50.9, more than 25% higher compared to Whites at 37.8 suggesting a health disparity.



Prostate cancer is a leading cause of cancer death among men in the United States. According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer and about 1 in 36 will die from prostate cancer. The two greatest risk factors for prostate cancer are age and race, with men over the age of 65 and men of African descent possessing the highest incidence rates of prostate cancer in the U.S. The overall prostate cancer rate in Washington Co. is 103.8 better than the state and national average with an

improving trend. However, there is a clear health disparity in the prostate cancer incidence rate among Black or African American men in Washington County of 194.4, that is nearly twice the rate of White men 94.8.

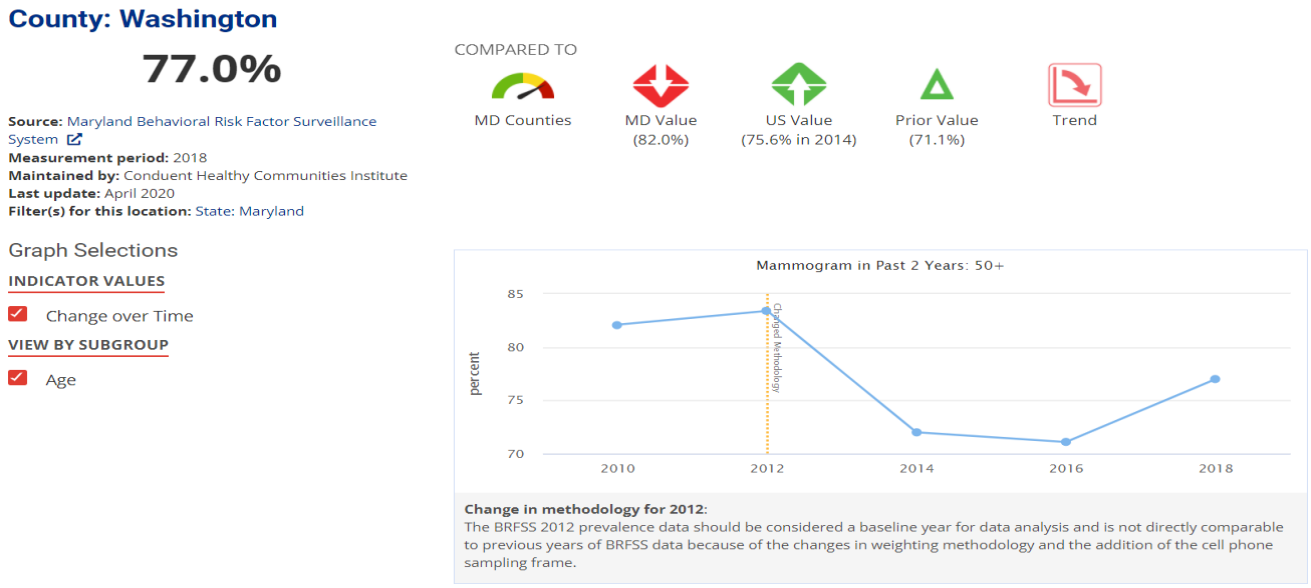


Preventive Cancer Screenings

Cancer screening tests aim to find cancer early, before it causes symptoms and when it may be easier to treat successfully. Effective screening tests are those that reduce the chance that someone who is screened regularly will die from the cancer and have more potential benefits than harms.

Mammogram

A mammogram is an x-ray of the breast that can be used to detect changes in the breast such as tumors and calcifications. The test may be done for screening or for diagnostic purposes. Although mammograms do not detect all cases of breast cancer, they have been shown to increase early detection, thus reducing mortality. The Washington Co. mammogram rate among females is 77%, below the state but higher than the national average. The trend has improved more than 5% over the past three years.



Colon Cancer Screening

The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented. This indicator shows the percentage of respondents aged 50-75 who have had either a fecal occult blood test in the past year, a sigmoidoscopy in the past five years AND a fecal occult blood test in the past three years, or a colonoscopy exam in the past ten years. Washington County demonstrates 65.8% compliance with colon cancer screening lower than the national average and 9% below the HP 2030 Target.

County: Washington

65.8%

Source: CDC - PLACES
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	US Value (66.4%)	HP 2020 Target (70.5%)	HP 2030 Target (74.4%)

Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.

Cervical Cancer Screening

Cervical cancer that is detected early is one of the most successfully treatable cancers, and can be cured by removing or destroying the pre-cancerous or cancerous tissue. Cervical cancer is detected by Pap test screenings and is most often caused by human papillomavirus (HPV), which is a type of infection transmitted through sexual contact and can lead to cervical cancer.

This indicator shows the percentage of women ages 21-65 who have had cervical cancer screening test. For women 21-29, every 3 years. For women 30-65, every 3 or 5 years depending on the type of test(s): (1) if Pap test alone, then every 3 years and (2) if HPV test alone or co-test, then every 5 years.

County: Washington

84.2%

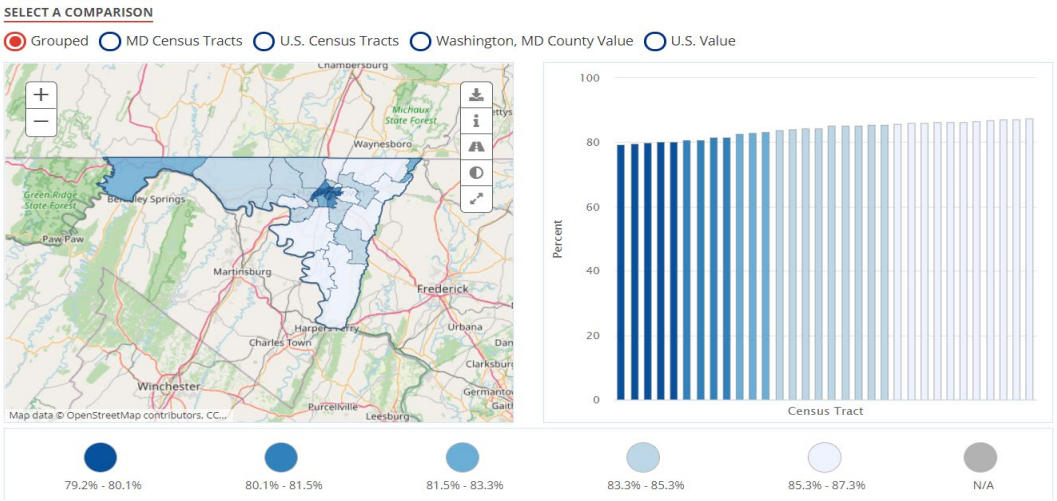
Source: CDC - PLACES
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	US Value (84.7%)	HP 2030 Target (84.3%)

More details:
Click here for more information on how to use the CDC - PLACES

Lower rates of cervical cancer screening occur in central Hagerstown 21740 and to the west around Hancock, Big Pool and Clear Spring. The darkest colors on the map correspond to the lowest screening rates by geography.

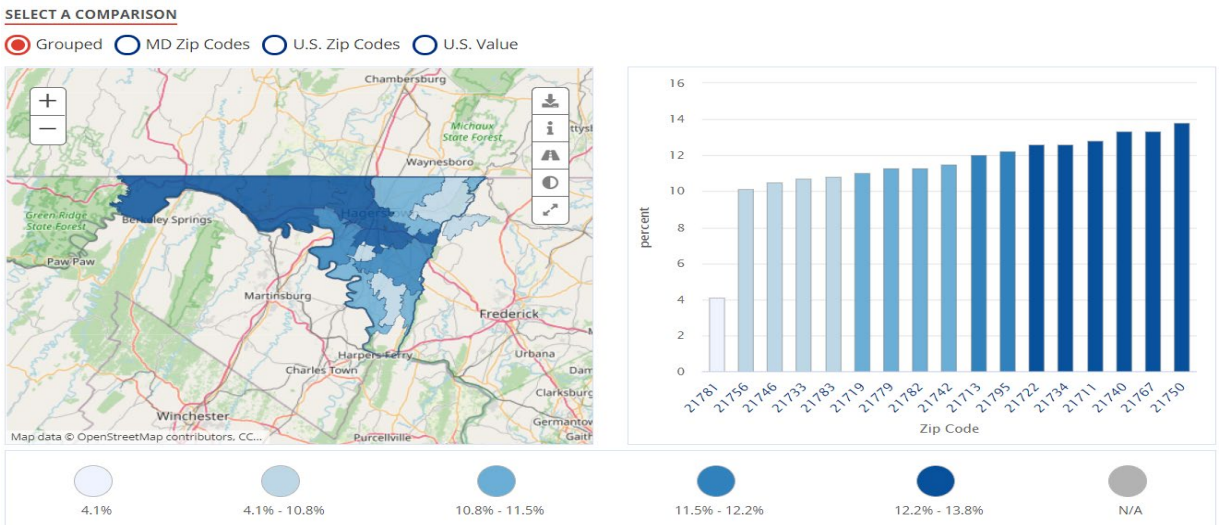


Diabetes

Diabetes is a leading cause of death in Washington Co. and can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. Diabetes disproportionately affects minority populations and the elderly, and its incidence is likely to increase as minority populations grow and the population ages.

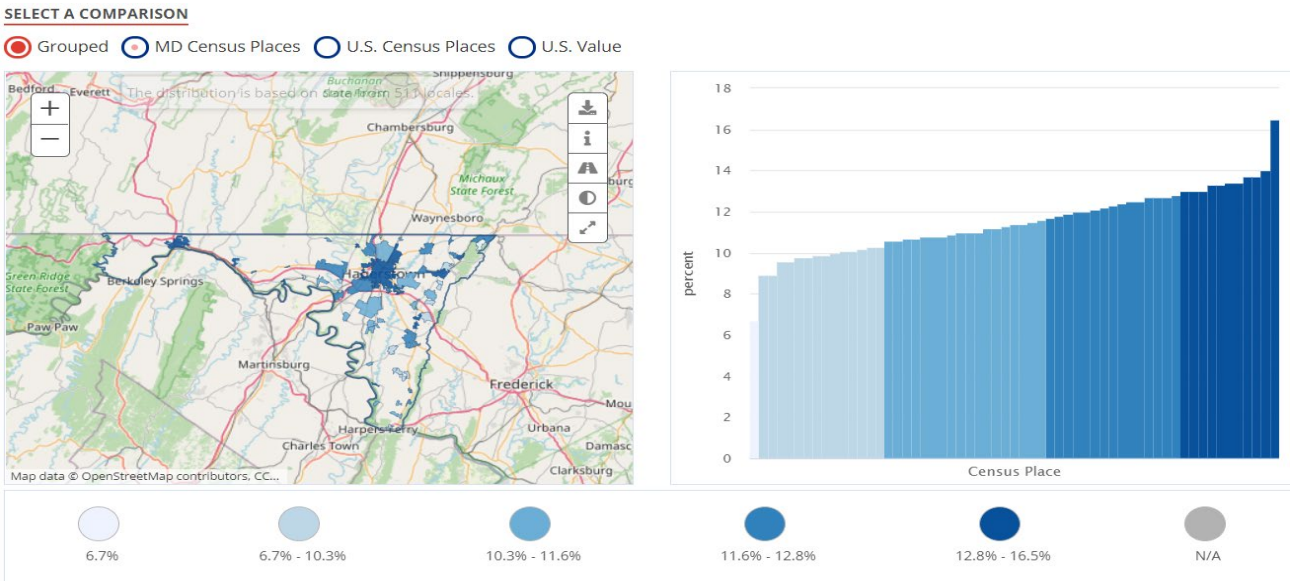
This indicator shows that 10.3% of Washington Co. adults who have been diagnosed with diabetes (women who were diagnosed with diabetes only during the course of their pregnancy were not included in this count). Approximately another 30 – 35% of adults are at risk for developing type II diabetes.

Percentage of adults diagnosed with diabetes, grouped by zip code.



There are 17 Zip Code values. The darkest colors correspond to the highest rates of diabetes. The lowest rate is St. James (4.1%), and the highest value is Hancock (13.8%). Half of the values are between 10.7% and 12.6%. The middle (median) value is 11.5.

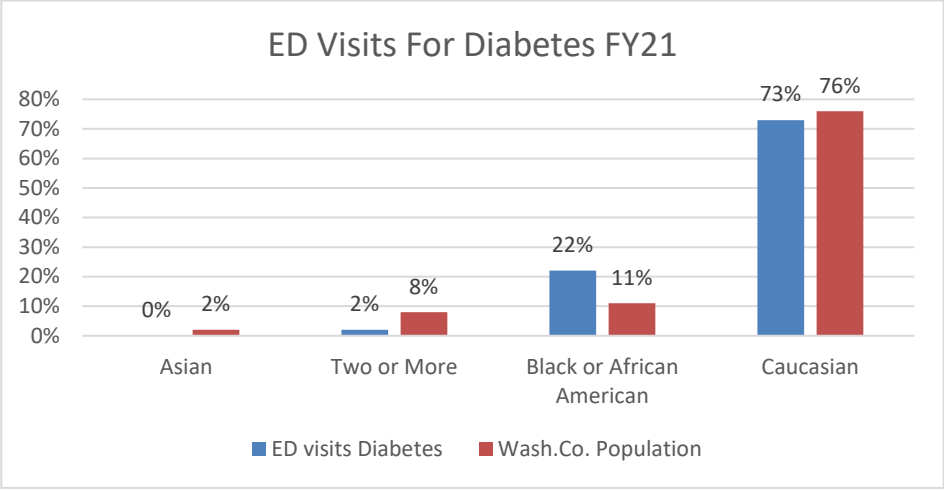
This prevalence indicator shows the percentage of adults who have ever been diagnosed with diabetes by census tract location. The map shows highest concentration of persons living in the core of the downtown Hagerstown (>16%) and Hancock (>13%) locations.



Source [*http://www.communitysolutionshub.org/indicators/index/view?indicatorId=81&localeId=171071*](http://www.communitysolutionshub.org/indicators/index/view?indicatorId=81&localeId=171071)

There are 59 Census Place values. The lowest value is 6.7 (Smithsburg, MD), and the highest values are 16.5 (Hagerstown) and 13.7 (Hancock). Half of the values are between 10.3 and 12.5. The middle (median) value is 11.4 (Fountainhead-Orchard Hills).

Emergency Department visits for unmanaged diabetes during FY2021 demonstrates a percentage of visits by Black or African Americans at twice the percentage of the general Black or African American population living in Washington Co. The higher rate of ED visits for Black or African Americans suggests a health disparity.



Source: Meritus Health Data Atlas Dec. 2021

Diabetes Mortality

Age-adjusted death rate due to diabetes is 32 per 100,000 persons. The Washington County diabetes mortality rate is 35% greater than the state average of 20.1 and remains among the highest in the state of Maryland. Diabetes mortality data by race and ethnicity is not readily available.

County: Washington

32.0

deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: June 2021
Filter(s) for this location: State: Maryland

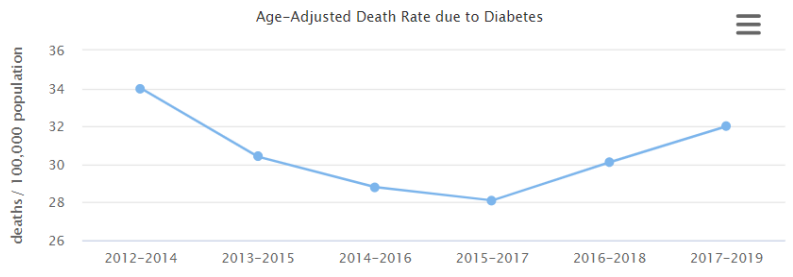
Graph Selections

INDICATOR VALUES

☑ Change over Time

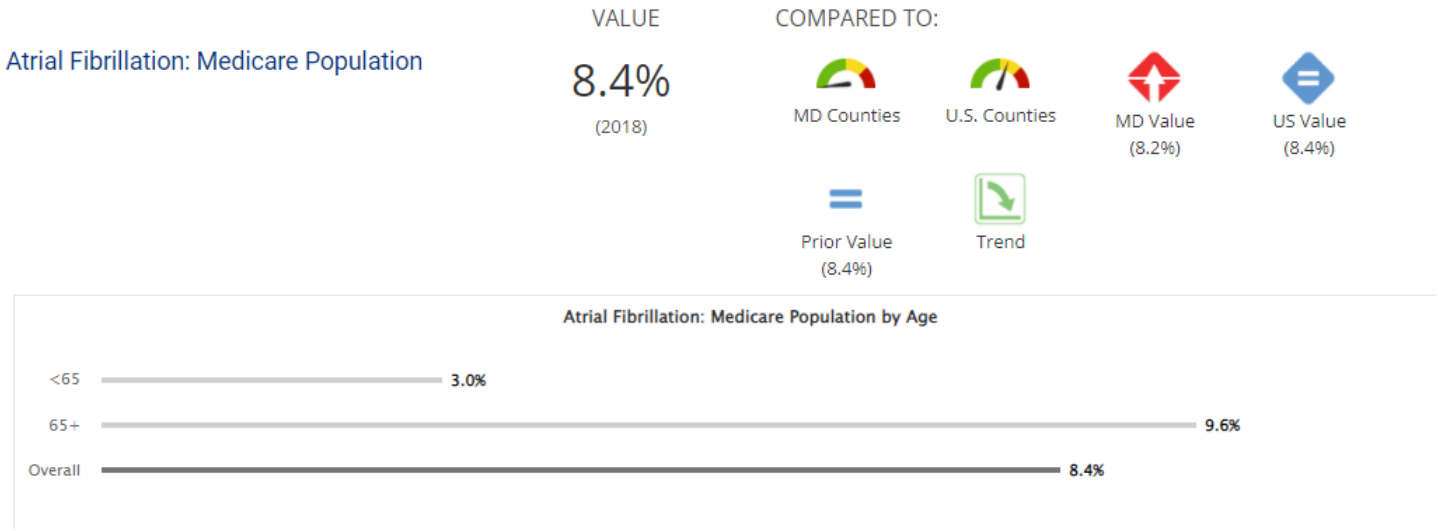
COMPARED TO

MD Value	US Value	Prior Value	Trend
(20.1)	(21.5)	(30.1)	

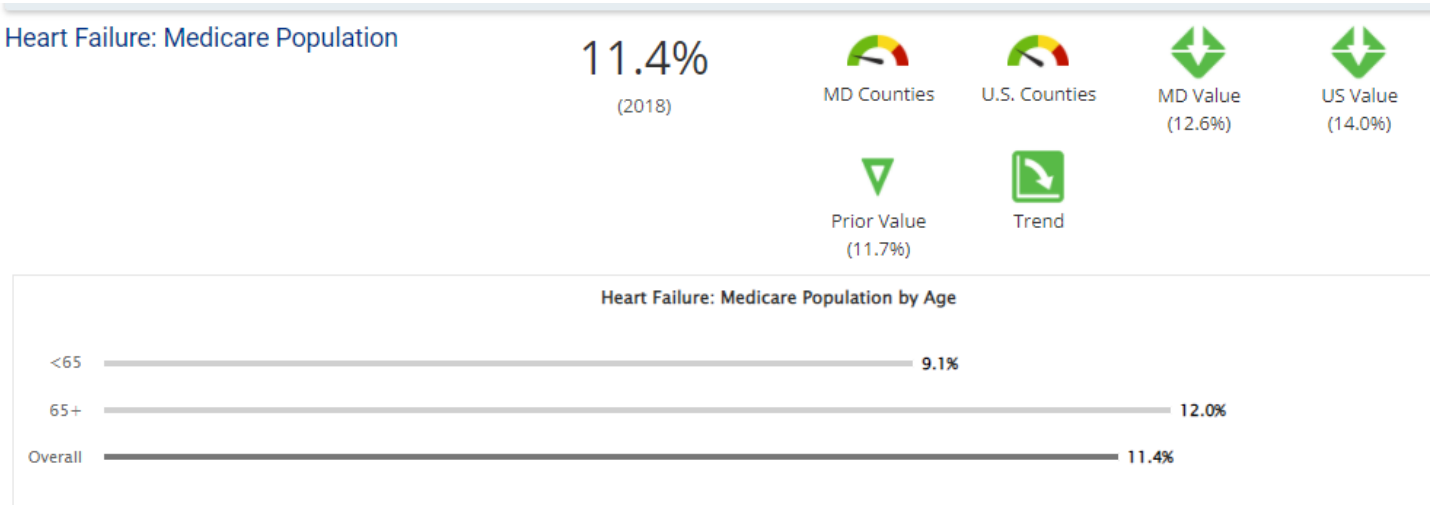


Heart Disease & Stroke

Atrial fibrillation (AFib) is an irregular heartbeat that commonly causes poor blood flow to the body. Symptoms of atrial fibrillation include heart palpitations, shortness of breath and weakness. Although AFib itself is not usually life-threatening, it can lead to blood clots, stroke, heart failure and other heart-related complications that do require emergency treatment. According to the American Heart Association, an estimated 2.7 million Americans are living with AFib and it is the most common "serious" heart rhythm abnormality in people over the age of 65 years. The Washington Co. value of 8.4% is similar to the state and national averages.

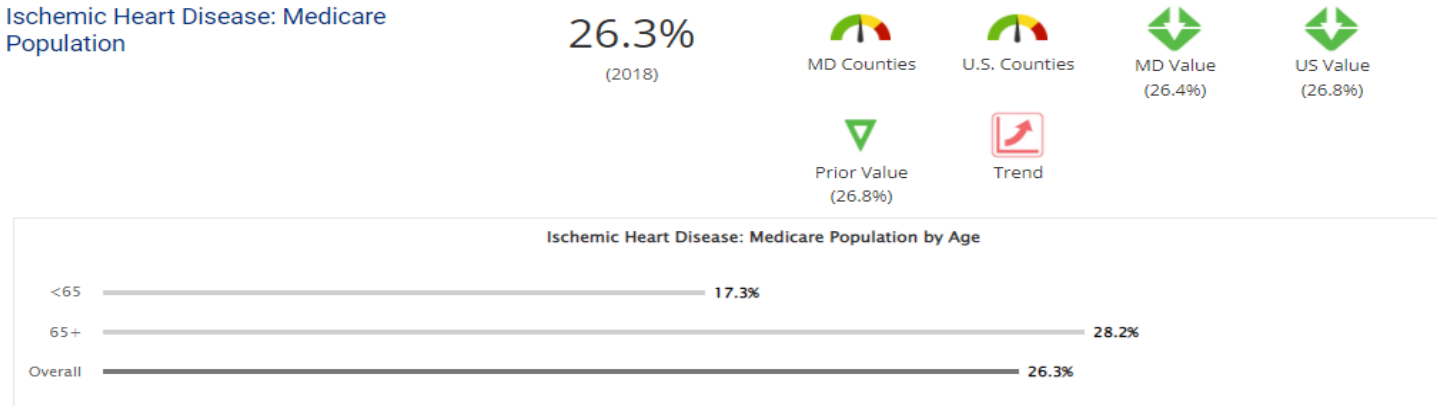


Heart failure occurs when the heart cannot pump sufficient amounts of blood to the rest of the body, resulting in increased blood pressure and fluid retention in the limbs and/or organs. Heart failure is caused by a variety of conditions that weaken the heart, including coronary artery disease, diabetes, heart attack, high blood pressure, and congenital heart defects. Treatment for heart failure begins with a combination of medication, lifestyle changes, and maintaining a low blood pressure to prevent heart failure from advancing. The National Institute of Health states that heart failure is most common in people age 65 and older and it is the number one reason older individuals are hospitalized. The Washington Co. average of 11.4% is better than the state and national averages.



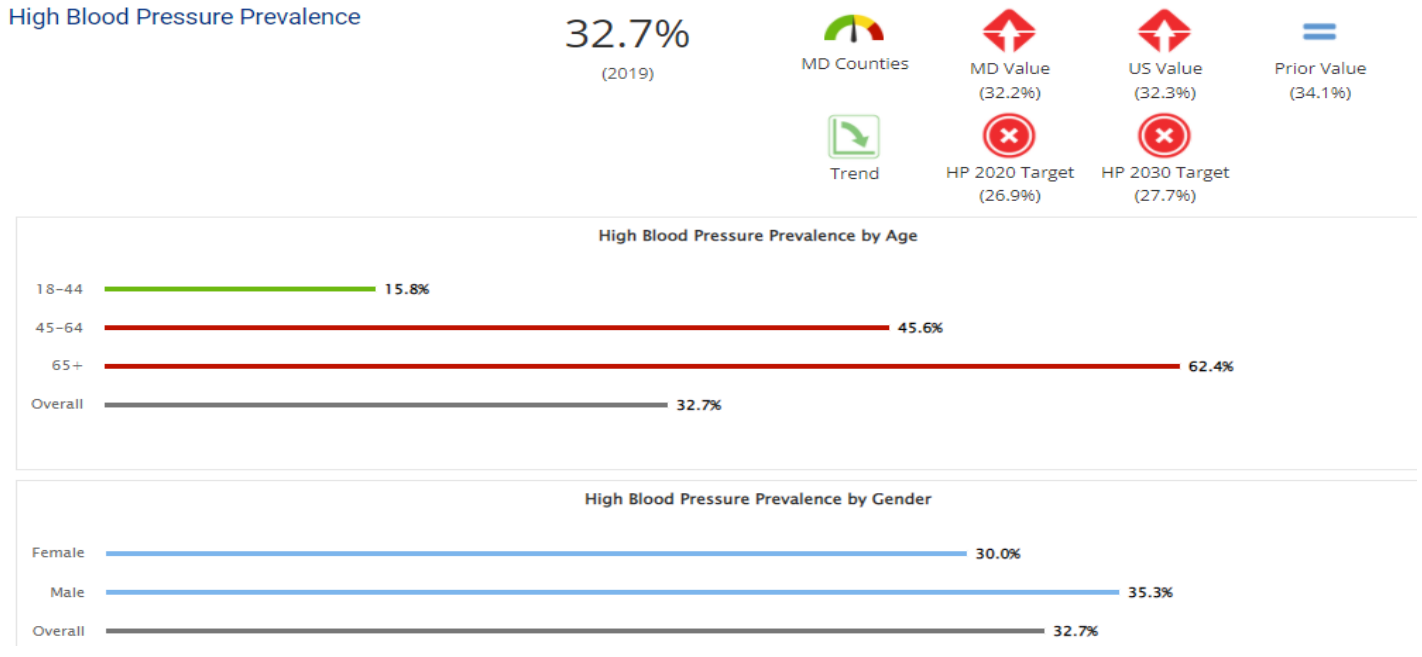
Ischemic Heart Disease

Ischemic heart disease is characterized by the narrowing of the arteries of the heart, resulting in less blood and oxygen reaching the heart muscle. Most ischemic heart disease is caused by atherosclerosis and can result in a heart attack. Risk factors for ischemic heart disease include increased age, smoking status, diabetes, hypertension, obesity, gender, and family history of the disease. Heart disease is the #1 cause of death in Washington Co. The 26.3% average aligns with the state and national averages.

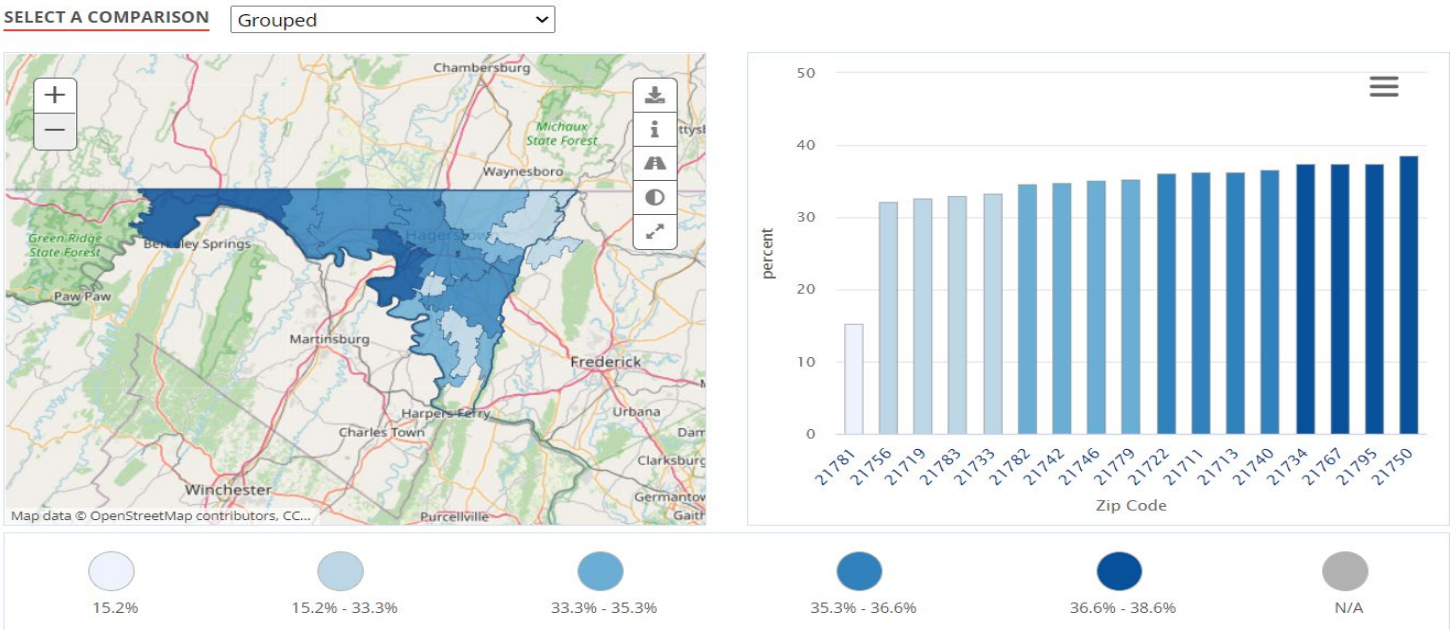


High Blood Pressure Prevalence

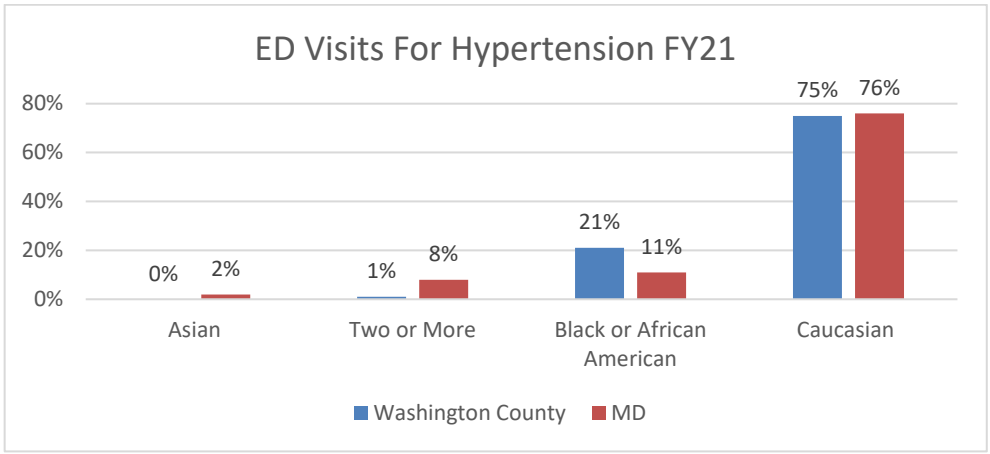
High blood pressure is the number one modifiable risk factor for stroke. High blood pressure contributes to heart attacks, heart failure, kidney failure, and atherosclerosis. The higher your blood pressure, the greater your risk of heart attack, heart failure, stroke, and kidney disease. As there are often no accompanying symptoms, the only way to tell if you have high blood pressure is to have your blood pressure checked. It is particularly prevalent in Black or African Americans, older adults, obese people, heavy drinkers, and women taking birth control. Blood pressure can be controlled through lifestyle changes, including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, controlling your weight, and staying physically active. This indicator shows that nearly on third or 32.7% of Washington Co. adults have been told they have high blood pressure.



In this area, the estimated prevalence of high blood pressure among adults aged 18 years and older was similar to the Maryland average (32.2%) and National value (32.3%). The HP 2030 Target is 27.7%. Rates of high blood pressure are found throughout the entire county but the highest rates include Hancock (>38%), Williamsport, Maugansville, and Funkstown (>37%) and Hagerstown, Boonsboro, Big Pool, and Clear Spring (>36%).



We see that Black or African Americans represent 22% of all emergency department visits for hypertension during FY2021, a percentage that is nearly double the Black or African American population of Washington Co.



Source: Meritus Health Data Atlas Dec. 2021

Increased ED visits also resulted in 20% higher rate of hospitalization for hypertension among Black or African Americans compared to Whites according to the recently published 2019 **Health Equity Resource Community** (HERC) Advisory Committee data (see **Appendix J**).

Cerebrovascular Disease (Stroke)

Cerebrovascular disease refers to conditions, including stroke, caused by problems with the blood vessels supplying the brain with blood. A stroke occurs when blood vessels carrying oxygen to the brain burst or become blocked, thereby cutting off the brain's supply of oxygen and other nutrients. Lack of oxygen causes brain cells to die, which can lead to brain damage and disability or death. Cerebrovascular disease is a leading cause of death in the United States, and although it is more common in older adults, it can occur at any age. The most important modifiable risk factor for cerebrovascular disease and stroke is high blood pressure. Other risk factors include high cholesterol, heart disease, diabetes mellitus, physical inactivity, obesity, excessive alcohol use, and tobacco use.

Washington Co. rate of stroke is 41.8 per 100,000 lives. The rate is slightly higher compared to the state (40.7) and nationally (37.2). The trend is upwards over time.

County: Washington

41.8

deaths/ 100,000 population

Source: Maryland Department of Health
Measurement period: 2017-2019
Maintained by: Conduent Healthy Communities Institute
Last update: June 2021
Filter(s) for this location: State: Maryland

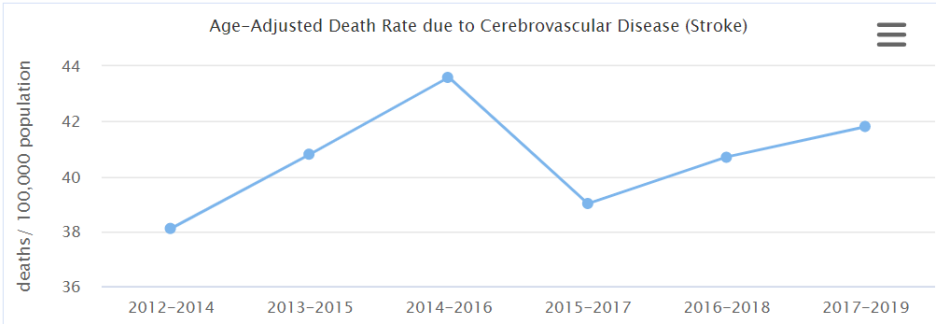
Graph Selections

INDICATOR VALUES

Change over Time

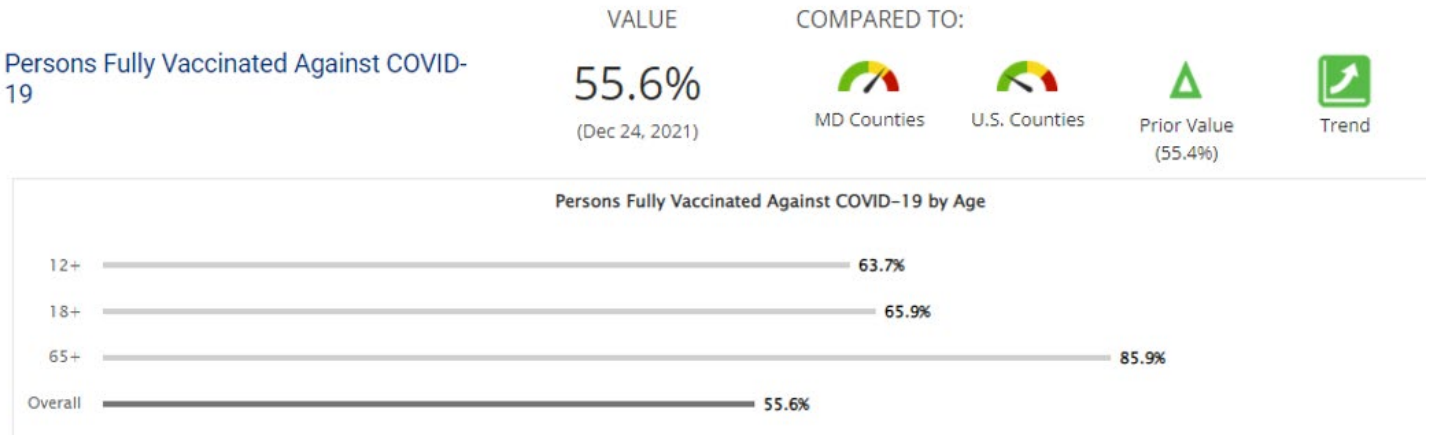
COMPARED TO

MD Counties	MD Value (40.7)	US Value (37.2)	Prior Value (40.7)	Trend	HP 2020 Target (34.8)	HP 2030 Target (33.4)



Infectious disease and Immunization

The Washington Co. response has resulted in > 55% of the population age 12+ being fully vacinnated against Covid-19 as of December 2021.



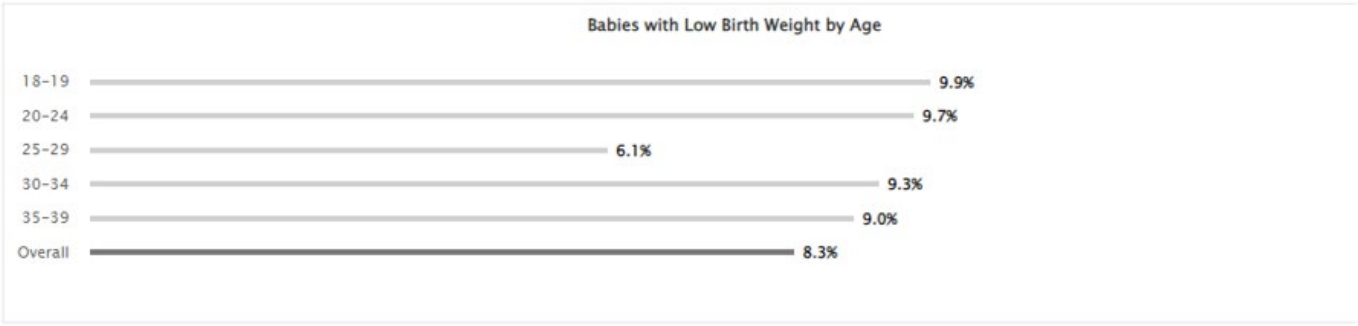
As of December 31, 2021 Covid-19 virus had been diagnosed in over 738,000 Maryland residents with more than 11,750 deaths. At the county level Washington County experience more than 32,000 positive cases and over 520 deaths. Testing was made widely available at the county level early on during the pandemic and through December 2021 over 120,000 persons had been tested. More than 88,000 doses of the Covid-19 vaccine had been administered. Surges of infection continue through the time of writing this CHNA document.

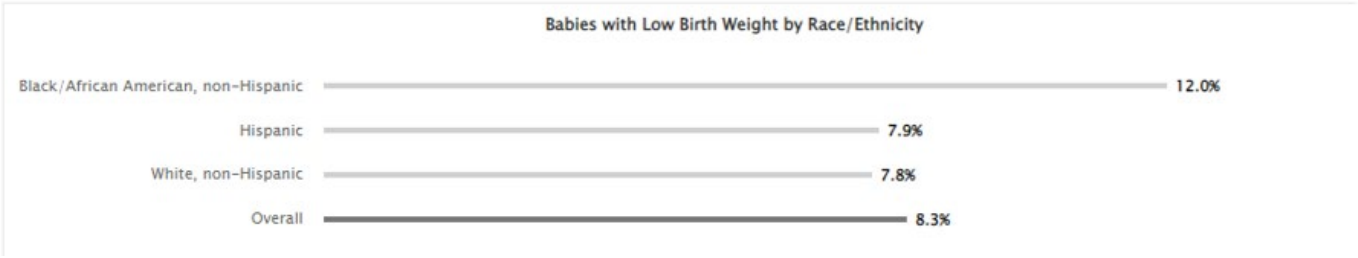
The impact of SARS-CoV-2, the virus that causes COVID-19, on people with or at risk for chronic disease cannot be overstated. COVID-19 has impeded chronic disease prevention and disrupted disease management.[6] From preventive health

[6]Hacker KA, Briss PA, Richardson L, Wright J, Petersen R. COVID-19 and Chronic Disease: The Impact Now and in the Future. Prev Chronic Dis 2021;18:210086. http://dx.doi.org/10.5888/pcd18.210086

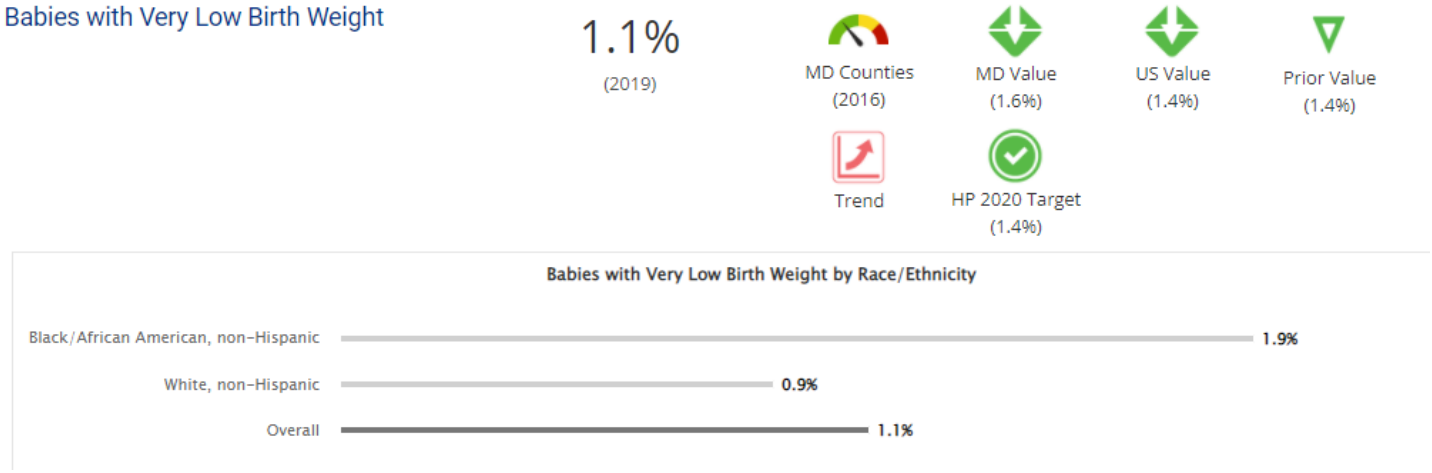
Maternal, Fetal & Infant Health

Babies born with low birth weight are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. Low birth weight is typically caused by premature birth and fetal growth restriction. The most important things an expectant mother can do to prevent low birth weight are to seek prenatal care, take prenatal vitamins, stop smoking, and stop drinking alcohol and using drugs. The HP 2020 national health target is to reduce the proportion of infants born with low birth weight to 7.8%. The Washington Co. rate is 8.3%, slightly better than the state and consistent with the National average. Low birth rates are higher among younger ages 18-24, and significantly high for Black or African American, non-Hispanic at 12%.

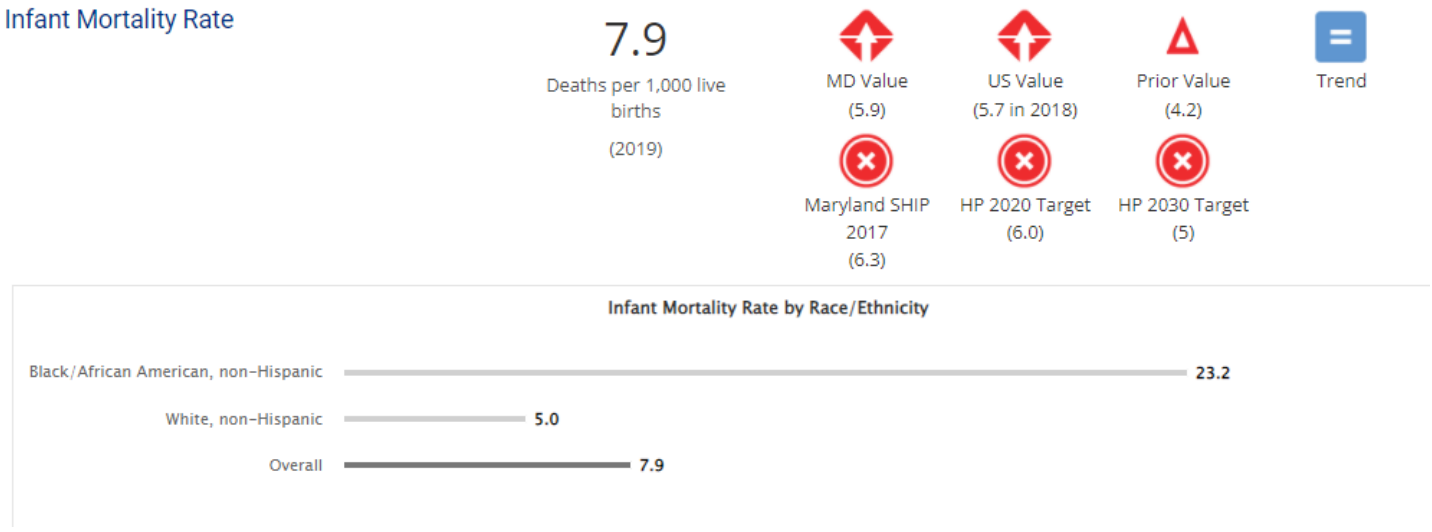




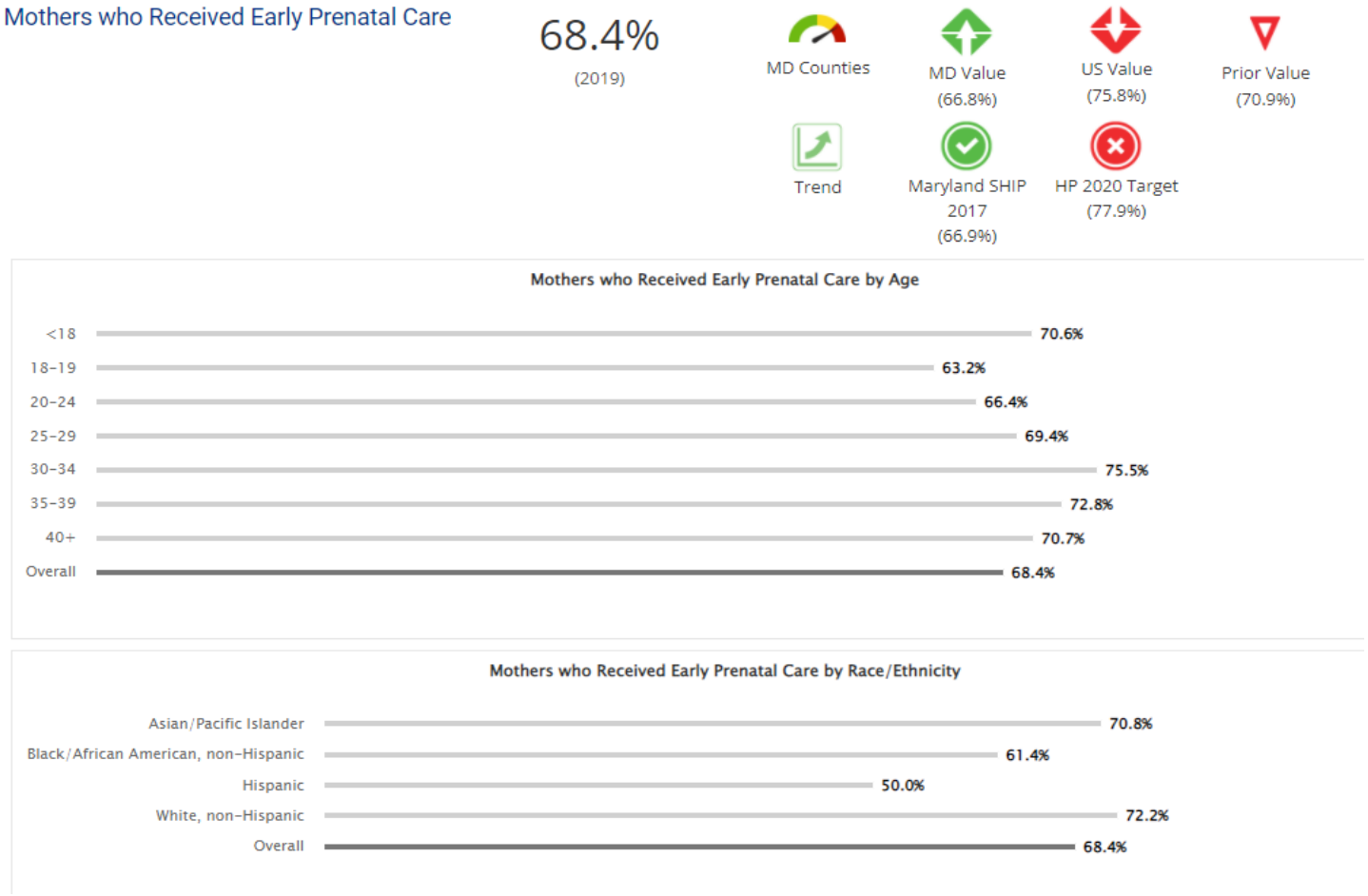
Babies born with a very low birth weight are significantly more likely than babies of a normal weight to have severe health problems; and nearly all require specialized medical care in the neonatal intensive care unit. While there have been many medical advances enabling very low birth weight and premature infants to survive, babies born with very low birth weight are at the highest risk of dying in their first year and are at risk of long-term complications and disability. Currently the Washington Co. average of 1.1%, is better than the state (1.6%) and National (1.4%) averages, and exceeds the HP 2030 Target of 1.4% However, the Black or African American Very Low Birth Rate of 1.9% is >40% higher than average, suggesting a health disparity.



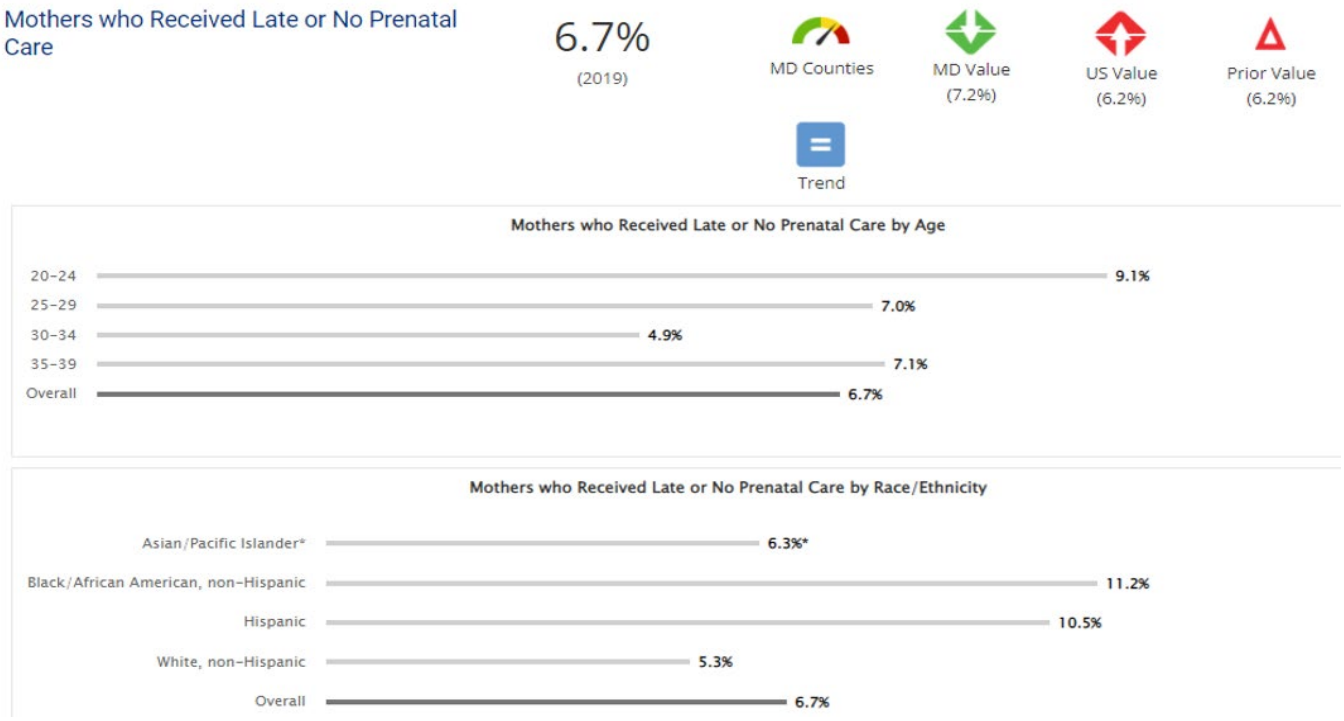
Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, preterm delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. The Healthy People 2030 national health target is to reduce the rate of infant deaths to 5.0 deaths per 1,000 live births. Infant mortality rates in Washington Co. of 7.9 per 1,000 live births is of concern, higher than state and national rates and a higher trend from a previous 4.2 rate six years ago. The high Infant Mortality Rate is due to the alarmingly high rate of 23.2 per 1,000 live births among Black or African Americans, 75% higher than the MD state average.



Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Early prenatal care (i.e. care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Mothers Who Received Early Prenatal Care (in the first trimester) in Washington Co. total 68.4%, better than the state (66.8%) but well below the national average (75.8%). The HP 2030 Target is 77.9%

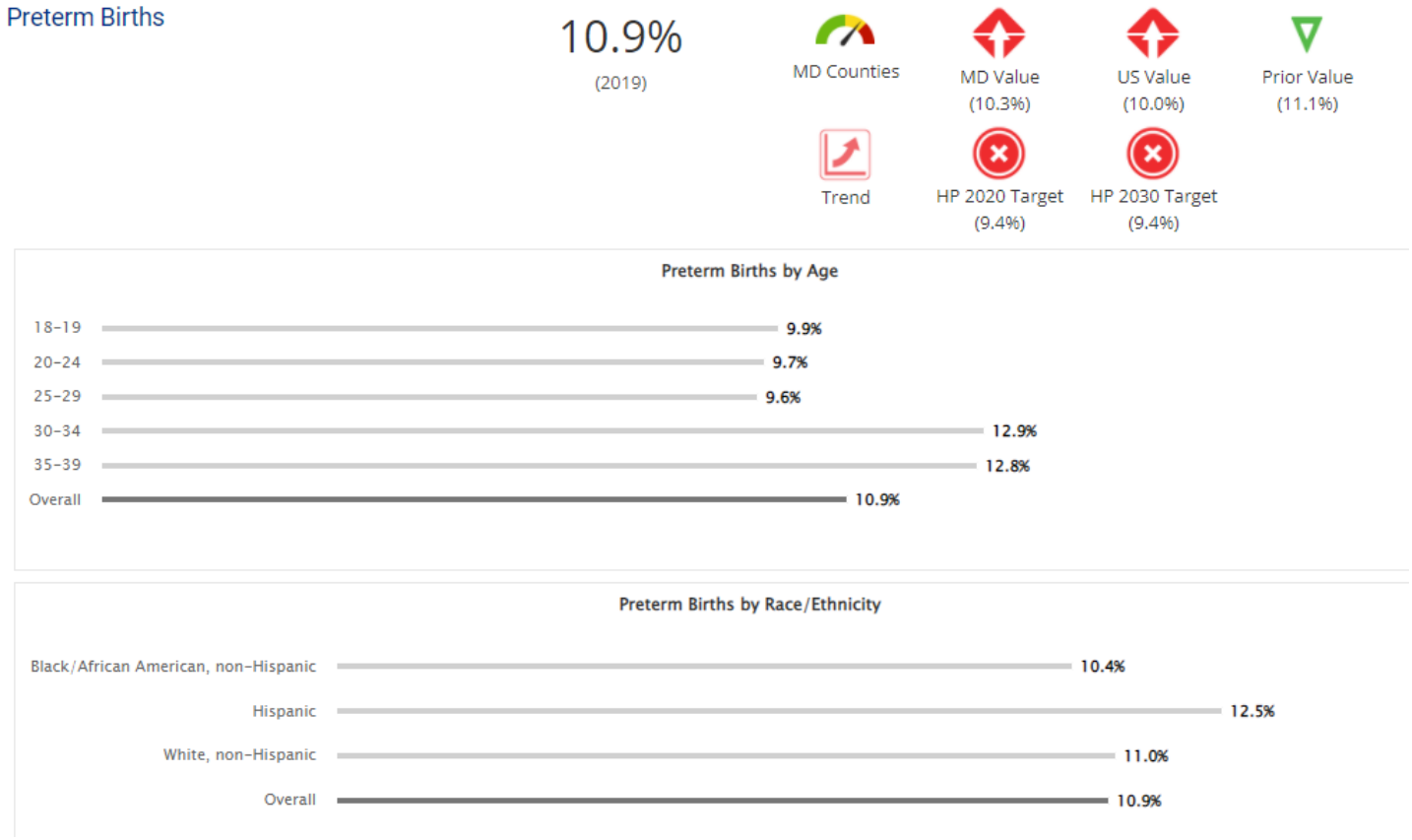


In Washington Co. only 50% of Hispanic mothers received early prenatal care, followed by 61.4% of Black or African American mothers, both suggesting a health disparity. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.



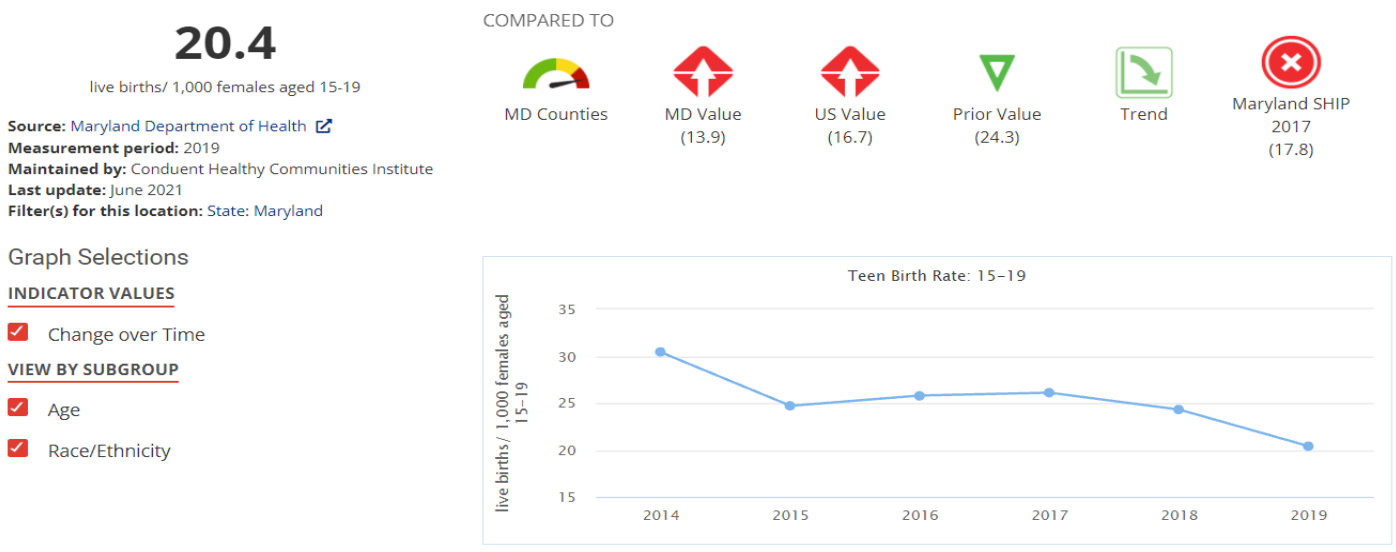
In Washington Co. 6.7% of the population received late or no prenatal care. Mothers younger than age 24 are the most likely to have received late or no prenatal care (9.1%). Again, a health disparity is likely among minority mothers to have received late or no prenatal care, Black or African American 11.2% and Hispanic 10.5%.

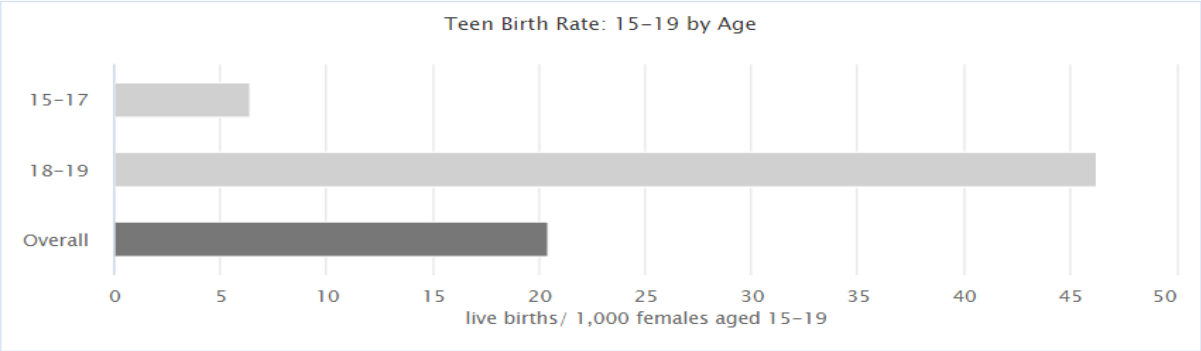
Babies born premature are likely to require specialized medical care, and oftentimes must stay in intensive care nurseries. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The most important things an expectant mother can do to prevent prematurity and low birth weight are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and get prenatal care. The Washington Co. rate of 10.9% is slightly higher than the state (10.3%) and Nationally (10%). The rate has improved slightly trending down from 11.1% over the past six years. The HP 2030 Target is to reduce preterm births to 9.4%. The Hispanic rate of 12.5% and White, non-Hispanic rate of 11% is slightly higher than the average (10.9%).



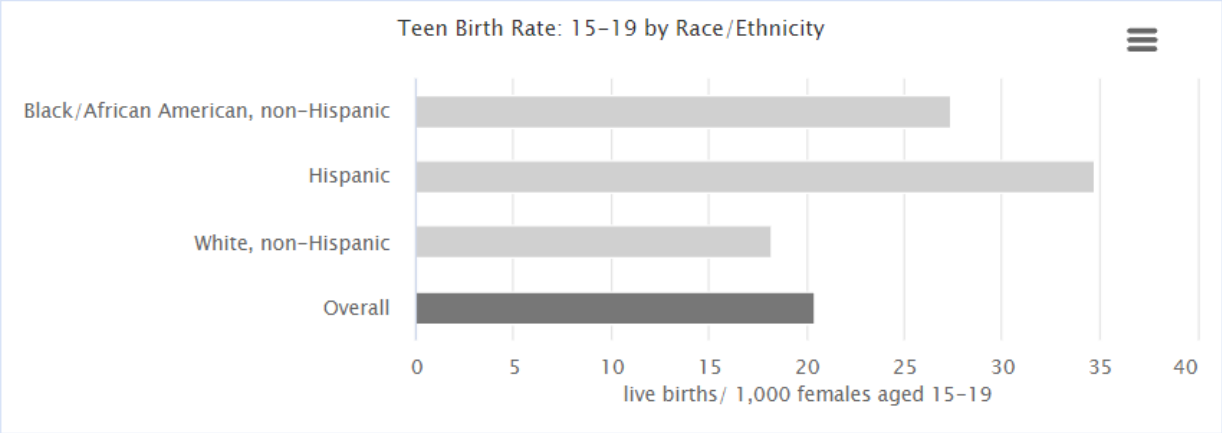
Teen Birth Rates

Teen birth is of concern for the health outcomes of both the mother and the child. Pregnancy and delivery can be harmful to teenagers' health, as well as social and educational development. Babies born to teen mothers are more likely to be born preterm and/or low birth weight. Responsible sexual behavior reduces unintended pregnancies, thus, reducing the number of births to adolescent females. The Washington Co. indicator shows the birth rate of 20.4 in live births per 1,000 females aged 15-19 years.





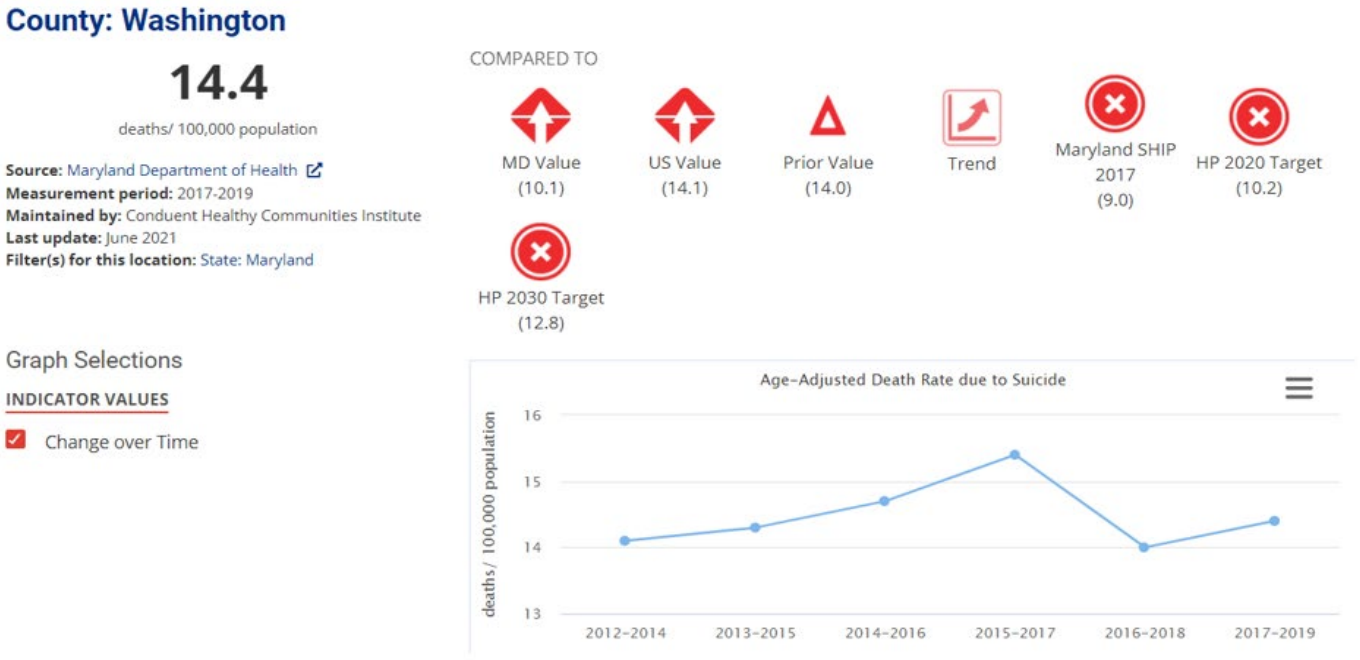
In 2019 ages 15-17 rate was 6.4%, with the ages 18-19 constituting the majority of teen births at 46.3%



The Hispanic rate of 34.8 a greater than 70% difference from the average. 27.4 a greater than 34% difference from the average. Both rates suggest health disparities in the Teen Birth Rate for minority mothers.

Mental Health

Suicide is a leading cause of death in the U.S., presenting a major, preventable public health problem. More than 33,000 people kill themselves each year according to the Centers for Disease Control and Prevention, but suicide deaths only account for part of the problem. An estimated 25 attempted suicides occur per every suicide death, and those who survive suicide may have serious injuries, in addition to having depression and other mental problems. Other repercussions of suicide include the combined medical and lost work costs on the community, totaling to over $30 billion for all suicides in a year, and the emotional toll on family and friends. Men are about four times more likely than women to die of suicide, but three times more women than men report attempting suicide. Suicide occurs at a disproportionately higher rate among adults 75 years and older. The age-adjusted rate of suicide for Washington Co. is 14.4 per 100,000 lives, much higher than the state average (10.1). The HP 2030 Target is to reduce the suicide rate to 12.8 deaths per 100,000 population.



Frequent Mental Distress

Psychological distress can affect all aspects of our lives. It is important to recognize and address potential psychological issues before they become critical. Occasional down days are normal, but persistent mental/emotional health problems should be evaluated and treated by a qualified professional. This indicator shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was not good for 14 or more of the past 30 days. The Washington Co. rate of Frequent Mental Distress of 14.6% is significantly higher than the state average 11.4% and slightly higher than the national average of 13%. Please note that the data is pre Covid-19 and is anticipated to be higher at present.

County: Washington

14.6%

Source: County Health Rankings
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: May 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	U.S. Counties	MD Value (11.4%)	US Value (13.0%)

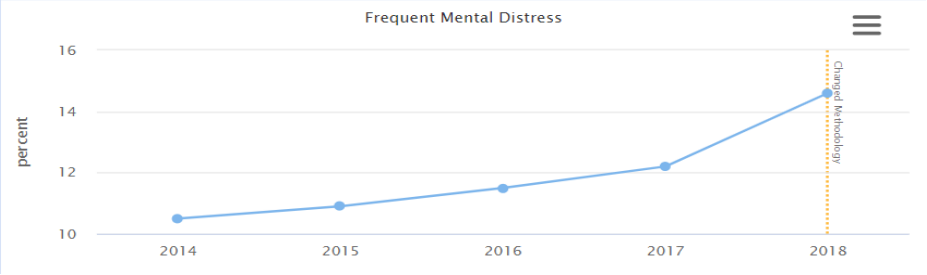
Technical note: These estimates are produced from survey data and created using a complex statistical model. It is not appropriate to use this data for tracking/evaluation purposes, as the data are collected using sophisticated sampling techniques that can make them difficult to use for small geographic areas and population subgroups without carefully applying the correct statistical techniques. Modeled estimates are also not particularly good at incorporating the effects of local conditions, such as health promotion policies.

More details:
Original Source: Behavioral Risk Factor Surveillance System

Graph Selections

INDICATOR VALUES

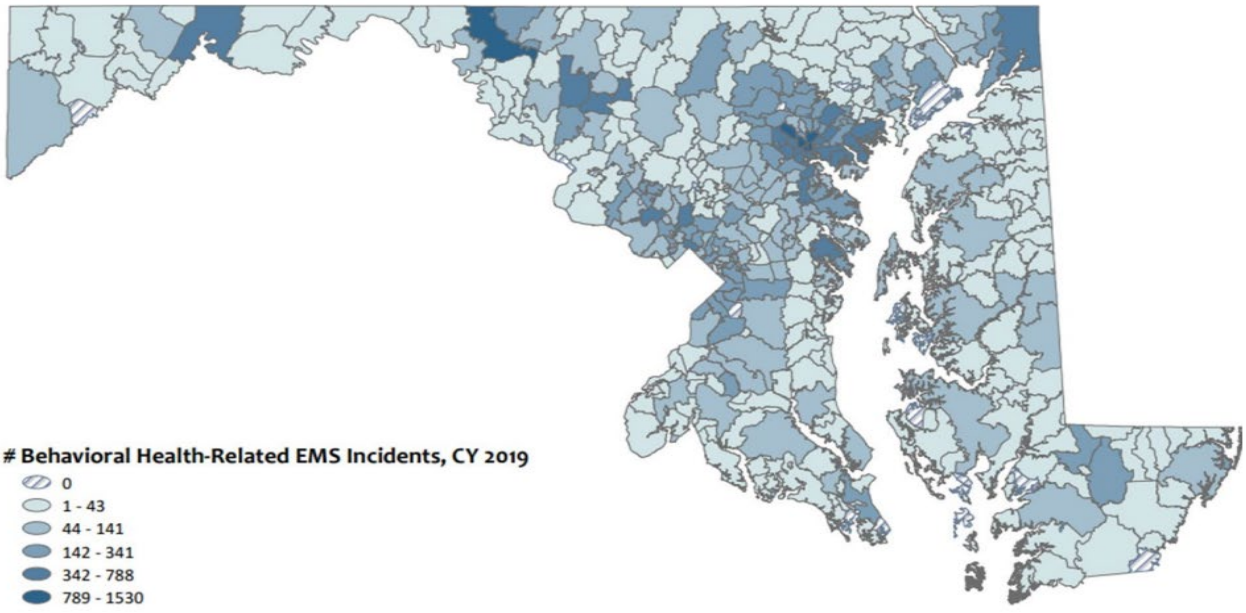
Change over Time



Behavioral Health Crisis Calls

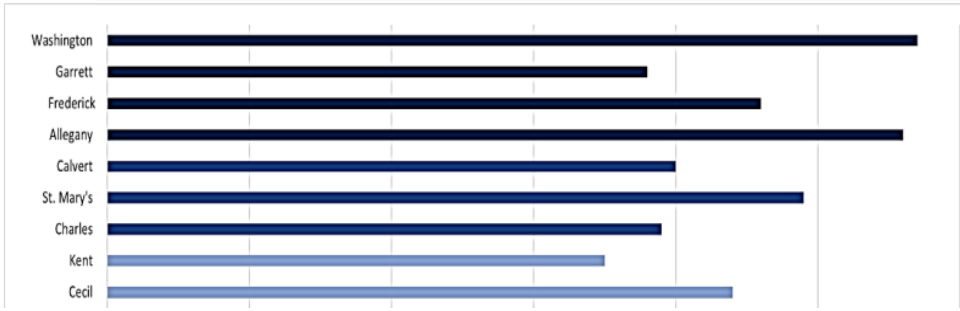
For behavioral health crisis 9-1-1 calls, Washington County is an outlier with one of the highest use rates in the state of Maryland.

GIS map of the frequency distribution of all 9-1-1 EMS calls for BH-crisis, by zip code, CY2019 (All-Payers, eMEDs data courtesy of MIEMSS)



The majority of the 9-1-1 behavioral health crisis calls did not result in need for acute hospitalization. Washington Co. had the second highest percent of emergency calls that could have been diverted to a crisis facility instead of the emergency department (57%); no crisis facility exists at this time.

Proportion of 9-1-1 EMS transports to EDs for BH (18 yrs +) who potentially could have been transported to a Crisis Facility, by county of residence (eMEDs data courtesy of MIEMSS, CY2019)



Five Highest Percentages

Montgomery	63%
Washington	57%
Baltimore	57%
Prince George's	57%
Allegany	56%

Depression: Medicare Population

Depression is a chronic disease that negatively affects a person's feelings, behaviors and thought processes. Depression has a variety of symptoms, the most common being a feeling of sadness, fatigue, and a marked loss of interest in activities that used to be pleasurable. According to the National Comorbidity Survey of mental health disorders, people over the age of 60 have lower rates of depression than the general population — 10.7% in people over the age of 60 compared to 16.9% overall. The Center for Medicare Services estimates that depression in older adults occurs in 25% of those with other illnesses, including: arthritis, cancer, cardiovascular disease, chronic lung disease, and stroke.

The Washington Co. indicator shows 21.3% of Medicare beneficiaries were treated for depression, a higher value compared to the state and nationally (18%) and a prior measurement of 21.5%. The data suggests an increased trend. It is interesting to note that 40.1% of the persons with depression and covered by Medicare are under the age of 65.

County: Washington

23.1%

Source: Centers for Medicare & Medicaid Services
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

Graph Selections

INDICATOR VALUES

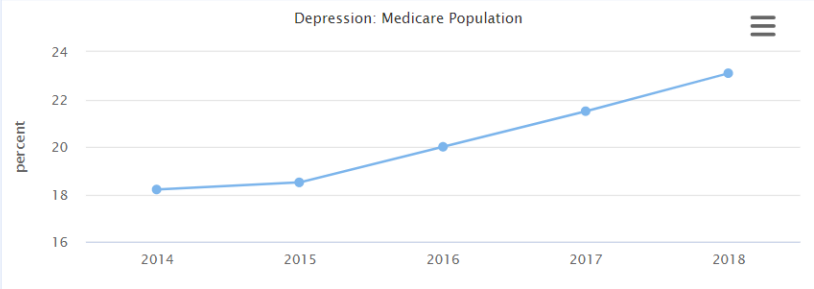
Change over Time

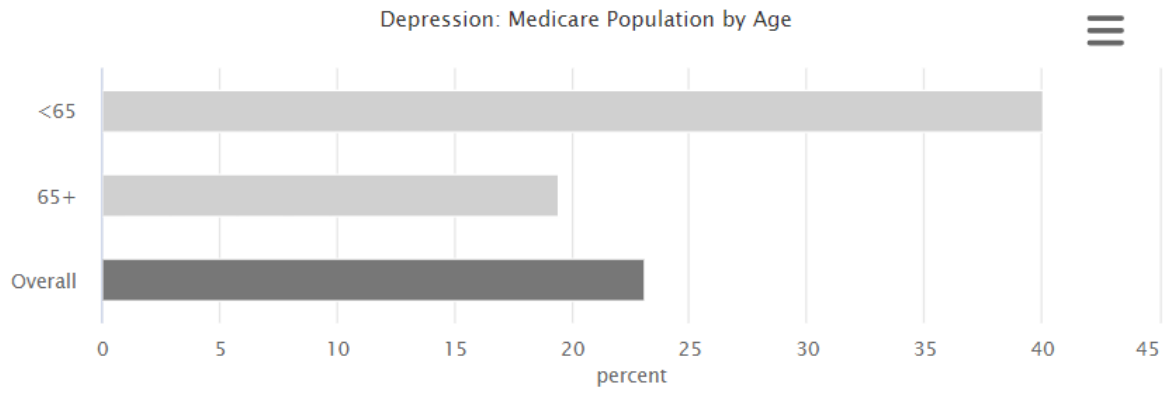
VIEW BY SUBGROUP

Age

COMPARED TO

MD Counties | U.S. Counties | MD Value (18.0%) | US Value (18.4%) | Prior Value (21.5%) | Trend





Poor Mental Health: 14+ Days

Psychological distress can affect all aspects of our lives. It is important to recognize and address potential psychological issues before they become critical. Occasional down days are normal, but persistent mental/emotional health problems should be evaluated and treated by a qualified professional. The Washington Co. indicator shows that 10.1% of adults who stated that their mental health was not good 14 or more days in the past month, slightly higher than the state average.

County: Washington

10.1%

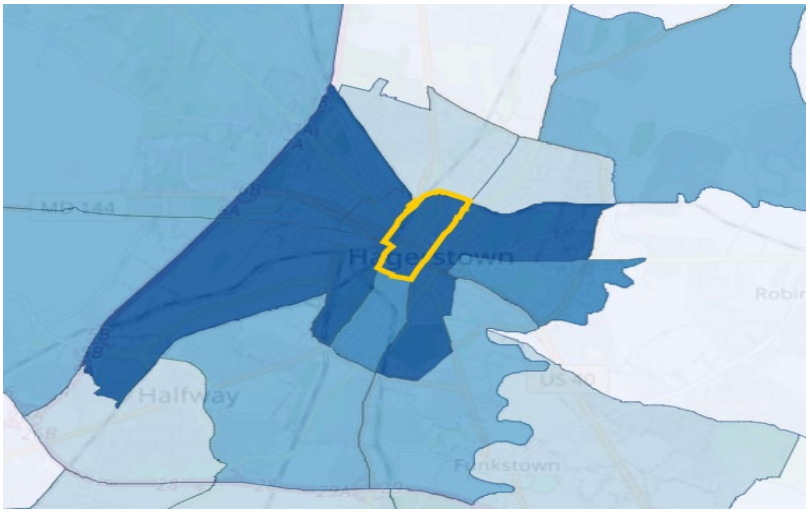
COMPARED TO

MD Counties

MD Value
(9.7%)

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2016
Maintained by: Conduent Healthy Communities Institute
Last update: May 2018
Filter(s) for this location: State: Maryland

The location of these persons live primarily in the central Hagerstown zip code 21740. Highest concentrations are in the City census tracts including 24043000500 18.9%, 24043000700 19%, 24043000302 19.9%, 24043000900 19.9%, and 24043000400 21%.



Overweight and Obesity

The percentage of overweight and obese adults is an indicator of the overall health and lifestyle of a community. Being overweight or obese affects quality of life and puts individuals at risk for developing many diseases, especially heart disease, stroke, diabetes, and cancer. The Washington Co. indicator shows 68.5% of adults who are overweight or obese according to the Body Mass Index (BMI), higher than state (66.1%) and national (66.7%) averages. BMI between 25 - 29.9 is considered overweight and a BMI >=30 is considered obese

County: Washington

68.5%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (66.1%)	US Value (66.7%)	Prior Value (64.7%)	Trend

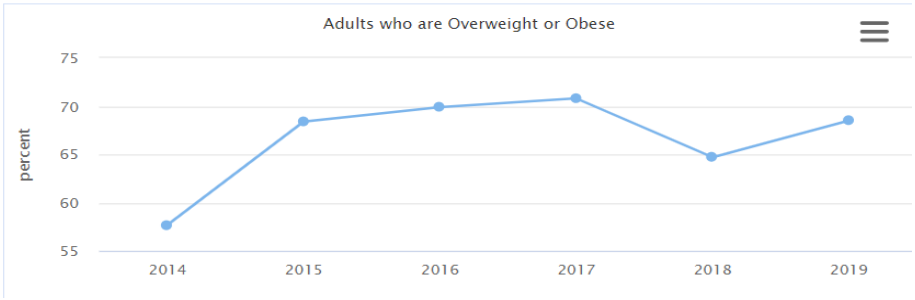
Graph Selections

INDICATOR VALUES

- [x] Change over Time

VIEW BY SUBGROUP

- [ ] Age
- [ ] Gender



Adults who are Obese

County: Washington

37.3%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (32.1%)	US Value (32.1%)	Prior Value (34.2%)	Trend	HP 2020 Target (30.5%)

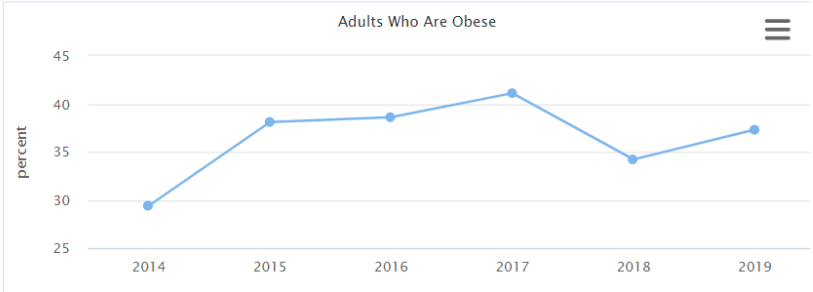
Graph Selections

INDICATOR VALUES

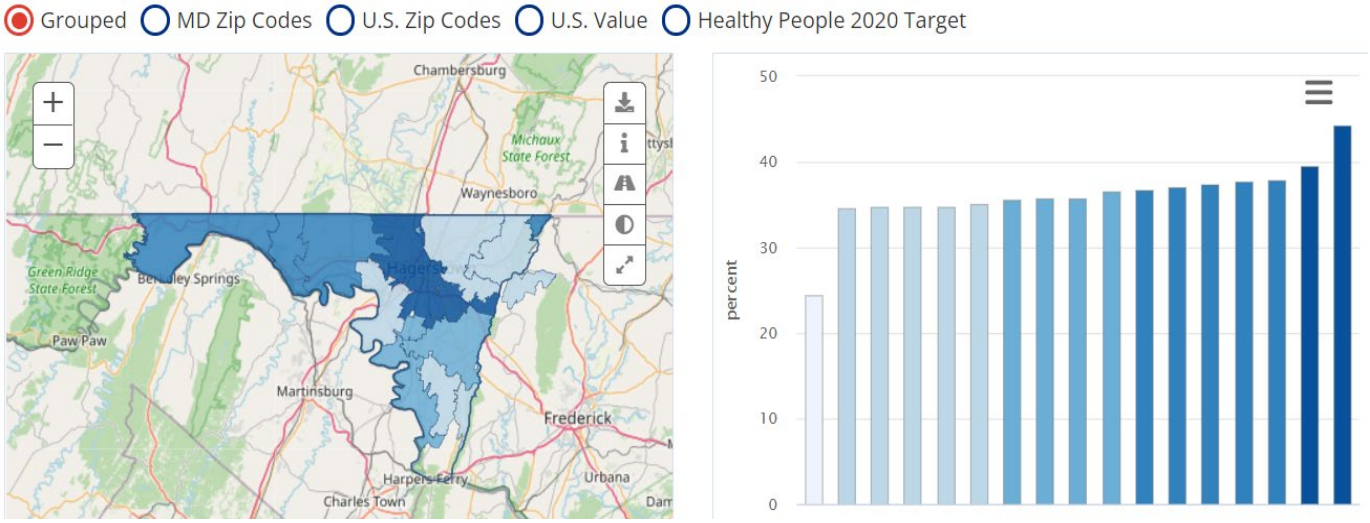
- [x] Change over Time

VIEW BY SUBGROUP

- [x] Age
- [ ] Gender



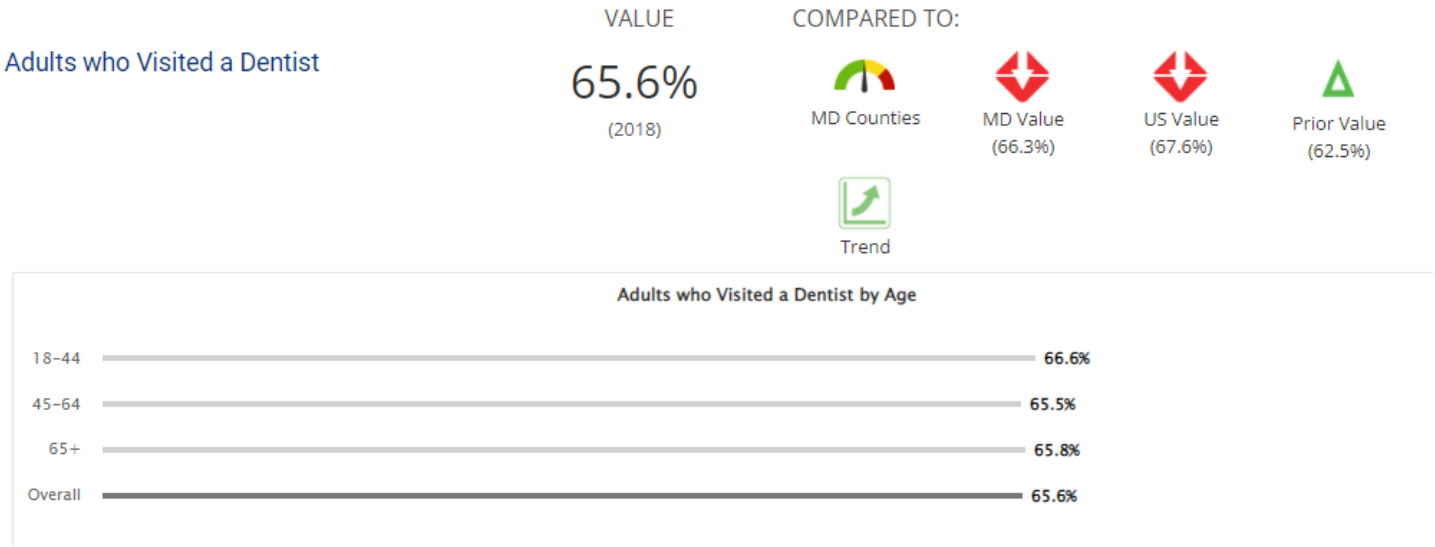
The rate of adult obesity at 37.3% is significantly higher than the MD average value of 32.1% and the Healthy People target of 30.5%. This trend is also increasing over time.



Sorted by zip code, the highest rate of obesity include central Hagerstown, followed by Hancock and the western parts of the county.

Oral Health

Oral health has been shown to impact overall health and well-being. According to the CDC, nearly one-third of all adults in the United States have untreated tooth decay, or tooth cavities, and one in seven adults aged 35 to 44 years old has gum disease. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions. Maintaining good oral health by using preventive dental health services is one way to reduce oral diseases and disorders.



Respiratory

Asthma

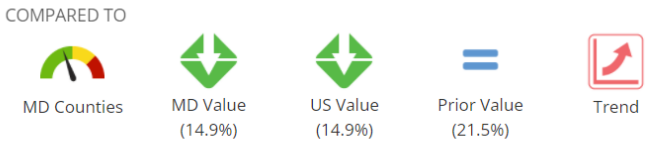
Asthma is a condition in which a person's air passages become inflamed, and the narrowing of the respiratory passages makes it difficult to breathe. Symptoms can include tightness in the chest, coughing, and wheezing. These symptoms are often brought on by exposure to inhaled allergens, such as dust, pollen, mold, cigarette smoke, and animal dander, or by exertion and stress. Reducing exposure to poor housing conditions, traffic pollution, secondhand smoke and other factors impacting air quality can help prevent asthma and asthma attacks. The Washington Co. average is 13.3% better than the state and National average of 14.9%

Adults with Asthma

County: Washington

13.3%

Source: Maryland Behavioral Risk Factor Surveillance System
Measurement period: 2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland



COPD

Chronic obstructive pulmonary disease, or COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. COPD most commonly includes chronic bronchitis and emphysema and usually results from tobacco use, although it can also be a result of pollutants in the air, genetic factors, and respiratory infections. Common symptoms include shortness of breath, wheezing, and chronic cough. Although there is no cure for COPD, smoking cessation, medications, and therapy or surgery can help individuals manage their symptoms.

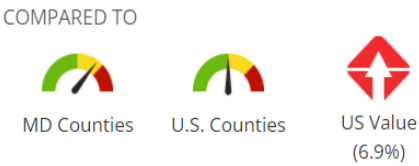
This indicator shows 8.9% of Washington Co. adults who have ever been told by a doctor they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis.

County: Washington

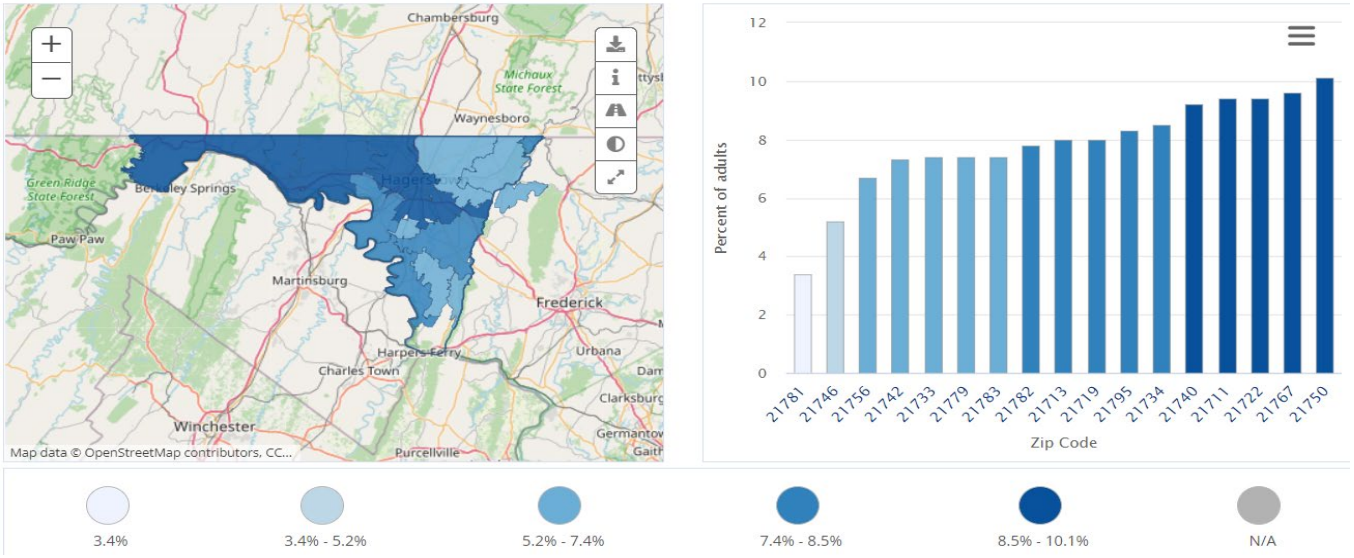
8.7%

Percent of adults

Source: CDC - PLACES
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: February 2021
Filter(s) for this location: State: Maryland



Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.



The highest rates for COPD are found in Hancock (>10%), Maugansville, Clear Spring, Big Pool, and Hagerstown (>9%), and Funkstown, Williamsport, Fort Ritchie, and Boonsboro (≥ 8%).

Children with Asthma*

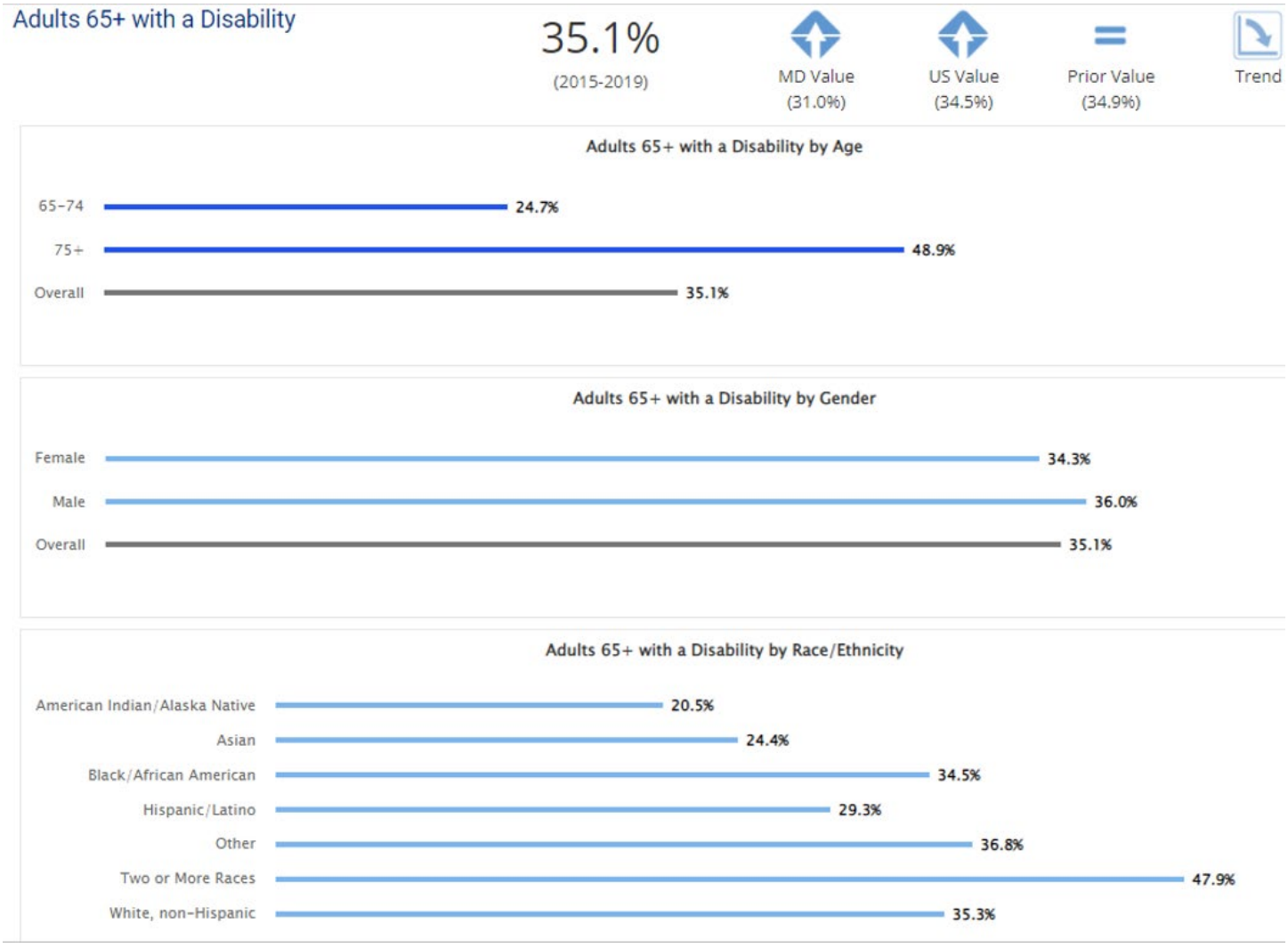
*The data for children with asthma has not been updated since 2015 and is considered insufficient for meaningful interpretation at this time.

Senior Health

Disability Age 65+

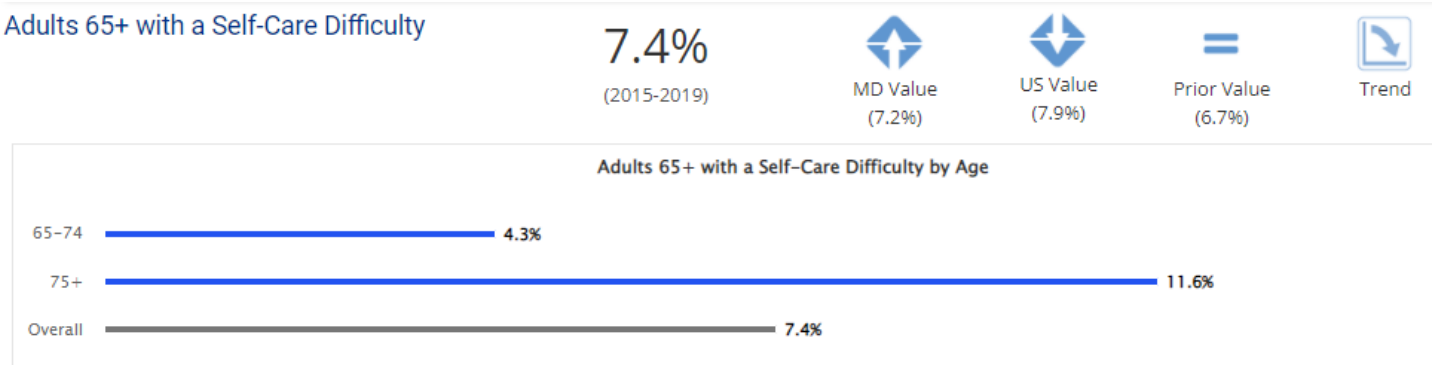
People with a disability have difficulties performing activities due to a physical, mental, or emotional condition. The extent to which a person is limited by a disability is heavily dependent on the social and physical environment in which he or she lives. Without sufficient accommodations, people with disabilities may have difficulties living independently. Rates of disability increase sharply with age. Disability takes a much heavier toll on seniors over age 65. There is often a strong relationship between disability status and reported health status, and many individuals with disabilities require more specialized health care and assistance as a result of the disability.

For Washington Co. 35% of adults age 65+ have a disability. The risk of disability increases with age. We observe a 27% higher rate of disability for adults age 65+ of two or more races, 47.9%.



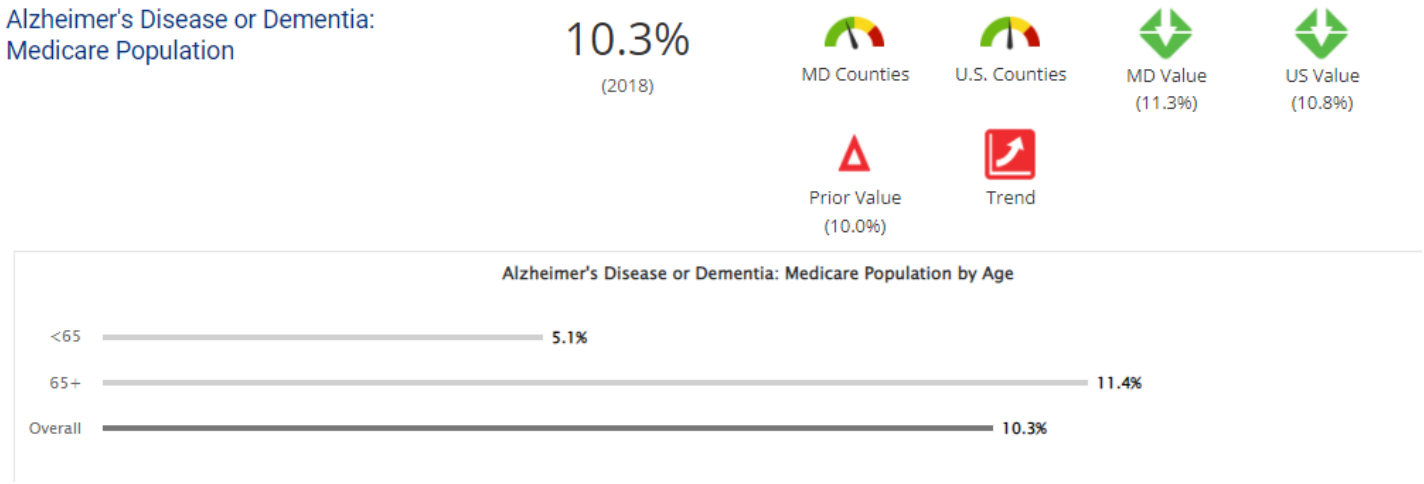
Self-Care Difficulty

People with a self-care difficulty encounter challenges in performing activities of daily living (ADLs), such as dressing or bathing. Older adults are at increased risk for experiencing self-care difficulties and may require additional assistance in the home to conduct ADLs. The Washington Co. rate of 7.4% is similar to state and national averages.



Alzheimer's Disease or Dementia

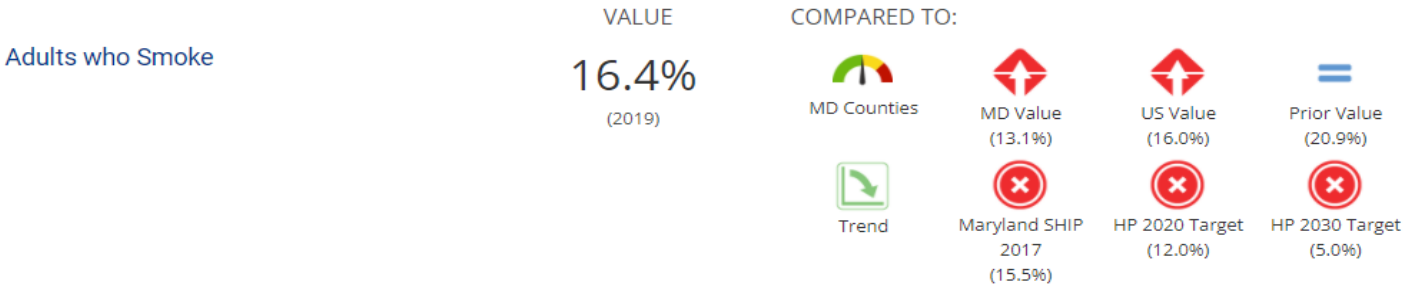
Dementia is a non-specific syndrome that severely affects memory, language, complex motor skills, and other intellectual abilities seriously enough to interfere with daily life. Alzheimer's disease is the most common form of dementia among seniors, accounting for 50 to 80 percent of dementia cases. According to the Centers for Disease Control and Prevention, Alzheimer's disease is the fifth leading cause of death among adults aged 65 and older. The Washington Co. average for dementia is 10.3%, better than the state (11.3%) and national (10.8%) percentages.

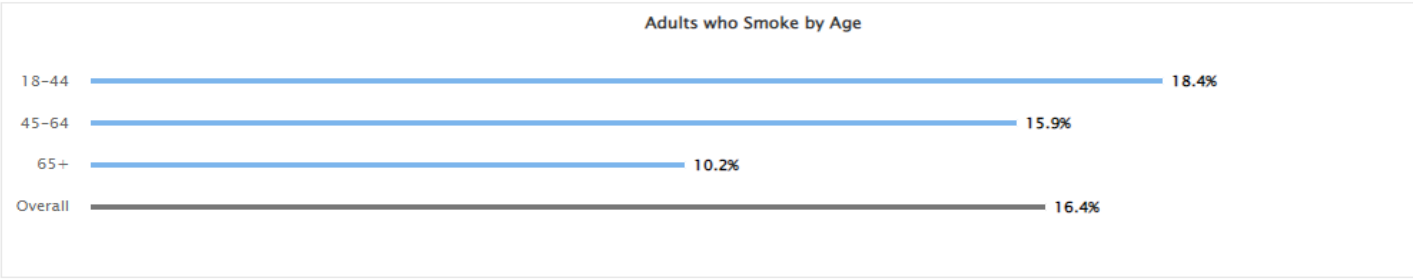


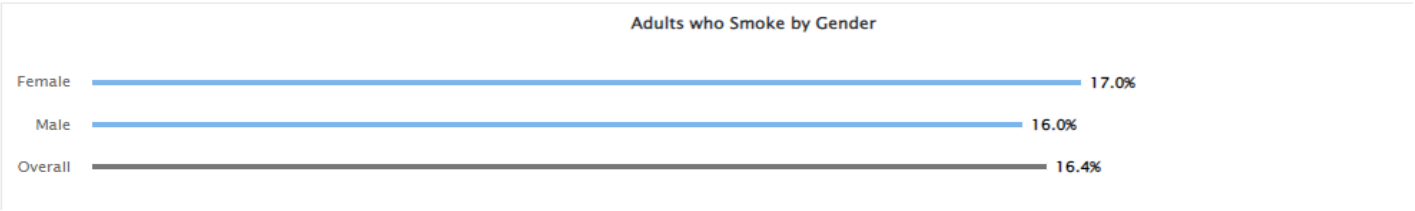
Tobacco Use

Tobacco is the agent most responsible for avoidable illness and death in America today. According to the Centers for Disease Control and Prevention, tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. The World Health Organization states that approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects such as cancer, respiratory infections, and asthma.

The Washington Co. average of adults who smoke is 16.4%, higher than the MD values of 13.1% and similar to the national average of 16%. The HP 2030 Target is to reduce current cigarette smoking in adults to 5%.







Conduent Healthy Communities Institute (HCI) provides demographic and secondary data on health, health determinants, and quality of life topics presented in comparison to the distribution of counties, state average, national average, or target values. The Conduent HCI indicator scores platform calculates and ranks health priorities. Top health needs are found to include addiction, mental health, hypertension, respiratory, diabetes, and social determinants of health.

Health Needs Prioritization

Indicator Scores

County: Washington
San Mar
Total indicators: 212
Monday 25th of October 2021 03:15:20 PM

Indicator	County Distribution State	County Distribution US	Value State	Value US	Target HP2030	Target Local	Trend	Score	Precision
Death Rate due to Drug Poisoning	3	3	3	3		1.5	3	2.84	High
Depression: Medicare Population	3	3	3	3		1.5	3	2.84	High
Households with Cash Public Assistance Income	3	3	3	3		1.5	3	2.84	High
Age-Adjusted ER Rate due to Alcohol/Substance Abuse	3	1.5	3	1.5		3	3	2.53	Medium
Hypertension: Medicare Population	2	3	2	3		1.5	3	2.53	High
Lung and Bronchus Cancer Incidence Rate	2	2	3	3		1.5	3	2.53	High
Age-Adjusted Death Rate due to Unintentional Injuries	3	1.5	3	2		1.5	3	2.45	Medium
Age-Adjusted Death Rate due to Colorectal Cancer	3	2	3	3		1.5	2	2.42	High
COPD: Medicare Population	3	2	3	3		1.5	2	2.42	High
Total Employment Change	3	2	3	3		1.5	2	2.42	High
Age-Adjusted ER Rate due to Diabetes	2	1.5	3	1.5		3	3	2.37	Medium
COVID-19 Daily Average Case-Fatality Rate	3	2	3	1		1.5	3	2.37	High
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	3	1.5	3	3		1.5	2	2.34	Medium
Age-Adjusted Death Rate due to Diabetes	3	1.5	3	3		1.5	2	2.34	Medium
Syphilis Incidence Rate	3	1.5	3	3		1.5	2	2.34	Medium
Food Insecurity Rate	3	2	3	3		1.5	1.5	2.29	Medium
Houses Built Prior to 1950	3	2	3	3		1.5	1.5	2.29	High
Adolescents who have had a Routine Checkup: Medicaid Population	3	1.5	3	1.5		3	2	2.26	Medium
Blood Lead Levels in Children	3	1.5	3	1.5		3	2	2.26	Medium
Homeowner Vacancy Rate	2	2	3	3		1.5	2	2.26	High
Hyperlipidemia: Medicare Population	2	3	2	3		1.5	2	2.26	High
Workers who Walk to Work	2	2	3	3		1.5	2	2.26	High
Teen Birth Rate: 15-19	3	1.5	3	3		3	1	2.24	High
Adults with Current Asthma	3	3	1.5	3		1.5	1.5	2.21	Medium
Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	3	1.5	3	3		1.5	1.5	2.21	Medium
Mean Travel Time to Work	1	3	1	3		1.5	3	2.21	High
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	2	2	2	2		1.5	3	2.21	High
Cervical Cancer Incidence Rate	3	2	3	3		1.5	1	2.16	High
COVID-19 Daily Average Incidence Rate	3	2	3	3		1.5	1	2.16	High
Diabetes: Medicare Population	2	3	3	3		1.5	1	2.16	High
Child Food Insecurity Rate	2	2	3	3		1.5	1.5	2.13	Medium
Infant Mortality Rate	3	1.5	3	1.5		3	1.5	2.13	Medium

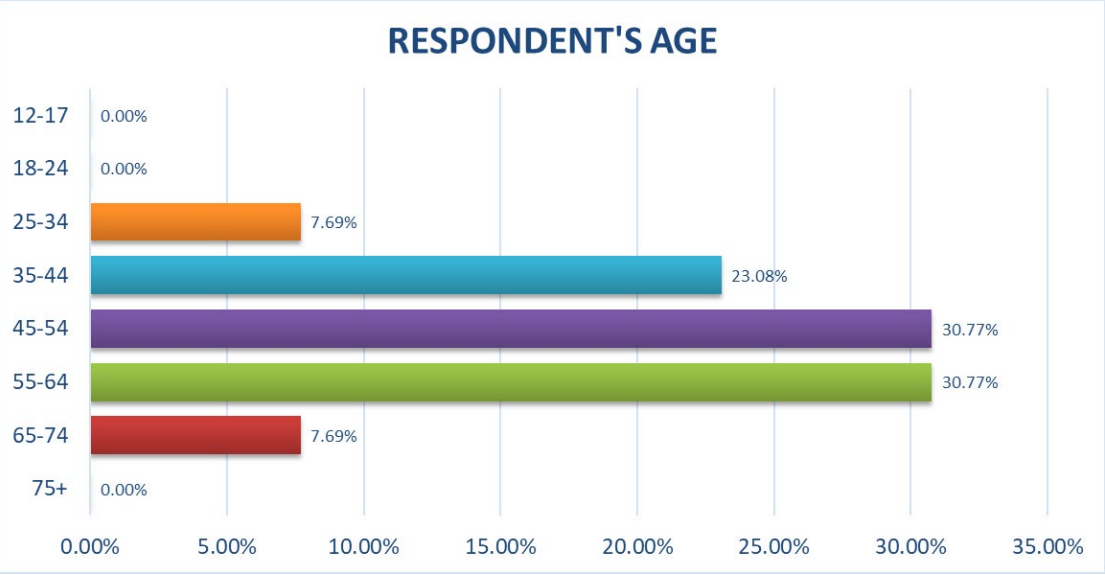
Community Engagement (primary data)

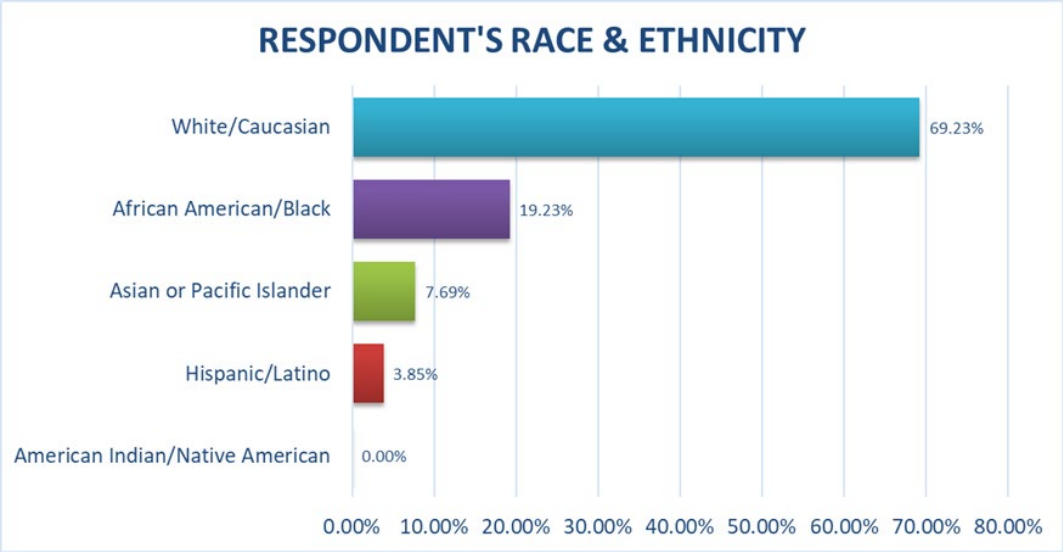
F. Key Informant Interviews

The primary data collection process for this community needs assessment included twenty-one (21) key informants who were interviewed between August 6, 2021 – September 7, 2021. Key informant interviews allow the collection of more detailed data on experiences, opinions, attitudes, insights and beliefs regarding community health issues and the impact of Covid-19. Members of the local health improvement coalition helped develop the questionnaire that was designed to obtain more detailed explanations of barriers that prevent people from accessing health care services; finances, transportation, hours of operation, social needs, limitations, etc. A standardized set of questions were designed and approved by the steering committee members who were also responsible for conducting the interviews (see **Appendix K**).

Thirty key community stakeholders recognized as having specific knowledge of health and health needs of people across Washington County were invited to participate in an interview and short health needs survey. Twenty-one stakeholders agreed to be interviewed and returned the survey questionnaire. A full list of the stakeholder participants are included in **Appendix L**. Individual interview and survey responses were de-identified and summarized (see **Appendix M**).

Key stakeholder demographics by age, race and ethnicity:





Summary of Key-Informant Interview Responses

A summary of answers provided grouped by question. In cases where the multiple same answers are provided, a percentage is included using the total number of interviewees (21) as the denominator.

What does a healthy community mean?

- A community that is thriving in all aspects of life where individuals are able to achieve their optimal health
- People feeling like they have a good of quality of life and a sense of belonging
- Having good physical, mental, social, financial, and spiritual health
- Equal access to good education, adequate employment, safe environment, and quality healthcare including behavioral health
- Sustainable programs and resources to achieve and maintain health
- People are treated equitably with dignity and respect regardless of economic stature, political affiliation, sexual orientation, gender, skin color, ethnicity, religious affiliation, destitution, or lack of health insurance
- Equal access to education, training and diverse resources
- Opportunity for recreation activities and events
- Equal access to healthy food
- A community with a sense of social responsibility
- Having strong leadership who makes opportunities for health possible

What are the important characteristics of a healthy community?

- A good quality of life; social, emotional, physical wellbeing
- A community that works together for its members in all aspects
- A sense of belonging and connectedness with the ability to make a contribution
- Access to quality, affordable healthcare and specialty services
- Diverse and innovative
- Equal opportunities and respectful
- Health literacy and accessible resources to meet needs

- Engaged, strong leadership that helps identify local solutions to problems
- Opportunity for a good education with children entering school ready to learn
- Employment opportunities that offer competitive wages and benefits
- Affordable housing
- Safe streets with low crime rate
- Transportation
- Access to arts & entertainment
- Ways to increase physical activity, recreation and outdoor activities
- Promotion of cultural and historic heritage

How healthy are residents in Washington County as a whole?

- Not very healthy 57%
- Average or similar to most other communities 29%
- Moderately healthy 10%
- Specific health concerns mentioned include: overweight, diabetes, heart disease, mental health, drug addiction and overdose
- Specific social concerns included: disparities, inequities, poverty rate, health illiteracy, gaps in care and resources
- Prevention has taken a backseat to COVID-19

Who is responsible for community health in Washington County?

- Everyone 57%
- Individuals taking personal responsibility 19%
- Health Care System; Meritus Health, Washington County Health Department
- Providers, Businesses, Non-Profits, Government, Hospital, Social Services
- Parents
- Employers, churches, schools, community health organizations
- Health policy makers; federal, state, local

"[Community Health] starts with the individual, but must be supported by healthcare system & community."

What changes have you seen in your community over the past 1-3 years regarding employment, health, crime, socioeconomic status, attitudes, and demographics?

COVID has greatly impacted many aspects of life in our community**.** Perception is that prior to COVID, Washington County was making strides to improve health of the community. Since the pandemic changes have included:

(Negative)

- Rise in mental health and substance use; increased levels of depression, anxiety, hopelessness, drug use, much exacerbated by isolation and unemployment
- Decreased socio-economic conditions; increased poverty, increased reliance government support, increased housing prices

- Labor shortages
- Increased crime, theft, more “panhandling” at intersections
- Increased disparities
- Weight gain and less physical activity
- Postponed health care and testing
- People seem more divisive, angry

(Positive)

- Increased diversity and who can serve in leadership roles; government, boards, business
- Better connection with the health system and improved access to care (telemedicine, testing, vaccines)
- More job opportunities
- Increased financial assistance, support available
- Community investment and revitalization

How has the Covid-19 pandemic affected health in Washington Co.?

"The pandemic has had a profound effect on the community: those directly affected by Covid, disruption in access to regular healthcare, disruption of education, financial stressors, and it has been used as a wedge issue to undermine public health efforts.”

(Negative)

- Rise in conflict, greater awareness with the disparities in health in lower SES groups, loss in trust in government officials with their decision making over health in our community
- Greater social isolation, inability to connect, less meaningful contacts
- Inequity and racism was heightened
- Widened the gaps of socio-economic status
- Attacked people’s mental well being
- Decreased support system to stay clean and sober
- Preventive and routine healthcare was delayed
- Businesses closed, students stopped attending school, eliminated social activities
- Physical health became a lower priority

(Positive)

- Ability to work remotely
- Reduced overhead costs for some business
- Increased access to health services
- Increased grant opportunities to re-build
- Increased funds for services (but demand has increased also)
- Improved awareness of personal health concerns
- Availability of testing and vaccines

“[Covid-19] has certainly put a strain on everyone and highlighted the need to come together as a community.”

What individuals, community organizations or governmental entities have the greatest influence in the community?

- Meritus Health 52%
- The Health Department 48%
- Local Government 48%
- Churches and faith leaders 29%
- Washington Co. Public Schools 29%
- Department of Social Services 19%
- Social Service Organizations 14%
- Private sector employers 19%
- The Chamber of Commerce 10%
- Commission on Aging 10%
- Mental Health Authority 10%
- Boys & Girls Club
- Brook Lane
- Community Action Council
- Greater Hagerstown Committee
- Hagerstown Community College
- Healthy Washington County
- Higher Education Systems
- MD Municipal League
- Law enforcement
- Primary care providers
- RuthAnn Monroe Summer Basketball League
- R.W. Johnson Community Center
- Tri-State and Community Health Centers
- YMCA

Influential individuals were identified as:

- Blackie Bowen
- Don Bowman
- Dr. Maulik Joshi
- Mayor Emily Keller
- Capt. Paul 'Joey' Kifer
- Dr. James Klabur
- Dr. Mitesh Kothari
- Neil Parrot
- Dr. Doug Spotts
- Earl Stoner
- Allen Twigg
- Bernadette Wagner

What strengths or resources are present in the community to build upon in improving quality of life and well-being for residents?

- Strong hospital and health dept.
- Good school system and opportunities for higher education
- Rural setting with plenty of outdoor space and natural resources; City park, C&O canal, state and national parks, the Appalachian Trail, the Potomac River
- Less traffic
- Wellness programs
- More a "small town" sense of community
- Strong leadership
- Support for youth
- Willingness to address health disparities and inequity
- Collaboration between providers
- Access to affordable, quality health care
- Geographic proximity to interstate highways, urban resources
- Farms, agricultures, healthy food
- Community case management
- Private mental health Core Service Agency
- Go for Bold initiative
- Washington Goes Purple initiative
- Affordable housing
- Strong faith community
- Community focused YMCA
- Many sports, exercise and recreation facilities
- Caring, generous community

"We can improve on working together to share resources and not 'work in silos'."

"The people are very giving community members … always room for improvement but we have a good foundation; caring, giving, generous."

"People know each other and (often) work well together, especially nonprofits. Community members are generous with their resources. A number of folks really try to understand true community issues and work to solve them."

"[A resource is] great faith and secular partnership that works well together, which isn't always the case in other communities."

What are the main health concerns of your community? Which of these do you think is the most important?

- Mental Health 43%
- Obesity, overweight 43%
- Substance abuse, lack of crisis and detox service 29%
- Diabetes 29%
- Healthy food/diet 19%
- Hypertension, heart disease 14%

- Prevention 10%
- Covid-19 10%
- Cancer
- Access to healthcare; affordability, transportation
- Adverse Childhood Experiences
- Equity
- Education
- Homelessness
- Physical inactivity
- Social determinants of health

"Obesity because it can be controlled and often leads to other health issues such as diabetes, high blood pressure and heart disease."

"Mental Health is the primary concern because it impacts every aspect of health. Individuals must have mental wellness before they can achieve wellness in other areas."

Which of these do you think is the most important?

- Overweight/Obesity
- Mental health
- Substance abuse
- Food, housing, homeless

Three years ago we identified substance use, mental health, weight and obesity, diabetes, wellness and prevention and heart disease as the most significant health priorities facing Washington County. Should all of these remain priorities?
Yes, all should remain priorities 90%

Are there any other health issues that should be added as a top priority?

- Mental health should be moved up on the priority list 29%
- Access to healthcare
- Access to healthy food
- COVID pandemic
- Equity
- Homelessness
- Prevention
- Youth services

Other comments:
*"I think we are concentrating on too many things. Yes, they are concerns but we need to hone in and work on 2 or 3 things. Things like heart disease spring from **obesity**."*

*"One other question that's come up is around **vaping**. We have decreased smoking but I see kids in cars where people are vaping. It seems like [vaping] isn't talked about very much."*

*"We should determine whether **COVID** and post-COVID long-term health issues need to be addressed as a priority as well or if they can be included in the existing priorities/action plans."*

***"Stigma** around **mental health** services and **drug addiction** should also be addressed."*

*"There is direct correlation of **ACEs** (Adverse Childhood Experiences) to long-term health so this is a huge priority. Preventing childhood trauma and building resilience is so important."*

***"Teen pregnancy** is a somewhat under the radar priority with profound long-term effects."*

Do you believe there are factors in your community that are keeping people from doing what needs to be done to improve the health and quality of life? What are they?

- Lack of awareness and access to existing resources
- Overall mindset of "no change"
- Financial constraints
- Social determinants of health
- Associate healthy eating with higher cost (not necessarily true)
- Lack of access to healthy foods in more urban areas
- Low health literacy
- Transportation barriers
- Fragmented delivery system
- Poor community infrastructure; walkability, public spaces for exercise
- Lack of funding to provide needed resources
- Fear of pushing people to grow
- Lack of trust especially within the African American/Black, and Hispanic communities, single parent households
- Stigma, shame, fear
- Lower socioeconomic barriers; making programs free or reduced cost
- Social media impact on informed decision making

Are you aware of any health-related projects that are being successfully implemented in the community?

- Go for Bold! Lose 1 million pounds in 10 years 62%
- Healthy Washington County, improve health status 29%
- Washington Goes Purple, reduce substance use and overdose 19%
- Diabetes prevention and management programs 19%
- YMCA & HEAL (Healthy Eating and Active Living) 14%

Other projects mentioned:

- Health care equity
- Farmer's markets
- Hagerstown City Parks & Rec health programs
- Education at the Washington County Senior Center
- Health care challenges; Hub City 100 Miler, Colorsplash, 10,000 Steps
- Bester Community of Hope / San Mar, strengthening families

"Bringing together the resources of Meritus and the Health Dept. has been very important."

Have you heard of Healthy Washington County?
Yes 62%
No 38%

Is there anything else that you would like to add about the topics we discussed?
"The time is now to fix these things due to the pandemic."

"How much of community is transient? We need more responsive care and access to resources to people passing through. What are we doing to connect with them regardless of who they are?"

"What health resources exist for non-citizens?"

"Heat map of our populations – are there areas of the county as a whole that do not have as immediate access? Are there areas of the community that don't have access to health and food?"

"Community colleges usually thrive in the midst of volatile issues. How do we still provide services? HCC students did not like the online classes. They liked face-to-face education."

"It's come to my attention recently – even though there is a lot of information on opioid risks, many doctors are prescribing opioids more flippantly."

Community Engagement

G. Focus Groups

To help ensure that key persons with unique knowledge of community needs and health topics were included in the study, a series of targeted focus groups were scheduled, promoted, and conducted in locations that would accommodate under-represented populations and reach community stakeholders.

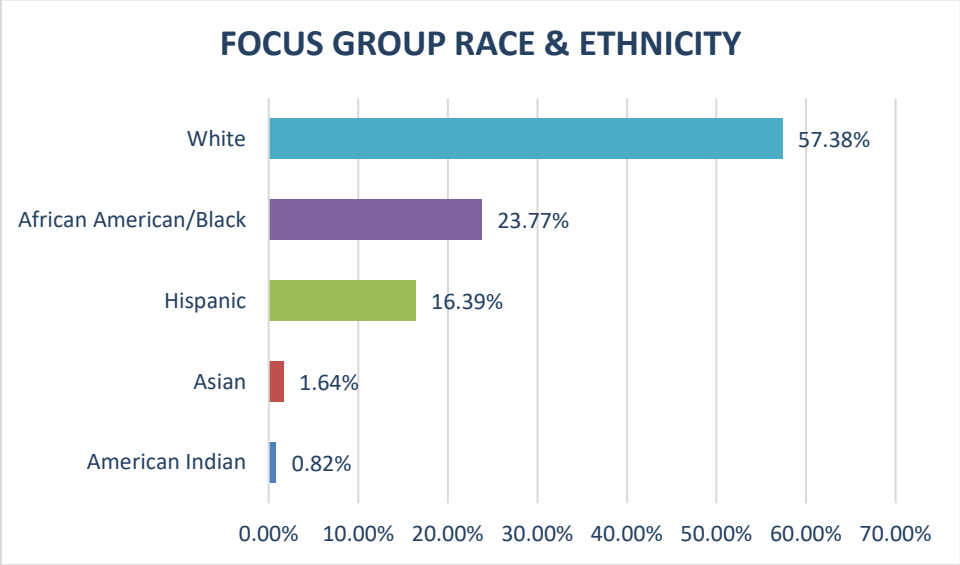
A series of eleven (11) community focus groups were conducted between September 25, 2021 and October 27, 2021 to obtain more specific information from persons having expertise, knowledge or interest in the following topics:

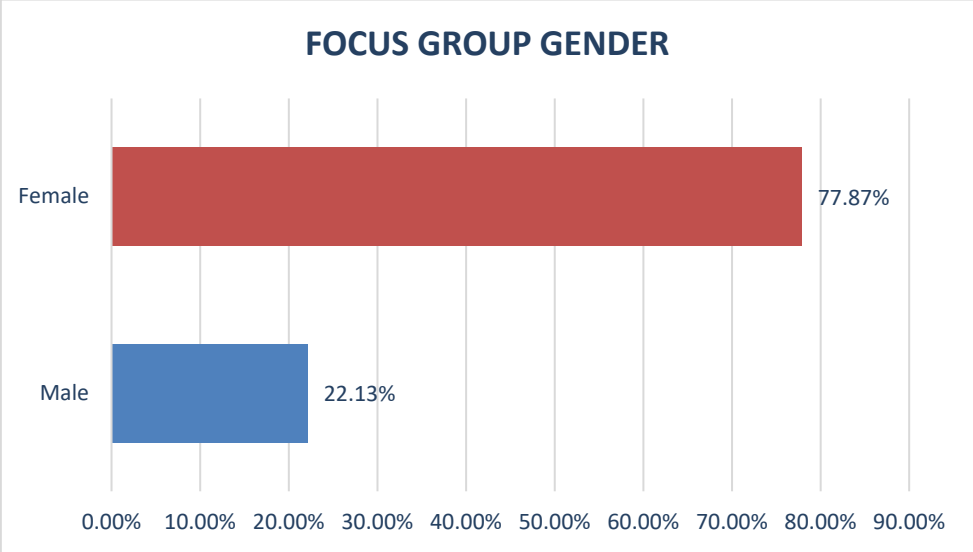
- Diabetes
- Health and physical activity
- Mental health and substance abuse
- Minority health issues
- Prevention and wellness
- Senior health issues

Focus Groups

Date	Location	Focus Group Topic	Number of Participants
September 21, 2021	Children in Need	Parent / Child health focus group	12
September 25, 2021	Fairgrounds Park	Health and Wellness focus group	6
September 28, 2021	YMCA	Wellness focus group	5
October 4-13, 2021	Commission Aging	Seniors focus groups	36
October 5, 2021	Zion Baptist Church	Black / African-American focus groups	9
October 7, 2021	Virtual	Mental Health focus group	6
October 9, 2021	Williamsport Park	Community health focus group	10
October 14, 2021	Robert Johnson Center	Black / African-American focus groups	6
October 10, 2021	Church of Nazarene	Hispanic focus group	19
October 13, 2021	Virtual	Diabetes focus group	10
October 27, 2021	Meritus	Addictions focus group	3
			Total 122

The race, ethnicity and gender of our focus group participants includes:





Members of the focus groups and volunteers who agreed to individual interviews provided invaluable insight into health needs and gaps as perceived by persons living in the community. Relevant input and feedback for each question is represented as a ***word cloud*** with frequency of responses represented by size of the words. Additional information follows the cloud. Detailed responses from each focus group is included, see **Appendix N**.

Focus Group Question and Response Summary

What do you like most about living in Washington County?

Washington Co. continues to maintain a sense of small town with friendly people making up a safe, inter-connected community. It is clear that people love the multitude of outdoor activities and recreation space; walking trails, C&O Canal, parks. Benefits of a strong agriculture community includes access to fresh foods and farmer's market. The community includes a quality health system and hospital, school system and churches. Washington Co. is conveniently located with access to interstates while considered to be in a "affordable" with a reasonable cost of living. It is becoming more diverse.

What concerns you most about living here?

The top concern named in all focus groups is increased drug addiction and crime reported in Washington Co. Also of concern is the affordability of healthcare, housing and general increases in the cost of living. There is unease regarding slow pace of economic and social change, attributed to "politics" and the political environment. Transportation to medical appointments was mentioned as a need. Direct observation of unhoused individuals and increased "panhandling" at traffic intersections was also identified. The minority focus groups identified racism and the lack of diversity as concerns, but also expressed hope that these are improving.

What do you or your family members do to stay healthy?

Many focus group participants talked about making good use of Washington County's outdoors and recreation space for many physical activities including walking, running, hiking and biking. Other mentions include swimming, golfing, gardening, dancing, and enjoying the natural setting of the parks. People understand the importance of healthy eating, specifically described as monitoring portion control, low salt and sugar, no soft drinks, low or no red meat and a low fat diet. Drinking plenty of water is also a must. Staying healthy includes an ability to laugh and keep things in perspective. Seeing a doctor on a routine basis and taking any medication as prescribed is important. Finally, being vaccinated against Covid-19 and wearing a mask to avoid infection were named.

What health problems do you deal with?

Group participants identified weight and obesity as the top health issue that they struggle with. Mental health disorders including depression and anxiety, attention deficit disorder, autism and bipolar were most frequently named. Chronic health issues include diabetes, high blood pressure, cancer, heart disease, asthma, and addiction were all named. Other common health issues include pain, fibromyalgia, vision and dental problems, and the effects of Covid-19.

What are the biggest health problems in Washington County?

Group participants named obesity as the biggest issue for Washington Co., followed by mental health, addiction, and diabetes. Opinions are largely informed via media and news, made by first-hand observations and having knowledge of family and friends' health issues. Other frequently mentioned issues include Covid-19 and residual symptoms, heart disease, respiratory illness and stroke. The primary social determinant identified was "homelessness."

Are you able to get health care when you need it?

The majority of our focus group members (80%) report being able to access healthcare when needed. However, 20% indicated that they could not.

What makes getting healthcare difficult?

Cost and being uninsured or under insured remain the top barriers to accessing healthcare when needed. A related issue is deductibles and high co-insurance can create barriers. The need for more doctors and specialists in the area was identified. The Mental Health group noted long waits for an appointment, providers not accepting new patients or willingness to take some insurance types were primary barriers to care. For people who do not have options, the lack of transportation can create difficulties. Language barriers can be challenging for people for whom English is not a primary language. Some group members identified telemedicine and technology as creating new challenges, while others viewed technology as lowering barriers. Covid-19 was identified as a barrier to receiving healthcare; masks, isolating, testing, vaccines, etc.

What changes to healthcare are needed in Washington County?

Generally, group members identified the need for more providers both general and specialists, who will provide care to all persons is desired. Having more doctors would allow for smaller practices with greater ability to provide individualized care to patients. The desire for more compassion and friendliness from providers was mentioned. The cost of healthcare was a frequently cited concern, so the desire to expand free or reduced cost care based on the ability to pay is needed. Specific specialty services that were identified as needs include addictions treatment, crisis and detox services, care for pregnant women, and healthcare for Hispanic families. While technology has some benefits including expanded access via telemedicine, concern about the loss of personal contact was a recurrent theme; referral process between providers takes too long, delays in getting results (if you don't have MyChart), hang up calls when trying for refills, EHR portal difficult to work through, "go back to a live person to answer phones and questions." Recommendations for additional services include providing clinics in the community and adding wellness and alternative holistic medicine options.

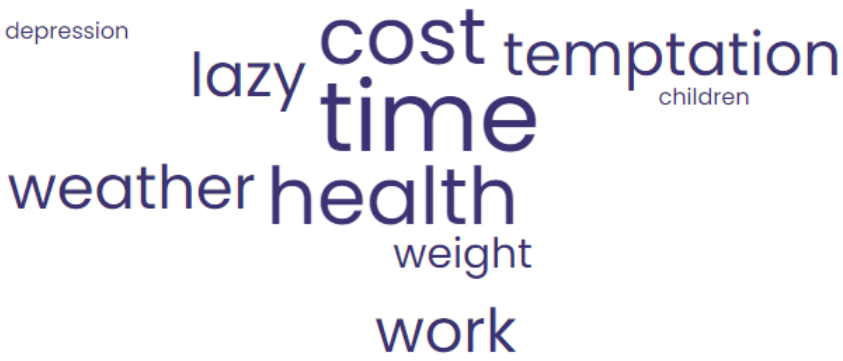
Are there health services needed that people are not receiving?

There are continued barriers to timely access to both mental health and addiction treatment when services are needed. Dental and vision services are frequently not included in health benefit coverage, so people go without these services. Specific gaps in health services include autism treatment, nutrition counseling and help for pregnant women. The Hispanic focus group identified needs including financial assistance, medications, pre-natal care and help for dental costs. Transportation to medical appointments is a gap, with the recommendation to expand mobile health clinics and screenings in the community.

Barriers to eating a healthy diet?

Group members indicated that it takes too much time to eat a healthy diet on a consistent basis. Work schedules and childcare are mentioned as conflicts. The availability and convenience of fast food with time constrained schedules add to the challenge of sticking with a healthy diet. Several identified "temptation" as a problem. High costs associated with eating heathy is also a primary barrier. Some indicated that a lack of knowledge about healthy diets and not knowing how to cook healthy get in the way. Some group members identified challenges with having access to healthy food, especially living in areas without a grocery store in walking distance.

What keeps you from getting enough exercise?



The number one barrier to people getting enough exercise is not having enough time. Schedules and the demands of work are frequently pointed to as being higher priorities over exercise. Bad weather was also named as a challenge. Cost and transportation issues were barriers to going to a gym or the YMCA. Other frequently mentioned reasons include laziness, health issues including weight and depression, caring for children and obligation to other community activities.

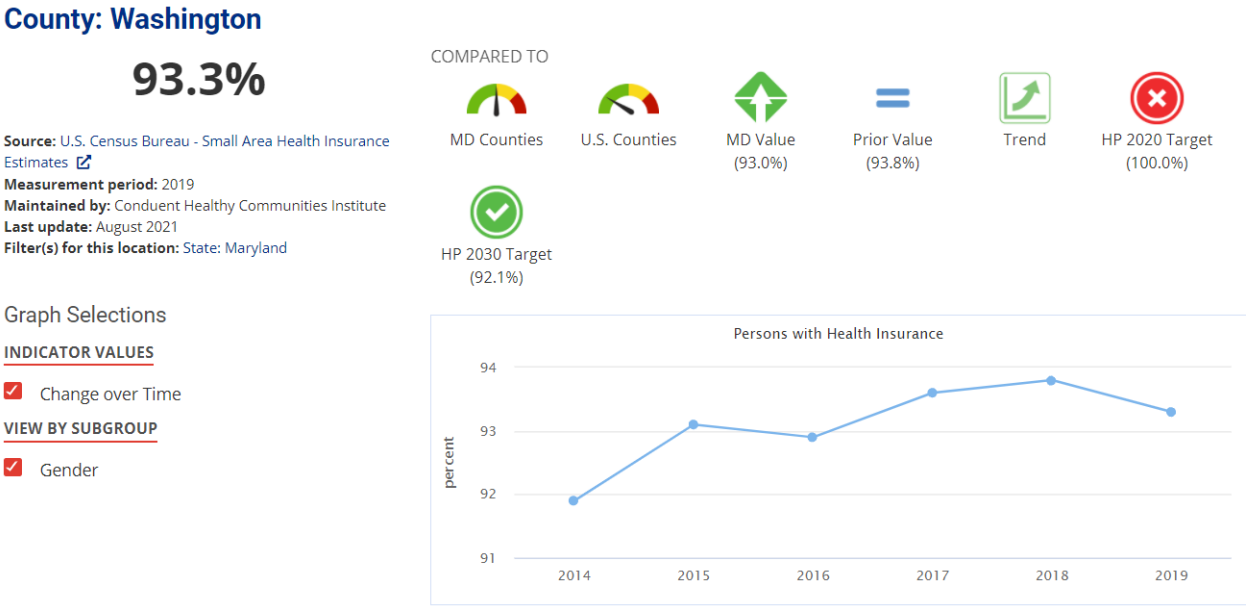
H. Social Determinants of Health

Social Determinants of Health (SDOH) are the conditions in which we are born, where we live, learn, work, and play, include underlying factors that contribute to or detract from overall health. These determinants have a major impact on people's health, well-being, and quality of life and are often the key-drivers in health disparities. Examples of measurable SDOH include:

- Housing, transportation, and neighborhoods
- Racism and discrimination
- Education, job opportunities, and income
- Access to nutritious foods and opportunities for physical activity
- Air and water quality
- Language and literacy skills

Adults without Health Insurance

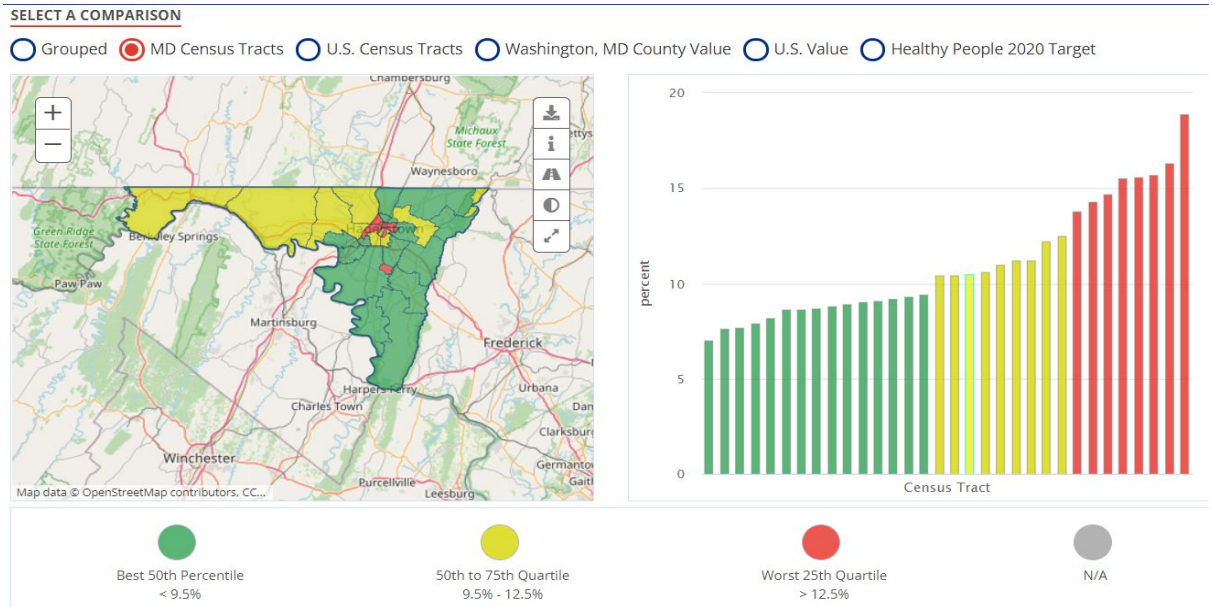
Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums. Options for uninsured residents include public options made known and available through the Maryland Health Connection.



The Washington Co. indicator shows the percentage of persons aged 0-64 years that have any type of health insurance coverage of the entire population covers 93.3%, or less than 7% of Washington County residents are uninsured through 2019.

Between March and August 2020, an estimated 142,000 Marylanders lost a job that provided health insurance. Of this group, an estimated 63,000 individuals became uninsured due to COVID related job loss. The MD Health Connector data suggests that the uninsured rate for Washington County may have increased during this time by 1% or more (data not final).[7]

The indicator shows the geographic location and percentage of adults aged 18-64 that do not have any kind of health insurance coverage. There are 32 Census Tract values. The lowest value is 7, and the highest value is 18.9. The highest rates of persons without insurance include the following zip codes 21746 (18.6%), 21740 (13%), 21767 (10.8%), 21722 (10.6%), 21750 and (10.5%).



Some health providers for uninsured persons include:

- Community Free Clinic Hagerstown 21740 – free; requires uninsured and Washington Co. residence
- Hagerstown Family Healthcare (FQHC) Hagerstown 21740 – sliding payment scale
- Meritus Health, Inc. Hagerstown 21742 - income-based financial assistance
- Tristate Community Health Clinic (FQHC) Hancock 21750 - sliding payment scale

[7] http://www.marylandhbe.com/wpcontent/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html#potential-covid-impact accessed 10.07.21

Doctors visit In Past Year

Routine checkups are integral to maintaining good health and preventive care. Regular screenings and exams that take place during routine checkups can help diagnose problems before they begin or early on when chances for treatment and cure are better. Age, current health status, family history, lifestyle choices, and other important factors determine how frequently one should have a checkup and which screenings and tests should be taken. A checkup may include, but is not limited to, cholesterol screening, blood pressure screening, breast and cervical cancer screening for women, and prostate cancer screening for men.

County: Washington

79.2%

Source: CDC - PLACES
Measurement period: 2018
Maintained by: Conduent Healthy Communities Institute
Last update: January 2021
Filter(s) for this location: State: Maryland

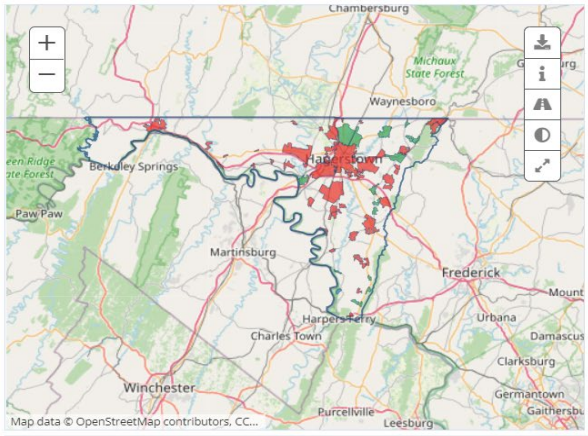
COMPARED TO

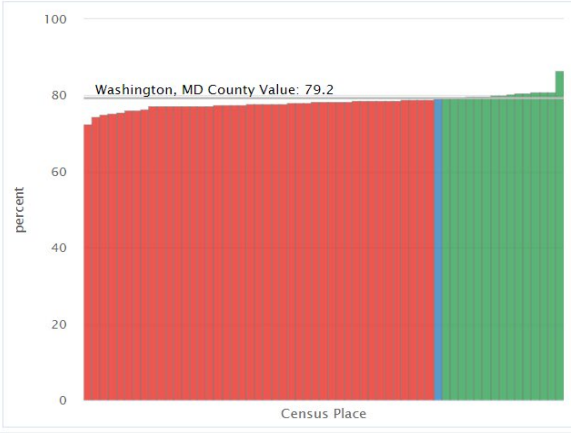
MD Counties | U.S. Counties | US Value (76.7%)

Technical note: Sub-county small area estimates use state and county data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) in tandem with demographic data for census tracts and cities. It is not appropriate to use this data for evaluation purposes.

SELECT A COMPARISON

Grouped | MD Census Places | U.S. Census Places | Washington, MD County Value | U.S. Value



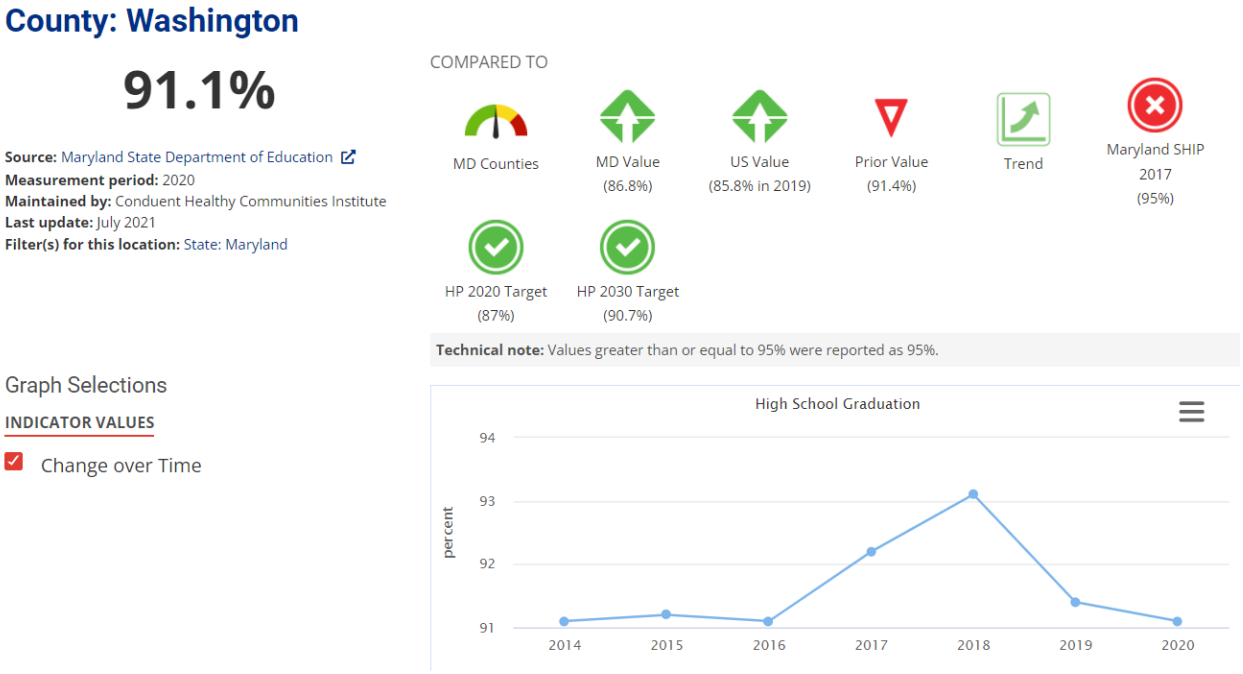


< 79.2% | = 79.2% | > 79.2% | N/A

Education

High School Graduation

Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime. The HP 2030 Target is to increase the proportion of high school students who graduate in 4 years to 90.7 percent**.** Washington Co. exceeds the target currently.

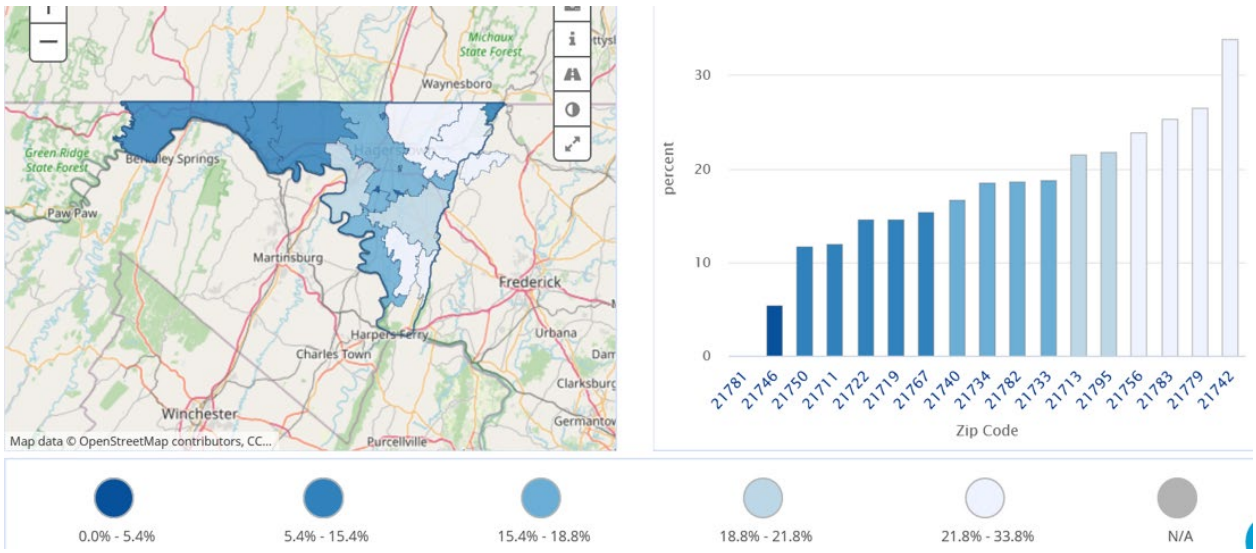


People Age 25+ with a Bachelor's Degree or Higher

For many, having a bachelor's degree is the key to a better life. The college experience develops cognitive skills, and allows learning about a wide range of subjects, people, cultures, and communities. Having a degree also opens up career opportunities in a variety of fields, and is often the prerequisite to a higher-paying job. It is estimated that college graduates earn about $1 million more per lifetime than their non-graduate peers. Adults with higher educational attainment live healthier and longer lives compared to their less educated peers.[8]

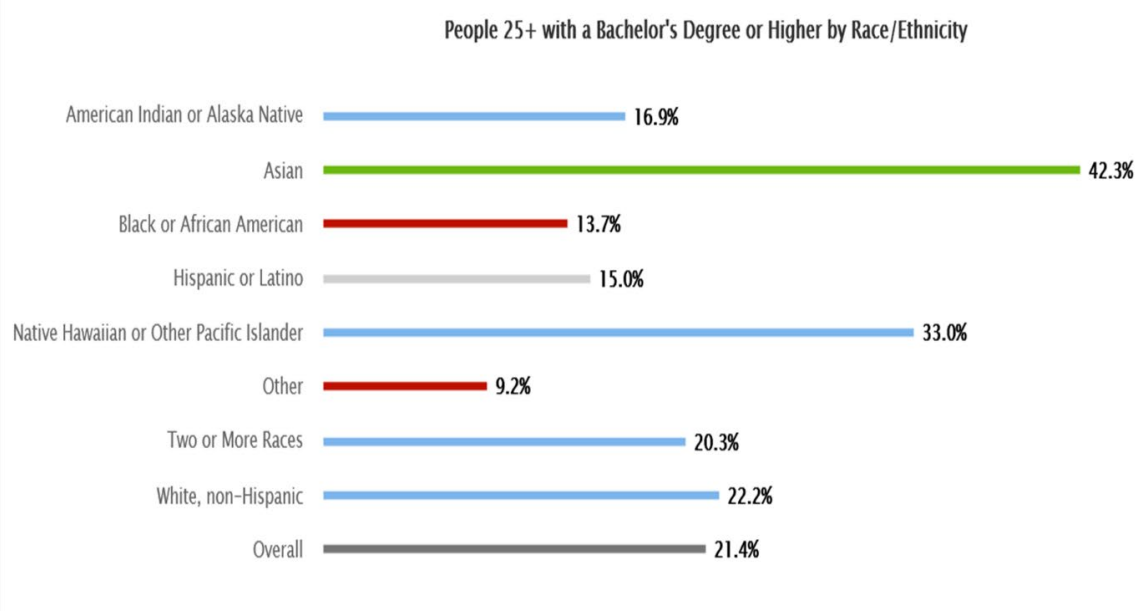
[8] Zajacova A, Lawrence EM. The relationship between education and health: reducing disparities through a contextual approach. Annu Rev Public Health. 2018; 39:273-289. Accessed: 11/18/2021

Bachelor's degree or higher by zip code (darker the color = lower the rate of attainment).



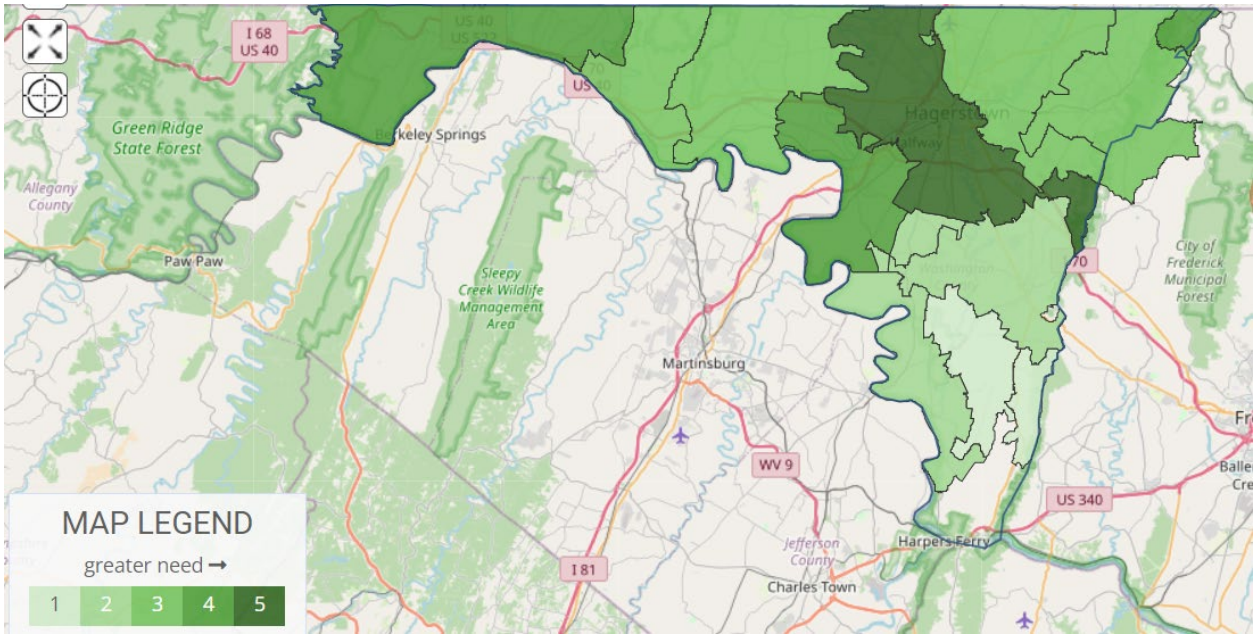
Adults with lower education have larger health inequalities and poorer health.[9] In Washington Co. we observe an improving trend for increase in the percentage of persons with a bachelor's degree or higher at 21.9%, however the total continues to lag behind the state of MD by nearly 50% less. The highest rates of higher education are among Asian (42.3%) and Native Hawaiian or Pacific Islander (33%) with the lowest rates among Black of African American (13.7%) and Hispanic or Latinx (15%).

[9] Marmot MG, Bell R. Action on health disparities in the united states: Commission on social determinants of health. JAMA. 2009;301:1169–71. Accessed: 11/18/2021


People 25+ with a Bachelor's Degree or Higher by Race/Ethnicity
American Indian or Alaska Native
16.9%
Asian
42.3%
Black or African American
13.7%
Hispanic or Latino
15.0%
Native Hawaiian or Other Pacific Islander
33.0%
Other
9.2%
Two or More Races
20.3%
White, non-Hispanic
22.2%
Overall
21.4%

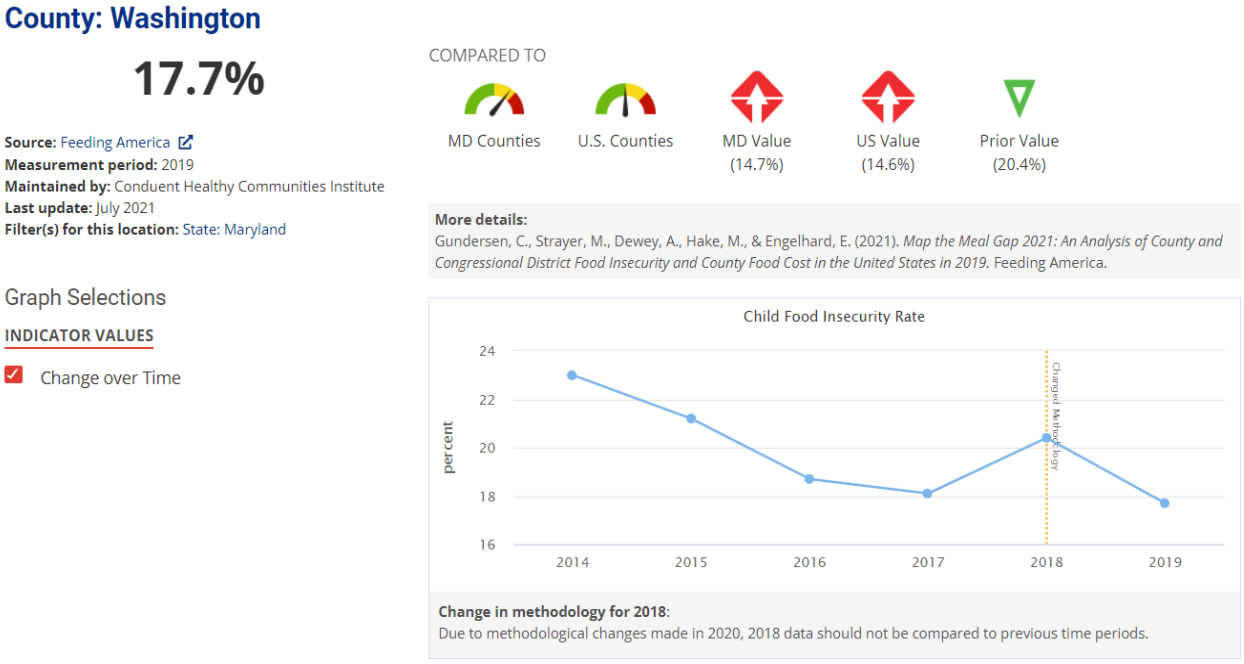
Food Insecurity

The 2020 Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of food access that is correlated with economic and household hardship. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need). To help identify the areas of highest need in our community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their index value**.** This map suggests that we have needs across our region, but the greatest needs are concentrated in the Hagerstown city area (21740) followed by Hancock (21750). Lower levels of income and poverty are consistent with greater food insecurity and a lack of healthy, nutritious diets. The two greatest areas of food insecurity in Washington CO. include Hagerstown (21740) and Hancock (21750).



According to Feeding America, the coronavirus crisis is likely to reverse the improvements that have occurred over the past decade as millions of people are newly at risk for food insecurity. [10]The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Children exposed to food insecurity are of particular concern given the implications scarce food resources pose to a child's health and development. Children who are food insecure are more likely to be hospitalized and may be at higher risk for developing chronic diseases such as obesity as a result in lower quality diet, anemia and asthma. In addition, food-insecure children may also be at higher risk for behavioral and social issues including fighting, hyperactivity, anxiety, and bullying.

This indicator shows the percentage of children (under 18 years of age) living in households that experienced food insecurity at some point during the year.



The Washington Co. percentage of 17.7% has improved from the prior measurement period but remains higher compared to the state 14.7% and nation 14.6%.

[10] Data source: https://www.feedingamerica.org/ Accessed 11/19/21

Persons with an Internet Subscription

County: Washington

83.2%

Source: American Community Survey
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: July 2021
Filter(s) for this location: State: Maryland

COMPARED TO

MD Counties	MD Value (89.4%)	US Value (86.2%)	Prior Value (79.9%)

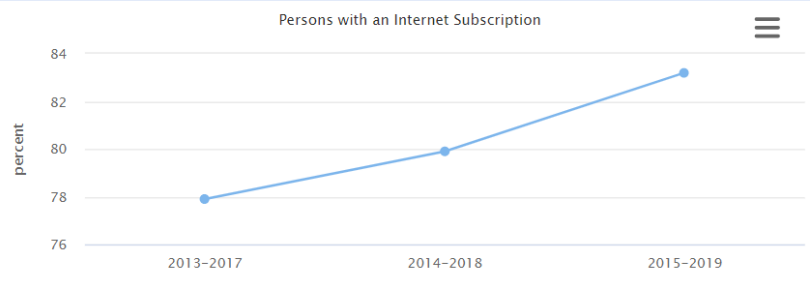
Graph Selections

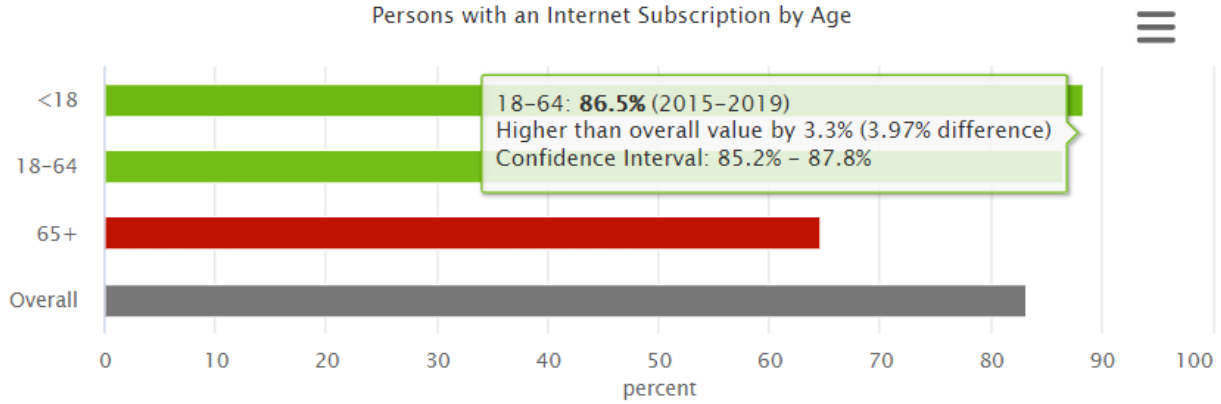
INDICATOR VALUES

- [x] Change over Time

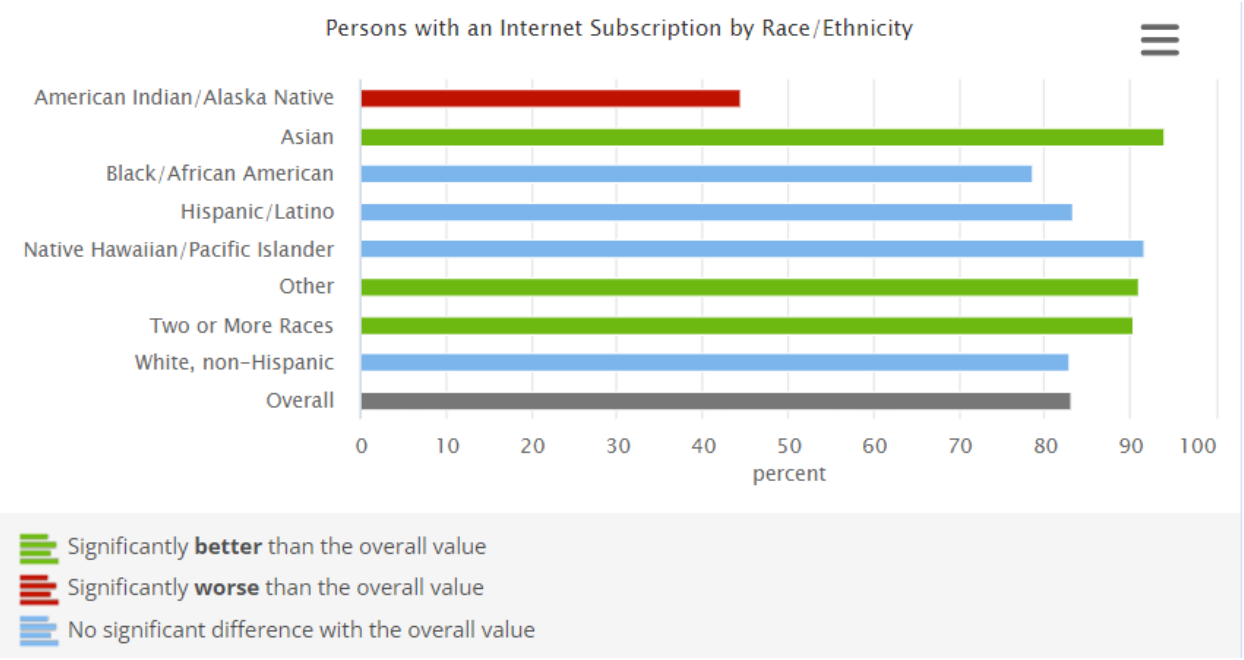
VIEW BY SUBGROUP

- [x] Age
- [x] Race/Ethnicity





Significantly **better** than the overall value
Significantly **worse** than the overall value

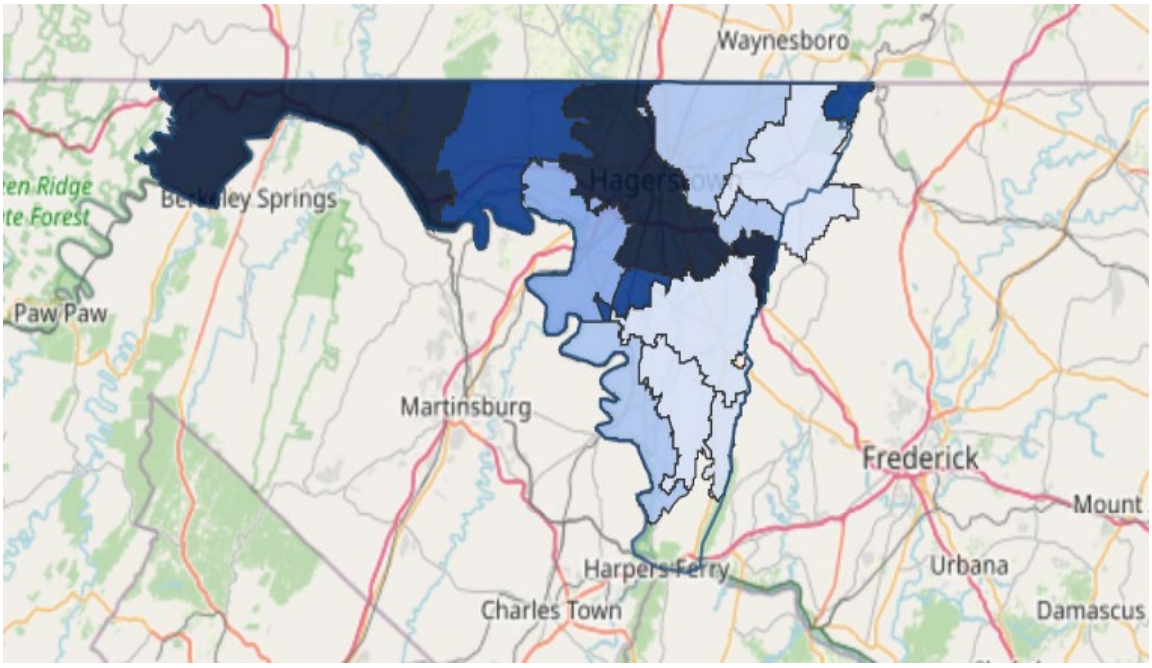


Having access to the internet is helping eliminate barriers to information, health and higher education. The advent of the pandemic has increased the use of telemedicine and increased access to healthcare for persons with the internet. Online higher education has become a standard over the past three years. However, telemedicine and online education are only accessible to persons with a reliable internet connection. More Washington Co. persons can connect with a positive, increasing more than 3% to a total of 83.2%. The data does not reflect the reliability or speed of the internet connection, which may be problematic for persons living in the more rural parts of our county. Older persons and American Indian/Alaska Natives are least likely to have internet.

Washington County SocioNeeds

The 2021 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes.

All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their index value.



Zip Code	Index	Rank
21740	75.8	5
21750	66.0	5
21711	65.2	5
21722	59.0	4
21733	52.4	4

ALICE Project (Asset Limited, Income Constrained, Employed)

With the cost of living higher than what most people earn, ALICE families – an acronym for Asset Limited, Income Constrained, Employed – have income above the Federal Poverty Level (FPL), but not high enough to afford a basic household budget that includes housing, child care, food, transportation, and health care. The United Way's "United for ALICE" project provides a framework, language, and tools to measure and understand the challenges faced by the growing number of ALICE households in our community.

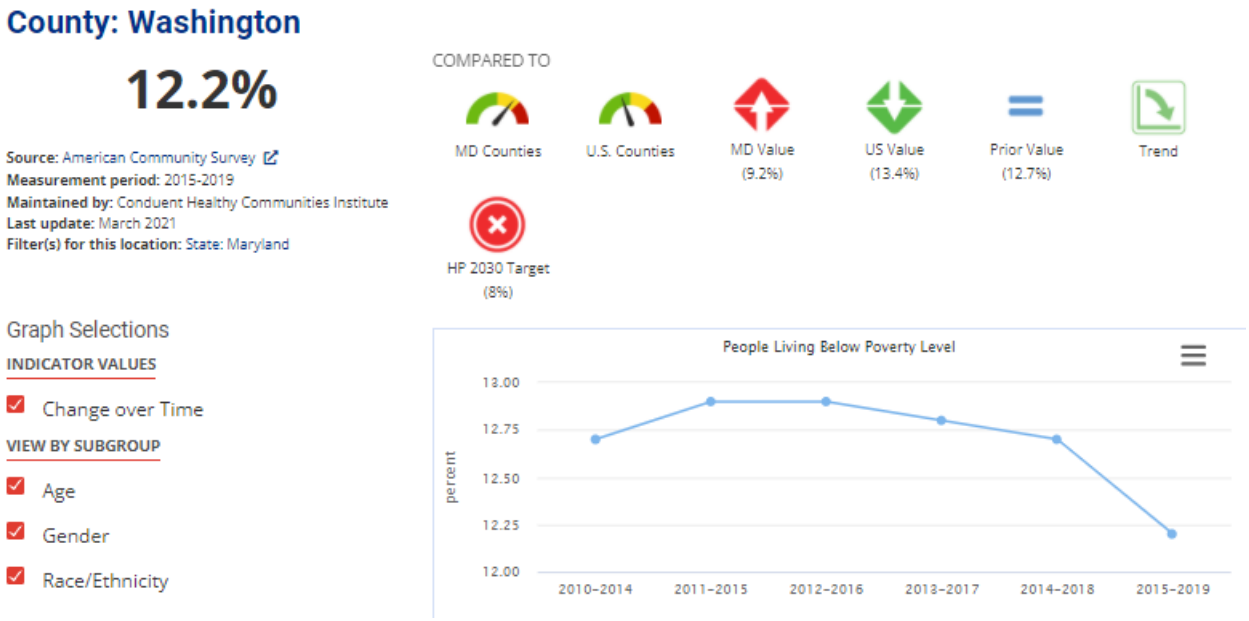
ALICE IN WASHINGTON COUNTY

2018 Point-in-Time-Data			
Population:	150,926	**Number of Households:**	56,306
Median Household Income:	$63,126 (state average: $83,242)		
Unemployment Rate:	6.0% (state average: 4.9%)		
ALICE Households:	29% (state average: 30%)		
Households in Poverty:	11% (state average: 9%)		

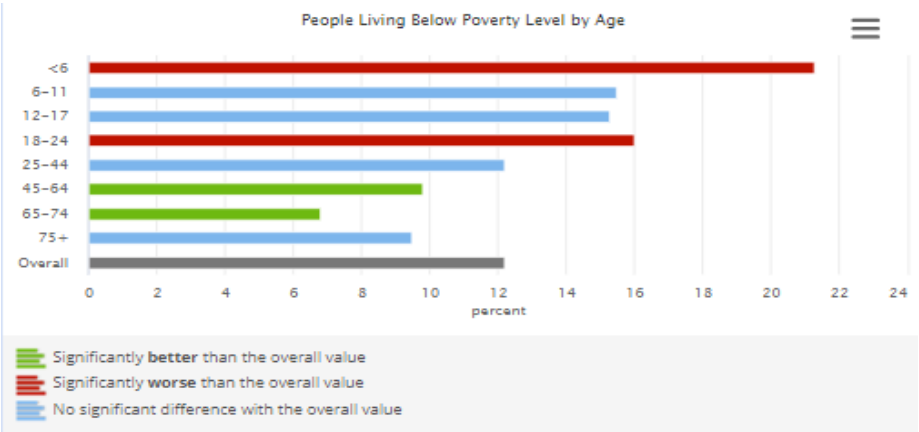
In 2016 there were 22,888 households (41%) in Washington County identified as "ALICE" households that struggled to afford basic household necessities like housing, food, health care, child care, and transportation despite many being employed. These were reduced to 16,086 in 2018. However, since the pandemic the United Way has released a new report, **The Pandemic Divide: An ALICE Analysis of National COVID Surveys,** providing a first look at the impact of the pandemic on ALICE households. The Report reveals that experiences and realities diverged during the pandemic: ALICE families fared significantly worse than higher-income households — financially, physically, and emotionally. The report drills down to state level data. The highest concertation of persons below the ALICE threshold lived in Funkstown (63%), Hancock (51%) and Hagerstown (50%) (see **Appendix O**).

Poverty

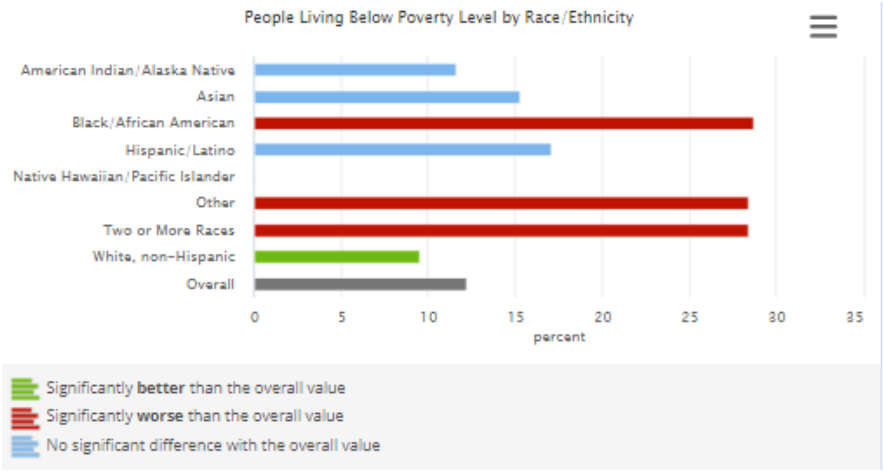
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival. The poverty indicator shows Washington Co. to be at 12.2% of the population living below the poverty level. While the trend is positive, we remain higher than the state (9.2%) and well above the HP 2030 Target of 8%.



Children under the age 6 account for 21.3% of the poverty rate among all age groups, a significant 75% difference.



In Washington Co. there are significantly higher rates of poverty for Black or African American 29.7% (+135% difference), Two or more races and "Other" race and ethnicities 28.4% (+133% difference), suggesting health disparities and inequity.



Persons with a disability are more likely to live in poverty as compared to the rest of the population. The poverty rate is especially high among persons with long-term disabilities. Without adequate income, individuals with disabilities may not be able to afford necessary expenses, such as rent or mortgage, utility bills, medical and dental care, and food. This indicator shows that 27.6% of Washington Co. residents aged 20 to 64, with any disability who are living below the poverty level.

County: Washington

27.6%

Source: American Community Survey
Measurement period: 2015-2019
Maintained by: Conduent Healthy Communities Institute
Last update: March 2021
Filter(s) for this location: State: Maryland

COMPARED TO

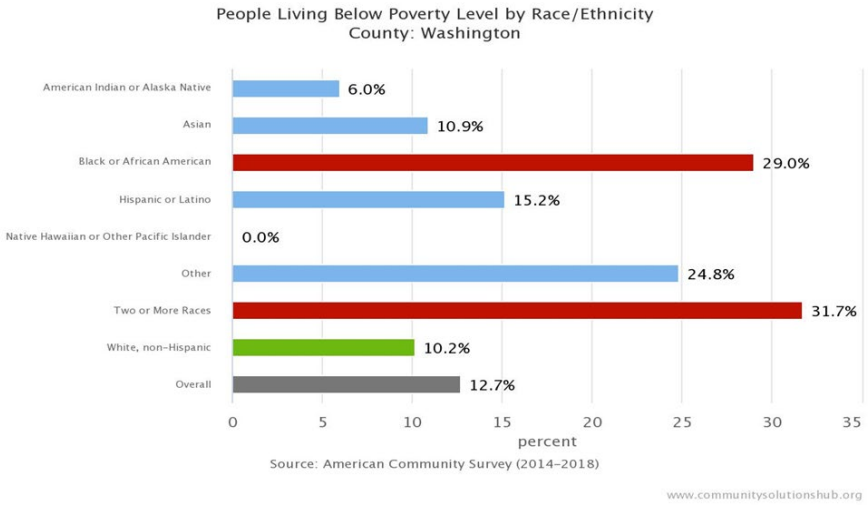
MD Counties	U.S. Counties	MD Value (20.9%)	US Value (26.1%)	Prior Value (28.7%)	Trend

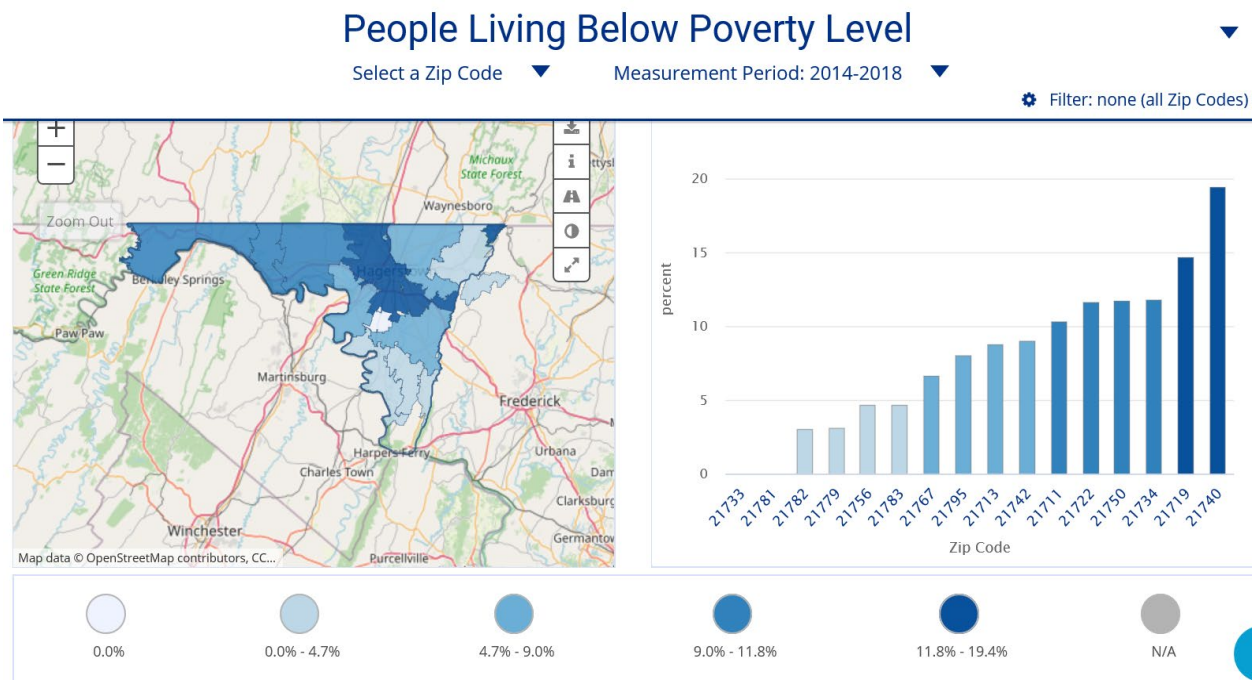
Graph Selections

INDICATOR VALUES

☑ Change over Time

We again note disparities and inequities with the higher rates of poverty for Black or African Americans 29% and persons of Two or more races 31.7% who have a disability.



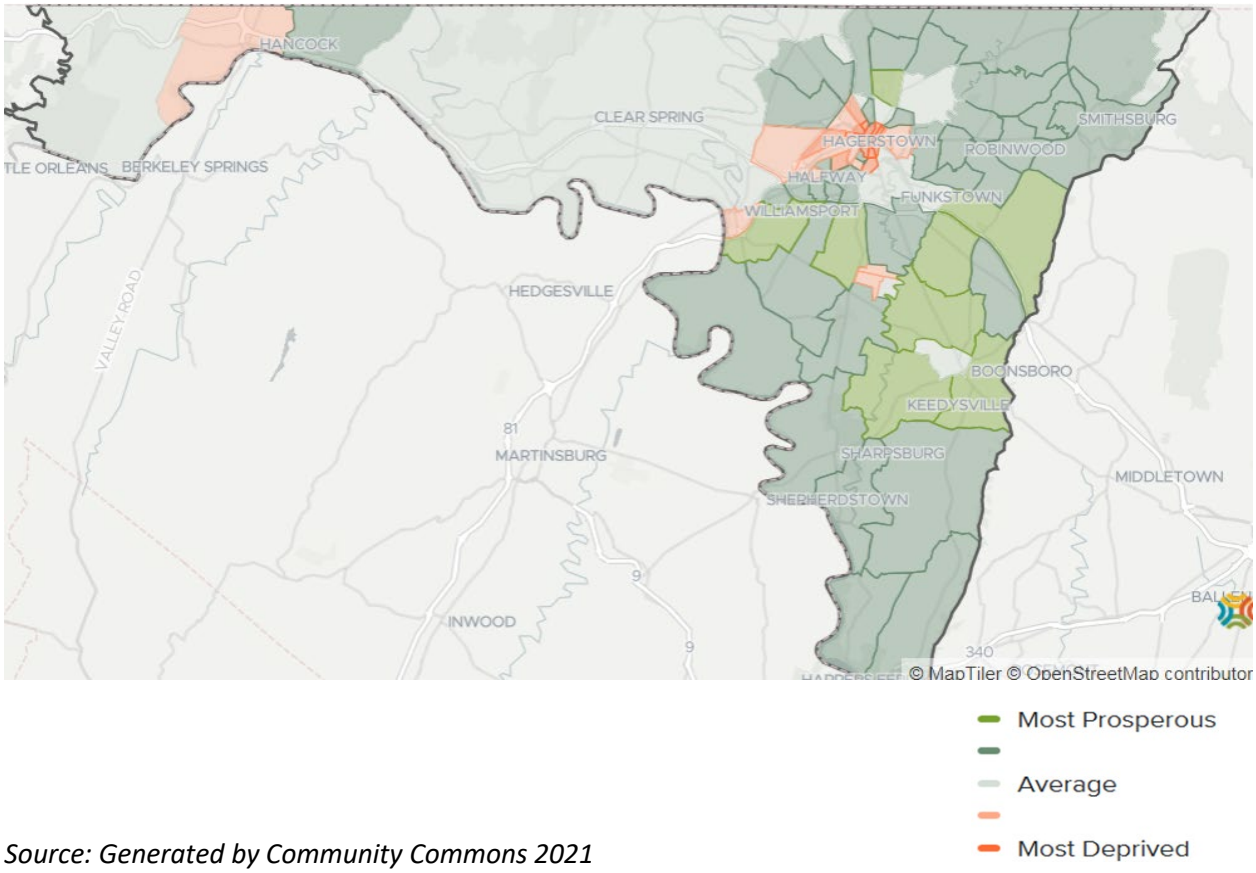


This indicator shows the location of people, aged 20 to 64, with any disability who are living below the poverty level. The highest concentration is the Hagerstown zip code 21740 (19%), Cascade (>14%), Funkstown and Hancock (12%).

Area Deprivation Index

The Centers for Medicare & Medicaid Services have previously mapped geographic locations to target improvement with underserved Medicare populations based on residence.[11] The Area Deprivation Index (ADI) is a measure of social vulnerability developed by Community Commons.[12] The ADI combines 17 indicators of socioeconomic status (e.g. income, employment, education, housing conditions) and has been linked to health outcomes such as 30-day re-hospitalization rates, cardiovascular disease death, cervical cancer incidence, cancer deaths, and all-cause mortality.[13] Within the Washington County community, there are defined geographic locations that include people facing moderate to severe deprivation. These locations correlate with health disparities and racial inequities for people living in the highlighted areas seen in the Deprivation map below.

Washington County Area Deprivation Map



Source: Generated by Community Commons 2021

[11] https://www.nimhd.nih.gov/news-events/features/community-health/disadvantaged-neighborhoods.html
[12] https://www.communitycommons.org/
[13] Ibid.

I. Health Disparities

The National Institutes of Health (NIH) define health disparity (HD) as differences and/or gaps in the quality of health and healthcare across racial, ethnic, and socio-economic groups.[14] A health disparity is a health difference linked with unfair economic, social, or environmental disadvantage. Health equity is the principle underlying a commitment to reduce and, ultimately, eliminate disparities in health and in its determinants, including social determinants.[15]

Differences in SDOH contribute to the stark and persistent chronic disease disparities in the United States among racial, ethnic, and socioeconomic groups, systematically limiting opportunities for members of some groups to be healthy.[16] Since the 2003 publication of the Institute of Medicine's landmark study, **Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,** increased focus has been placed on eliminating health disparities and achieving health equity in the United States. The pandemic and economic conditions have increased the focus on disparities, health inequities are seen as more enduring due to structural policies and practices that have systematically limited health access and opportunities.[17]

We must address both health disparities and inequities because:

- Inequities are unjust – health inequities result from an inequitable distribution of the underlying determinants of health including education, safe housing, access to health care, and employment;
- Inequities affect everyone – conditions that lead to health disparities are detrimental to all members of our community resulting in lower income, less potential and lower life span;
- Inequities are avoidable – many health inequities stem directly from government policy including taxes, regulation, public benefits, and health care funding and can be changed through policy intervention and advocacy; and,
- Interventions to reduce health inequities are cost-effective – evidence-based public health programs to reduce or prevent health inequities can be very cost effective compared to the long-term financial burden of continued disparity.

Health disparities in Washington County have become more apparent during the COVID-19 pandemic, at least in part a reflection of the underlying social determinants of health that negatively impact the health status of minorities. New publically available data make it abundantly clear that significant work is needed to address health disparities, equity and racism in Washington County, MD.

---

[14] NIH (National Institutes of Health). Health disparities. 2014. [November 2, 2016]. http://www.nhlbi.nih.gov/health/educational/healthdisp

[15] Braveman P. What are health disparities and health equity? We need to be clear. Public Health Rep. 2014;129 Suppl 2(Suppl 2):5-8. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/

[16] Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129 Suppl 2(Suppl 2):19-31. http://journals.sagepub.com/doi/10.1177/00333549141291S206

[17] Thornton RL, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. Evaluating Strategies for Reducing Health Disparities By Addressing The Social Determinants Of Health. Health Aff (Millwood). 2016;35(8):1416-1423.

Health Disparity and Inequity Findings

- 22% of all ED visits due to poorly managed diabetes were by Black or African Americans, compared to comprising only 11% of the general population. This trend suggests that a health disparity exists for diabetes management
- 22% of all ED visits due to hypertension were by Black or African Americans, compared to comprising only 11% of the general population. This trend suggests that a health disparity exists for hypertension management among Black or African Americans in Washington County.
- Hospitalization for hypertension demonstrates 20% difference between Black or African American and Whites

In the past year, Meritus Health analyzed thirteen quality and safety measures across race, ethnicity, and language in an effort to identify health disparities among the patients served. Using the Institute of Medicines six domains of healthcare quality (STEEEP): safe, timely, effective, efficient, equitable, and patient centered, thirteen quality and safety measures were analyzed across race, ethnicity, and language using FY2020 data. Of the thirteen measures, six were identified as disparities that require further investigation:

- Decreased core measure compliance for Black or African American patients with sepsis,
- Increased preterm birth rates for Black or African American, Hispanic or Latinx, and Spanish-speaking patients,
- Decreased rates of exclusive breast milk feeding for Black or African American and Hispanic or Latinx newborns,
- Decreased emergency department opioid administration for Black or African American, Hispanic or Latinx patients,
- Increased percentage of diabetic patients with HbA1c greater than or equal to 9.0% among Black or African American, Hispanic or Latinx patients, and
- Longer emergency department median throughput time for Spanish-speaking patients who are discharged or admitted.

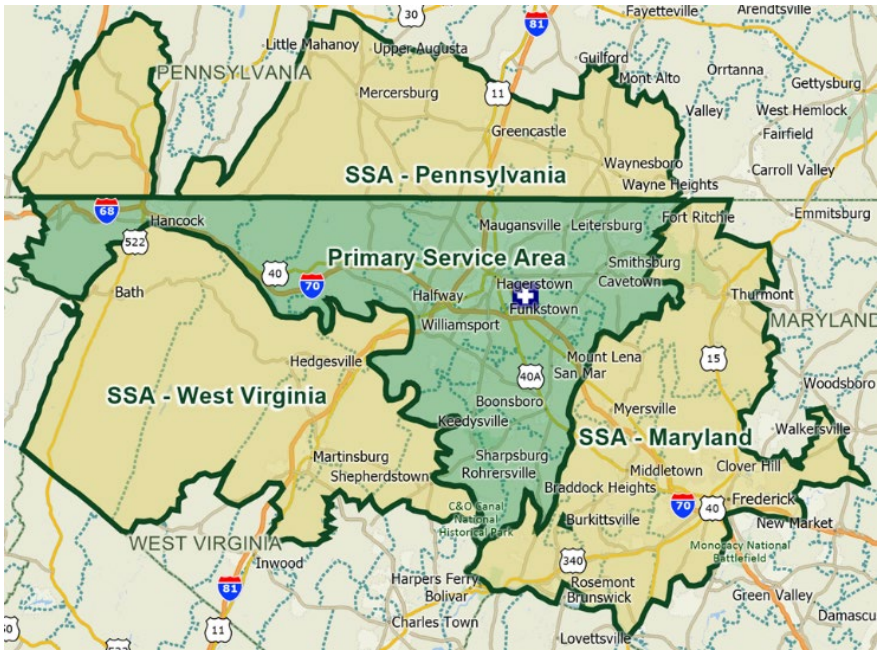
Meritus Health published a summary of findings and detailed plan for improvement to address health inequities in the Meritus FY2020 Health Equity Summary (see **Appendix P).**

J. Physician Needs

A physician needs assessment with specific benchmarking data was completed by a third party vendor for the years July 2019 – June 2022 for Meritus Health. The assessment documented physician demand, physician assets and defined the gaps and needs for medical providers in the community. The document helps forms the basis to identify and support physician recruitment and needs for the community.

As required under HG§19-303, Meritus Health provided a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital. Washington County has very limited Health Professional Shortage Areas (HPSAs) status for Primary Care and Mental Health. These designations are specifically assigned to the two Federally Qualified Health Center facilities, one located in downtown Hagerstown and the other in Hancock. The entire county is designated as a HPSA for Medical Assistance patients requiring dental care.

The defined Centers for Medicare (CMS) Service Area for the Physician Needs Assessment completed in 2019 included the same zip codes as the CHNA identified Primary Service Area (see page 15) plus an additional 8 zip codes in Pennsylvania and 6 zip codes in West Virginia whose residents access health care services in Washington County. The Planning Service Area ("Market") defined by Meritus Health and currently includes 487,080 residents.



General Provider Surplus / Deficit Results for CMS Service Area

Based on the methodology and analysis the vendor calculated that there is a demonstrated community need for the majority of Primary Care providers analyzed within the designated geographic CMS Service Area. A demonstrated community need for physician services is defined as a current deficit equal to or greater than (0.5) FTEs within the CMS Service Area.

The largest assessment gaps were identified as General Primary Care (73.6), Family Medicine (32.8), and Internal Medicine (24.5). Other deficits included Advanced Care Providers (16.3), OB/GYN (9.9) and Geriatric Medicine (5.0).

A surplus of providers in the current market include Urgent Care 22.1, Pediatrics 9.6, and Nurse Midwives 2.4.

According to the County Health Ratings published by Robert Wood Johnson Foundation, the ratio for Primary Care Physicians to patients is 1:1,780 in Washington County, compared to a Maryland state average of 1:1,130. The Washington Co. ratio has improved 1.7% since 2018.

	Current Market FTEs						
Specialty	Supply	Demand	Surplus / (Deficit)	PSA	SSA - MD	SSA - PA	SSA - WV
Primary Care							
Family Medicine	*128.7*	*161.5*	*(32.8)*	*(15.1)*	*(4.5)*	*1.0*	*(14.4)*
Internal Medicine	*74.3*	*98.8*	*(24.5)*	*(10.4)*	*(8.1)*	*(6.3)*	*0.3*
Advanced Care Provider	*49.7*	*66.0*	*(16.3)*	*(4.7)*	*(5.9)*	*(2.4)*	*(3.2)*
General Primary Care	252.7	326.3	(73.6)	(30.2)	(18.5)	(7.6)	(17.3)
Geriatric Medicine	1.8	6.8	(5.0)	(0.4)	(2.1)	(1.0)	(1.5)
Nurse Midwife	*3.8*	*1.4*	*2.4*	*3.4*	*(0.5)*	*(0.2)*	*(0.3)*
Obstetrics & Gynecology	*55.0*	*64.9*	*(9.9)*	*0.8*	*(2.7)*	*(3.2)*	*(4.7)*
Obstetrics & Gynecology - Total	58.8	66.3	(7.5)	4.2	(3.2)	(3.4)	(5.1)
Pediatrics	70.2	60.7	9.6	6.3	13.7	(5.1)	(5.3)
Urgent Care	29.0	6.9	22.1	8.8	(1.2)	13.3	1.1
Total Primary Care	**412.5**	**466.9**	**(54.5)**	**(11.3)**	**(11.3)**	**(3.8)**	**(28.0)**

The current market surplus/(deficit) includes 100% of supply and demand for physicians within the Service Area, regardless of alignment with Meritus Health.

Similarly, there is a patient access gap identified across all provider specialties. Some of the greatest needs include cardiology, ophthalmology, dermatology, endocrinology, psychiatry, and urology.

Specialty	Local Market Reality			Current Meritus Gap vs. PCP Base
	Interviews	Survey	Patient Access	
Allergy & Immunology		✓	✓	(2.0)
Cardiology - Medical			✓	*(5.5)*
Cardiology - Electrophysiology			✓	*(0.5)*
Cardiology - Interventional			✓	-
Cardiology - Total				(6.0)
Dermatology		✓	✓	(4.3)
Endocrinology	✓	✓	✓	(0.9)
Gastroenterology			✓	-
Hematology/Oncology	✓		✓	-
Infectious Disease			✓	(0.6)
Nephrology			✓	-
Neurology	✓	✓	✓	(2.2)
Pain Management		✓	✓	-
Physical Medicine & Rehab			✓	(2.5)
Psychiatry		✓	✓	(3.0)
Pulmonary			✓	(0.1)
Reproductive Endocrinology			✓	(0.1)
Rheumatology		✓	✓	(1.4)
Sleep Medicine			✓	-
Sports Medicine			✓	(0.8)
Cardiac Surgery		✓	✓	*(0.7)*
Thoracic Surgery		✓	✓	*(0.0)*
Cardio/Thoracic Surgery				(0.7)
Bariatric Surgery			✓	*(0.1)*
Breast Surgery			✓	-
Colon & Rectal Surgery			✓	*(0.4)*
General Surgery			✓	-
Oncology Surgery		✓	✓	*(0.2)*
Transplant Surgery				*(0.0)*
Vascular Surgery			✓	-
General Surgery - Total				(0.7)
Maternal Fetal Medicine				(0.5)
Neurosurgery - Cranial			✓	*(0.4)*
Neurosurgery - Spine			✓	*(0.7)*
Neurosurgery - Total				(1.1)
Ophthalmology			✓	(5.4)
Orthopedic Surgery - General			✓	*(0.9)*
Orthopedic Surgery - Hand			✓	*(0.0)*
Orthopedic Surgery - Spine			✓	*(0.6)*
Orthopedic Surgery - Total				(1.6)
Otolaryngology				(2.8)
Plastic Surgery			✓	(1.4)
Podiatry			✓	(0.9)
Urology	✓		✓	-

As a sole community hospital provider, Meritus Health provides around the clock care in the Emergency Department including specialist coverage: Cardiology, Critical Care, ENT, Eye, GI, General Surgery, Interventional Cardiologist, Neurology, Neurosurgery, Ortho, Pediatrics, Plastics, and Urology.

In addition, Meritus Health subsidizes the Hospitalist program in response to a community need for this service. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured population necessitated the need for a Hospitalist program subsidized by the Hospital.

Top Findings from the Physician Needs Assessment include:

- access is difficult for new patients in specialties,
- the potential need for succession planning is a significant component of the plan,
- growth in primary care results in a need for additional specialist FTEs, and
- there is a need for all physicians based on current shortages of specialists.

VI. Conclusions

Overall lifespan In Washington County is on a downward-sloping trend, similar to the state and nation, but more significant.

The ongoing impact of Covid-19 on potential future costs associated with postponed treatment and reduced preventive care (screenings for behavioral, cognitive, social, and chronic medical conditions) is unknown at this time.

The occurrence of telehealth services is reshaping delivery of health care. Health integration to treat the whole person is rapidly becoming "virtual integration" providing virtual telemedicine and education services with real-time patient exchange via EHR as the foundation. The transformation is shifting the locus of health and human services from professional offices to consumer homes. New barriers in access to and use of digital devices observed when technology is not available. Access to high-speed internet access is an issue in some rural parts of the county.

Health disparities and inequities exposed during the pandemic must redirect our actions and decision-making across the health system and community to ensure equitable care for all persons.

These conditions represent an excellent opportunity and potential to improve access and engagement towards our purpose of improving health for all people.

Despite the pandemic and changes to health care delivery over the past two years, the health needs and priorities for Washington County are largely unchanged from three years ago.

As summarized by Dr. Maulik Joshi, Meritus Health CEO "It's time to move from assessment to improvement."[18]

Summary of Findings

Health needs and priorities are largely unchanged from the FY2019 CHNA findings.

Improvement

- Improving Washington County trends include fewer uninsured persons, increased supply of dentists, and lower rates of air pollution
- The majority of Washington County residents have health insurance 93%; approximately 7% of adults are not insured
- The mortality rate for heart disease and cancer both decreased 2% since last measurement period in 2018
- Diabetes mortality rate is decreasing

[18] http://www.modernhealthcare.com/opinion-editorial/community-health-its-time-move-assessment-improvement Accessed: 8/10/21

- Alcohol binge drinking rates of 16% are lower than the state average
- Drunk driving fatalities are trending down and are better than the state and HP targets
- Fewer opioid prescriptions are being prescribed by providers
- ED visits for behavioral health crisis declined
- Mammography screening trend is improving
- Lung and colon cancers are being diagnosed at earlier stages
- The survival rate for colon, and head and neck cancers are improving

Wrong direction

- Life expectancy has declined over ten years in Washington County, largely attributed to overdose fatalities and an increased rate of suicide
- Washington County slipped to 18th out of 24 Maryland counties in the County Health Rankings
- Cautious trends include increases in physical inactivity, preventable hospital stays, unemployment, and crime
- Concerning trends include premature death rate, increased adult obesity rates, a lack of available primary care physicians, and more children living in poverty
- Overweight adults (BMI $\geq$ 25) increased by 3.3% since last CHNA
- Adults who are physically inactive increased 2% since last CHNA
- While diabetes prevalence at 10.3% is similar to the rest of the state, Washington County has the second highest rate of diabetes mortality, 32
- Given the higher than average rates for physical inactivity, and being overweight and obese in our community, residents are at higher risk for pre-diabetes and developing diabetes in the future
- Washington County is an outlier for 9-1-1 calls for behavioral health resulting in more Emergency Department visits for mental health and crisis assessment than the state of Maryland average
- The rate of suicide at 14.7 per 100,000 lives has increased in Washington County while the state average has slightly decreased over the past six years
- There is a steady increase of drug overdose fatalities over the past ten years, at a rate that is higher than the state of Maryland average
- The trend of drug overdose deaths has increased significantly since 2014 and are primarily attributed to fentanyl

Objective findings

- The leading causes of death among adults in Washington County are heart disease 22% and cancer 19%
- Only 20% of health outcomes are attributed to the quality of clinical care provided (70% is accounted for by health behaviors 30%, social and economic determinants 40%)

- The most frequent health concerns reported include behavioral health issues including anxiety and depression, ADHD, autism and bipolar disorder, being overweight, having type II diabetes, high blood pressure, cancer, asthma, addiction, allergies, arthritis, back pain, high cholesterol and heart disease
- Other health concerns include dental, smoking, and Chronic Obstructive Pulmonary Disease (COPD)
- Community informants view the health status of people living in Washington County as "unhealthy" 57%, "average" or similar to most other communities 29%, "healthy" 10%
- The primary barriers to accessing health care include the cost of care, including inability to afford co-pays and health insurance deductibles, and inability to see a provider when needed
- More than 68% of the adult population is overweight or obese (BMI > 25)
- There was no change in the percentage of persons who maintained a healthy weight over the past three years, 31.5% (BMI < 25)
- The report of high blood pressure 32.7% is similar to the state and national averages
- There is a clear correlation between health, wellness and the rate of poverty which is higher in Washington County (12.2%) than is found in the state of Maryland (9.2%)
- Transportation to outpatient medical services is a barrier for patients who do not have independent transport

Health Disparities

- There is a health disparity among the Black or African Americans observed in a higher rate of Emergency Department visits for poorly managed health issues including diabetes and hypertension
- Black or African Americans have a higher age-adjusted death rate of 45.9 for lung cancer compared to Whites, 42.3
- The colorectal cancer rate for Black or African Americans is 50.9, more than 25% higher compared to Whites at 37.8
- The prostate cancer incidence rate among Black or African American men in Washington County is 194.4, nearly twice the rate of White men 94.8

Identified Health Service Gaps

- Over-weight and obesity is a primary health concern and people desire information regarding diet, nutrition, weight loss, and help making healthy lifestyle changes
- There are delays stretching an average of more than three weeks for a new patient to be seen by a psychiatrist
- There is a shortage of primary care and specialty providers available in Washington County
- There are no mental health crisis beds in the county

- There is a delay to timely access for substance abuse treatment when a person desires help; specifically the lack of detoxification or crisis services or ability to be admitted for inpatient/residential treatment levels of care
- There are significant health disparities with Black or African Americans, and Hispanics or Latinx

Other Health Needs

At the conclusion of the CHNA health needs ranking it was recognized that many more needs were identified and exist than the top five identified health needs alone. Some of the health needs for the community include **cancer**, access to **dental care,** access to **affordable healthcare, teen pregnancy, senior needs, homelessness, and poverty** among others. Our community providers are using the results of the CHNA to help target these unmet needs based on the strengths, expertise and resources of individual organizations, and when interests are shared, new collaborative relationships between organizations can be formed. Findings from the FY2022 CHNA may be used to support grant procurement, donations and gifts to fund new program services.

Cancer continues to be the second leading cause of death for Washington County residents. Meritus Health will continue investment in the cancer service programs to include the development of the Meritus Hematology Oncology Specialists practice, providing four Registered Nurse Clinical Navigators, adding registered dietitian services, and initiating the Hope Soars Survivorship Program as a support to patients in recovery.

Hagerstown Family Healthcare (FQHC) has expanded access to **dental care** to persons in Washington County. The Hagerstown Family Healthcare Dental Practice provides comprehensive dental care to children and adults. They provide a pediatric dentist who specializes in the dental needs of children of all ages, as well as special needs patients. The Healthy Smiles in Motion mobile dental program provides dental care to students of Washington County Public Schools on-site at their home schools.

Healthy Washington County is using the CHNA to **address access to affordable healthcare issues** and a **lack of health insurance** by providing locations for the MD Health Exchange Navigators to reach uninsured persons. Both Brook Lane and Meritus Health have a **financial assistance policy** for persons deemed unable to afford the cost of care. The county is fortunate to have two Federally Qualified Health Centers, (FQHC) located in Hancock and Hagerstown, MD, both of which are committed to **providing quality healthcare services** on **a sliding-scale basis.** The Community Free Clinic located in Hagerstown provides **quality, comprehensive outpatient health care services, free of cost,** to all Washington County residents who are **uninsured** and is launching expanded **mental health services**.

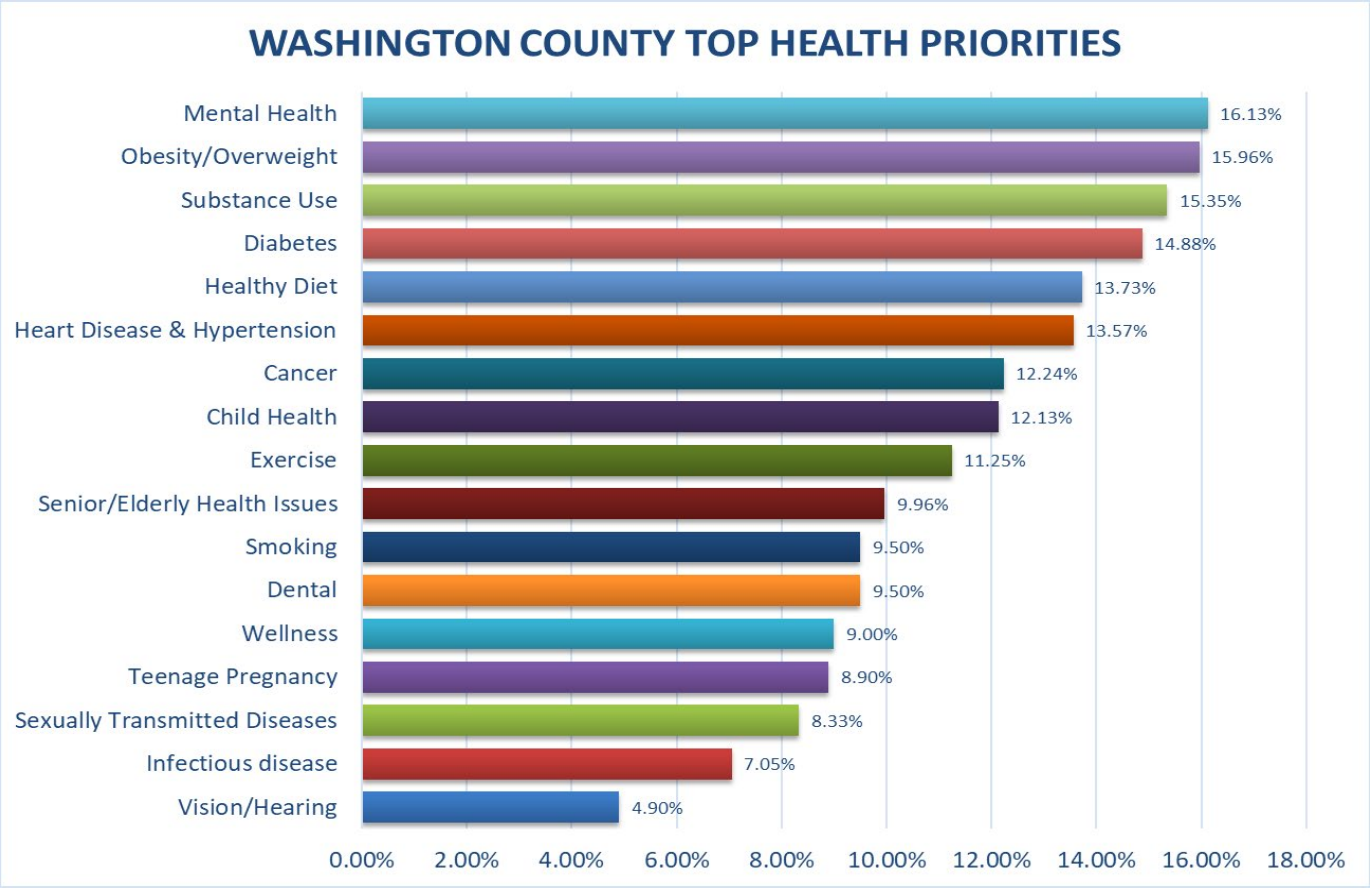
To **help prevent teen pregnancy** The Community Free Clinic provides services to reduce teen pregnancy as a part of the YOLO program (Youth Overcoming Life Obstacles) serving adolescents age 13-24. Youth may present to the Clinic without appointment to receive strictly free and confidential services including contraception, STI testing, HIV testing, pregnancy testing, counseling, educational information and appropriate

referrals to other community resources. The program offers honest conversation around lifestyles, behavioral concerns and seeks to answer questions. Substance abuse, assault, violence and general safety is also addressed at each visit. The CFC has expanded to meet comprehensive **health needs of uninsured youth** in the community. Mental Health services were expanded 3 years ago to provide counseling, crisis intervention and emotional support for those experiencing life difficulties such as anxiety, depression, grief, trauma and more

Health care organizations and community resource agencies must work collaboratively across sectors to address **health, wellness, housing, transportation, food insecurity, and child development needs** in both practice and policy. The United Way of Washington County will use this report as another tool that helps determine appropriate **funding for local programs** that are tackling pressing community issues. The funding process begins with funding strategies that are formulated with data, and input from multiple community members, businesses and nonprofit organizations. Data is very important and is used to set goals that help meet the mission: "The United Way of Washington County inspires collaborations to impact community improvement. To do this, we function as a rallying point for attracting and fostering leadership to advance collective action."

VII. Health Needs Prioritization

On November 2, 2021, Healthy Washington County conducted a public meeting to review the data, findings, needs and issues identified from the Community Health Needs Assessment process. Upon reviewing all the key data and findings, attendees endorsed the prioritized ranking of health needs and social determinants of health.



A full list of the health priorities identified for Washington County in ranked order include:

1. Mental Health
2. Obesity / weight loss
3. Substance Use
4. Diabetes
5. Healthy diet
6. Heart Disease and Hypertension
7. Cancer
8. Child health
9. Exercise
10. Senior health
11. Smoking

12. Dental
13. Wellness
14. Teenage Pregnancy
15. Sexually transmitted disease
16. Infectious disease
17. Vision/ hearing

The top ranked health priorities for the Washington County community include:

#1 Mental health
#2 Obesity / weight loss
#3 Addiction
#4 Diabetes
#5 Heart disease and hypertension

The top ranked community health priorities for Meritus Health implementation plan includes:

1. **Obesity;** lose 1 million community pounds by promoting increased **physical activity (DO)**, eating a **healthy diet (EAT),** and achieve **emotional balance (BELIEVE)**

2. Improve **behavioral health** by ensuring timely access to appropriate, quality **mental health treatment** and support, and reduce **addiction** and **overdose fatalities** to protect the health, safety and quality of life for all

3. Improve prevention and the management of type II **diabetes** and reduce mortality,

4. Prevent **heart disease,** reduce **mortality** and manage **hypertension**

5. Increase **healthy equity** by helping all people **attain the highest level of health**

6. Engage and empower people to **choose healthy behaviors** and make changes to **reduce risks**

The top ranked community health priorities for Brook Lane implementation plan includes:

1. Improve mental health through prevention, early intervention and education

2. Lessen **substance abuse** to safeguard the health, safety and welfare of all

VIII. Planning and Implementation

The Community Health Needs Assessment provides a framework for community action, coordination, engagement, and accountability in addressing the health needs of our citizens. The CHNA's significance as a resource to community organizations is paramount as it identifies our health need priorities and establishes a framework to begin addressing these issues collectively. As required by the PPACA, both of the hospitals developed a community health implementation plan.

Meritus Health Implementation Plan

Meritus Health, Western Maryland's largest health care provider has committed to caring for the community for more than a century. Meritus Health exists to improve the health status of our region by providing comprehensive health services to patients and families. The FY2022 CHNA key findings and prioritized health needs were used to develop a draft action plan that includes objectives, baseline data, and expected outcomes over the next three years, strategies, tactics, accountability and budget. Meritus Health CHNA objectives and measurable goals were detailed in the draft Community Health Improvement Plan (CHIP) FY2023 – 2025 (see **Appendix Q)**.

Obesity

Our Bold Goal to lose 1 million pounds by 2030 will be achieved by:

- increasing the number of registered users in the community weight tracker
- having users actively track weight to document total pounds lost
- increase the number of engaged community partners

Behavioral Health

Improve access to timely behavioral health treatment and recovery

- Explore construction of free-standing behavioral health hospital
- Establish regional crisis stabilization services
- Decrease number of overdose fatalities in Washington County
- Reduce suicide rate
- Establish a psychiatric residency / graduate medical school

Disease Management

Improve management of diabetes and hypertension

- Improve management of hbA1c in patients with diabetes
- Provide Diabetes Prevention Program (DPP)
- Provide Diabetes Self-Management Program (DSMT)
- Improve management of hypertension

Wellness & Prevention

Engage and empower people to choose healthy behaviors and make changes to reduce risks

- Increase health screening
- Increase vaccinations
- Reduce loneliness
- Increase health literacy

Health Equity

Attain the highest level of health for all people

- Establish community equity collaborative
- Increase racial/ethnic diversity in the workforce that looks like the community
- Eliminate health disparities
- Address SDOH
- Improve access to healthy food

To deliver on our mission, execute our vision, and embody our values, Meritus Health will strive to achieve health equity for the patients we serve. To effectively do this effectively, we must identify health disparities, understand why they exist in our health system. We will publish an annual Health Equity Summary as an initial step toward achieving health equity. It will serve as the foundation for an annual Health Equity Report.

We will continue to analyze data across race, ethnicity, and language using the Institute of Medicines six domains of healthcare quality (STEEEP): safe, timely, effective, efficient, equitable, and patient centered. Six of the thirteen quality and safety measures analyzed were identified as health disparities. Each has an active work group of key stakeholders who are making necessary changes to correct and eliminate the disparity.

To fully leverage the findings, next steps will include the following:

1. Continue the work of the Leadership in Equity and Diversity (LEAD) Council, including measuring the impact of the "Rooney Rule" to increase diversity representation in leadership positions,
2. Achieve 100% employee participation in unconscious bias and cultural competency training,
3. Solicit feedback from throughout the organization to determine new metrics to add for the annual Health Equity Report (as well as metrics that may no longer need to be measured), and
4. For all of the above, involve key stakeholders, determine target dates to reach specific goals, and create accountability mechanisms to ensure that our goals are being monitored and met.

The plan for implementation was developed in coordination with Community Health leadership, Strategic Planning and the Board of Director's Strategic Planning Committee. The Meritus Health final CHIP with objectives, action goals and responsibility were approved by the Board of Directors on February 24, 2022 and finalized (see **Appendix R**). The CHIP will be used to guide strategy and operations to fully implement the plan and meet stated goals for the community by FY2025. As resources become available and can be allocated, the

action plan will incorporate additional needs and goals. The plan will be reviewed periodically to measure progress towards goal achievement and modify any action steps or goals as needed.

Brook Lane Implementation Plan

Brook Lane will:

Improve **mental health** through prevention, early intervention and education

- Hold eight Mental Health First Aid trainings annually
- Screen 400 people in the community for depression annually
- Hold four community education events per year
- Collaborate with community groups and organizations

Lessen **substance abuse** to safeguard the health, safety and welfare of all

- Grow the InSTEP Program to provide treatment services
- Increase community education on substance abuse

The FY2022 CHNA key findings and prioritized health needs were used to develop a Strategy Summary plan that includes objectives, goals, strategies and tactics over the next three years (see **Appendix S).** The plan includes a collaborative strategy between Brook Lane and Healthy Washington County to guide and implement community-wide initiatives that will help address the prioritized health needs and improve the overall health of people living in the region.

The plan for implementation was developed from November 2021 to March 2022 in coordination with Brook Lane Leadership and the Board of Directors. The final Brook Lane implementation plan with objectives, action goals and responsibility were approved by the Board of Directors on January 28, 2022 and are summarized as **Appendix T**. The plan will be reviewed periodically to measure progress towards goal achievement and modify any action steps or goals as needed.

Adoption by Healthy Washington County

The Community health Implementation Plans received from both hospitals were incorporated into a comprehensive strategy to address the top health priorities of people living in our community. On March 1, 2022 Healthy Washington County formally recommended adoption of the action plans as received from the respective hospital Boards of Directors. As resources become available and can be allocated, the Healthy Washington County community action plan will incorporate additional health needs and goals. The plan will be reviewed periodically to measure progress towards goal achievement and modify any action steps or goals as needed.

Publication

Following the approval of the Action Plans, the final FY2022 CHNA report was published on May 4, 2022 and was made widely available to the public as posted on the following websites:

www.brooklane.org
www.meritushealth.com
www.healthywashingtoncounty.com
www.washcohealth.org

IX. Appendices

A. CHNA Action Plan Update FY2021
B. Healthy Washington County Membership 2021
C. Community Health Needs Assessment Timeline FY2022
D. Washington County Demographics 2021
E. Washington County Health Resources 2021
F. Washington County Health Rankings 2021
G. Maryland Vital Statistics 2019
H. Maryland Vital Statistics Summary 2019
I. Community Solutions Hub Description 2021
J. Health Equity Resource Community (HERC) Data 2019
K. Key Informant Questionnaire
L. Key Community Stakeholders
M. Key Community Stakeholders Responses Summary
N. Focus Group Summaries
O. A.L.I.C.E. Washington County 2018
P. Meritus FY2020 Health Equity Summary
Q. Meritus Health Community Health Improvement Plan (CHIP) FY23-25 DRAFT
R. Meritus Health Community Health Improvement Plan (CHIP) FY23–25 FINAL
S. Brook Lane Strategy Summary FY23-25 DRAFT
T. Brook Lane Strategy Summary FY23–25 FINAL

CHNA Dashboard

Meritus Medical Center Action Plan FY2019 - FY2021

Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY21 Outcomes
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line	
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin addiction	Meritus Community Health	**80 (26% increase)**
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line	
		Decrease number of opioid prescriptions by 25%	2717 MEPPE	2038 MEPPE	1705 MEPPE	1359 MEPPE	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO	1702 MEPPE (37%
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines	
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines	
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line	788 (44% reduction)
							Support county-wide effort to fund and operationalize a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line	
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line	
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line	4367 (18% reduction)
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line	
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line	
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line	15% (reduced by 2%)
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO	

pending Lori A

CHNA Dashboard

Meritus Medical Center Action Plan FY2019 - FY2021

Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY21 Outcomes
Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach	**31.5% (+3.3%)**
		Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health	CATCH suspended FY21 due to Covid
		Go for Bold! Lose 1M by 2030	N/A	Kick off	10,000 lbs lost	35,000 lbs lost	Community initiative to lose pounds; DO, EAT, BELIEVE in a healthy Washington County	Organizations pledge pounds, promote resources, registered users track weight	Meritus Community Health	11,200 lbs lost
		Decrease the percentage of the population that report food insecurity by 5%	*Changed 2021 to Conduent Index		151.93	Reduce by 10% (136)	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health	151.93 Index
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health	**28% (+2%)**
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health	**37% (+3%) RWJ CHR**
Wellness #4	Improve health-related quality of life and well-being for all	MMG practice patient population has SDOH documented; unique patients with visits each month	10%	New	10%	25%	Screen for SDOH with percentage of adult MMG patients per month	Outpatient RN Care Managers to begin completing SDOH screen and provide linkage to resources to address, PRN.	ACO, CTO, MPA	17% (+7%)
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health	41 Partners Go for Bold
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept.**, Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health	16.4% (decrease 2.4%)
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program	Suspended FY21 due to Covid

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2019 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY21 Outcomes
Diabetes #5	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2%	10.7 per 100 adults MD Vital Stats 2015	10%	9.4%	8.7%	Make the evidenced-based Diabetes Prevention Program widely available in Washington County	Partner with the local **Dept. of Healt**h to provide diabetes prevention program and **community providers** and **pharmacists** to identify at-risk patients	Meritus Community Health	**10.3% (+0.3%)**
		Decrease the diabetes mortality rate by 2% over three years	35.9 per 100,000 MD Vital Stats 2016	< 35	< 34	< 33	Increase availability of diabetes education and support to primary care practices	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	32 MD Vital Stats 2019
		Reduce # of ED visits for diabetes by 5%	FY18 778 visits Meritus	< 764	< 752	< 739	Provide diabetes education, dietary counseling and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	Partner with the **Hagerstown Parks & Rec, the Health Dept and the Senior Center** to provide Living Well and outreach services	Meritus Community Health	**830 ED visits (+6.3%)**
		ACO measure: 90% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%.	Determine data	75%	80%	85%	Provide individualized Diabetes Education and 1:1 Self-Management support to high risk patients to improve disease control and decrease unnecessary hospital utilization.	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	79.4%
Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1%	194 per 100,000 MD Vital Stats 2016	193	192	< 192	Provide community and employer health education events to increase heart health awareness	Partner with the **Health Department, Meritus Cardiac Services** to promote healthy lifestyle education and evironments	Meritus Community Health	184.6 per 100k MD Vital Stats 2019
		Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months	2%	10%	20%	25%	Provide evidence-based smoking cessation program to teens and adults	Partner with the **Meritus School Health** and **Health Department** to provide smoking cessation programs and support	Meritus Community Health	Measure suspended
		Decrease the # of ED visits for hypertension by 5%	FY18 375 visits Meritus	368	362	< 356	Provide heart health screening and educational interventions at the community level	Partner with **local churches** to provide blood pressure screening and education	Meritus Parish Nursing Program	Data says 1734 pulling secondary dx
							Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	Partner with **Zion Baptist, Wash. Co. Parks and Rec** and the **Senior Center** in the provision of screenings and cardiac health education to their populations	Meritus Community Health	1,979 BP screens 2021
		ACO Measure: 90% of patients age 18-75 with a diagnosis of HTN will have a BP < 140/90.	Determine data			90% pts BP 140/90 or <	Provide individualized hypertension education and 1:1 self-management support to improve blood pressure control	Utilize Meritus outpatient care managers to provide education, discharge follow up, transition of care, and chronic disease management services	MPA, ACO, CTO	Measure suspended
Cancer #7	Reduce the mortality of cancer cases and improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10%	158	152	148	142	Earlier detection of lung cancer	Low dose CT screening, Physician education, Utilize EHR reminders	Oncology Service Line	145 (8.2% reduction)
		Increase 5 yr. survival rates for head and neck cancer diagnosis by 5%	Survival 5 yr 65%	66%	68%	Survival 70%	Improve coordination of care for head & neck cancer patients	Create head & neck dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 78%
		Reduce Stage III & IV diagnosis of colon cancer by 10%	45	43	42	41	Earlier detection of colon cancer	Increase colonoscopy screening awareness, provide physician education, utilize EHR reminders	Oncology Service Line	37 (17.7% reduction)
		Increase 5 yr. survival rates for colon cancer by 5%	Survival 5 yr 59%	61%	63%	Survival 5 yr 64%	Improve coordination of care for colon patients	Create colon dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 68%

CHNA Dashboard
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY22 Outcomes
Substance Abuse #1	Reduce substance abuse to protect the health, safety and quality of life for all	Decrease number of overdose fatalities in Washington County by 10%	CY18 projected 59 deaths	< 53	< 48	< 43	Provide Medication Assisted Treatment (MAT) consultation to patients prior to discharge	Partner with **University of Maryland** to establish inpatient order set for MAT induction and provide in acute and ED	MMC BH Service Line	
							Increase community awareness of the opioid addiction risk, signs and symptoms and how to access help	Partner with **Priority Partners, Zion Baptist** and the **COA** to provide community seminars addressing opioid and heroin	Meritus Community Health	**80 (26% increase)**
							Increase early identification and intervention with pregnant women using substances	**Nurse outreach to primary and specialty care** practices	Women's Service Line	
		Decrease number of opioid prescriptions by 25%	2717 MEPPE	2038 MEPPE	1705 MEPPE	1359 MEPPE	Reduce provider use of prescribed opioids for front-line pain management	**Community provider** education of pain management alternatives	CMO, CPHO	1702 MEPPE (37%
		Decrease ED visits for addictions related conditions by 5%	FY18 1,409 visits	< 1,339 visits	< 1,272 visits	< 1,208 visits	Screen adult patients for substance use disorder and offer brief intervention and referral to treatment (SBIRT)	Partner with **Mosaic, Inc**. to ensure SBIRT training for all ED nurses with expansion to other high-risk acute areas; LDRP, Women's services, med/surge	MMC BH, ED and Women's and Children's Service Lines	
							Provide evidenced-based Peer Recovery Support program	Partner with **Mosaic and MD Dept of Health** to continue Peer Recovery Support services for warm handoff and community linkage	MMC BH, ED and Women's and Children's Service Lines	
							Complete ASAM evaluation and advocate for treatment when appropriate	Partner with lo**cal and regional treatment providers** to transfer patients to proper ASAM level of care. Provide consultative expertise to **Brooke's House** to ensure successful open / operation	MMC BH Service Line	788 (44% reduction)
							Support county-wide effort to fund and operationalize a 24/7 crisis center	Participation on **Washington County Senior Opioid Policy Task Force** for advocacy	MMC BH Service Line	
Mental Health #2	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services	Decrease ED visits related to mental health conditions by 7%	FY18 5,321 visits	< 5,196 visits	< 5,072 visits	< 4,948 visits	Provide community case management to patients at-risk for re-visit or hospitalization	Partner with **Potomac Case Management Services** to provide community case management	MMC BH Service Line	
							Provide "Accelerated Care Program" creating timely access to outpatient psychiatry evaluation to prevent ED visits	Coordinate with **community physicians** to access prompt psychiatry evaluation as diversion to ED visits	MMC BH Service Line	4367 (18% reduction)
							Increase access to psychiatric evaluation through telemedicine technology	Provide psychiatric evaluation to community patient via telemedicine; **SNF, FQHC, Human Development Council**	MMC BH Service Line	
		Decrease behavioral health hospital readmissions within 30 days by 5% over 3 years	FY18 Avg. 17%	< 15%	< 13%	< 12%	Improve coordination of discharge planning with community providers	Invite **community BH programs** to participate in patient treatment rounds and discharge planning from Meritus 1West	MMC BH Service Line	
							Improve clinical integration and treatment coordination with primary care	Provide embedded BH professionals in **community PCP** as expert resource, crisis stabilization and access to psychiatry	MMC BH Service Line	15% (reduced by 2%)
		Screen 75% of adults for depression in primary care practices annually	FY18 Avg. 32%	> 50%	> 65%	> 75%	Improve rate of standardized depression screening of adults in PCP offices	Protocolize PHQ 2/9 depression screening for all adults through Epic optimization	MPA, ACO, CTO	

pending Lori A

CHNA Dashboard
Meritus Medical Center Action Plan FY2020 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY22 Outcomes
Weight Status and Nutrition #3	Promote health and reduce risk of chronic disease through the consumption of a healthy diet and achievement of healthy body weight	Decrease the percentage of overweight adults whose BMI was over 25 but less than 30 by 2%	2018 28.2% MD BRFSS	> 27.5%	> 26.8%	> 26.2%	Provide BMI screening and healthy nutrition education and to adults	Partner with the **Consumer Goods Forum, YMCA, Priority Partners, WC Food Council** and **local farmers** to offer 3 new opportunities, activities or community events designed to improve healthy eating during 2019	Meritus Community Health and Outreach	**31.5% (+3.3%)**
		Children self-report that they increased their exercise and their consumption of fruits and vegetables by a minimum of 50% each FY.	Determine data	50% or >	50% or >	50% or >	Provide evidenced-based preventative services to at-risk youth	Partner with the **YMCA and Rehobath Learning Center** to provide evidenced-based Coordinated Approach To Child Health (CATCH) in their after-school program and summer camps	Meritus Community Health	CATCH suspended FY21 due to Covid
		Go for Bold! Lose 1M by 2030	N/A	Kick off	10,000 lbs lost	35,000 lbs lost	Community initiative to lose pounds; DO, EAT, BELIEVE in a healthy Washington County	Organizations pledge pounds, promote resources, registered users track weight	Meritus Community Health	11,200 lbs lost
		Decrease the percentage of the population that report food insecurity by 5%	*Changed 2021 to Conduent Index		151.93	Reduce by 10% (136)	Promote and increase access to food resources	Partner with **U.S. Food and Nutrition Servi**ce at local sites to promote Supplemental Nutrition Program for Women, Infants, and Children (SNAP/WIC) and the Farmers' Market Nutrition Program (FMNP)	Meritus Community Health	151.93 Index
		Decrease percentage of adults who are physically inactive by 2%	2018 26% RWJ	25%	24%	< 24%	Provide health education and health coaching in collaboration with community organizations that provide exercise classes and events	Partner with the **City Parks and Rec, YMCA, COA and the United Way** to offer 3 new opportunities, activities or community events designed to increase physical activity	Meritus Community Health	**28% (+2%)**
		Decrease the percentage of obese adults by 2%	2018 34% CDC	33%	32%	< 32%	Provide population health interventions at the community level through retail outlets, community centers and churches	Partner with **Consumer Goods Forum, Healthy Washington County, Zion Baptist and the COA** to provide outreach, health education, dietary counseling and free screenings to targeted neighborhoods.	Meritus Community Health	**37% (+3%) RWJ CHR**
Wellness #4	Improve health-related quality of life and well-being for all	MMG practice patient population has SDOH documented; unique patients with visits each month	10%	New	10%	25%	Screen for SDOH with percentage of adult MMG patients per month	Outpatient RN Care Managers to begin completing SDOH screen and provide linkage to resources to address, PRN.	ACO, CTO, MPA	17% (+7%)
		Implement community wellness and healthy lifestyle strategies within 3 workplaces	0	1	2	3	Help at least 3 employers develop workplace wellness programs	Partner with the **Consumer Goods Forum, local Chamber of Commerce and YMCA/HEAL** to develop the One for Good initiative in Washington County	Meritus Community Health	41 Partners Go for Bold
		Decrease the proportion of adults that report that they smoke cigarettes by 6%	2018 18.8% MD BRFSS	16.8%	14.8%	12.8%	Make access to smoking cessation services widely available	Partner with local **Health Dept**., Meritus Respiratory Care, Care Management and the **Consumer Goods Forum** to support smoking cessation classes through education, referral and events	Meritus Community Health	16.4% (decrease 2.4%)
		Improve early identification of student health intervention needs	Provide screen 100% eligible	100%	100%	100%	Provide screening of school children to identify risk educational opportunities and needs	Partner with **Washington Co. Public Schools** to provide health screening and education to at-risk children and families	Meritus School Nursing Program	Suspended FY21 due to Covid

Community Health Needs Assessment
Meritus Medical Center Action Plan FY2019 - FY2022
Strategic Plan Goal: 16b Partner with community agencies/programs on health, prevention, and wellness with a focus on CHNA areas of need

HEALTH NEED	OBJECTIVE	EXPECTED OUTCOME	Baseline	FY20	FY21	FY22	STRATEGIES	TACTICS	Accountability	FY22 Outcomes
Diabetes #5	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 2%	10.7 per 100 adults MD Vital Stats 2015	10%	9.4%	8.7%	Make the evidenced-based Diabetes Prevention Program widely available in Washington County	Partner with the local **Dept. of Healt**h to provide diabetes prevention program and **community providers** and **pharmacists** to identify at-risk patients	Meritus Community Health	**10.3% (+0.3%)**
		Decrease the diabetes mortality rate by 2% over three years	35.9 per 100,000 MD Vital Stats 2016	< 35	< 34	< 33	Increase availability of diabetes education and support to primary care practices	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	32 MD Vital Stats 2019
		Reduce # of ED visits for diabetes by 5%	FY18 778 visits Meritus	< 764	< 752	< 739	Provide diabetes education, dietary counseling and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	Partner with the **Hagerstown Parks & Rec, the Health Dept and the Senior Center** to provide Living Well and outreach services	Meritus Community Health	**830 ED visits (+6.3%)**
		ACO measure: 90% of patients age 18-75 with a diagnosis of diabetes will have a Hemoglobin A1c below 9%.	Determine data	75%	80%	85%	Provide individualized Diabetes Education and 1:1 Self-Management support to high risk patients to improve disease control and decrease unnecessary hospital utilization.	Utilize embedded RN care managers and diabetic educators at Meritus Medical Group practices to provide education and chronic disease care management services	MPA, ACO, CTO	79.4%
Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1%	194 per 100,000 MD Vital Stats 2016	193	192	< 192	Provide community and employer health education events to increase heart health awareness	Partner with the **Health Department, Meritus Cardiac Services** to promote healthy lifestyle education and evironments	Meritus Community Health	184.6 per 100k MD Vital Stats 2019
		Over 3 years, 25% of class participants will attempt to quit by one month, and/or sustain their efforts at 6 and/or 12 months	2%	10%	20%	25%	Provide evidence-based smoking cessation program to teens and adults	Partner with the **Meritus School Health** and **Health Department** to provide smoking cessation programs and support	Meritus Community Health	Measure suspended
		Decrease the # of ED visits for hypertension by 5%	FY18 375 visits Meritus	368	362	< 356	Provide heart health screening and educational interventions at the community level	Partner with **local churches** to provide blood pressure screening and education	Meritus Parish Nursing Program	Data says 1734 pulling secondary dx
							Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	Partner with **Zion Baptist, Wash. Co. Parks and Rec** and the **Senior Center** in the provision of screenings and cardiac health education to their populations	Meritus Community Health	1,979 BP screens 2021
		ACO Measure: 90% of patients age 18-75 with a diagnosis of HTN will have a BP < 140/90.	Determine data			90% pts BP 140/90 or <	Provide individualized hypertension education and 1:1 self-management support to improve blood pressure control	Utilize Meritus outpatient care managers to provide education, discharge follow up, transition of care, and chronic disease management services	MPA, ACO, CTO	Measure suspended
Cancer #7	Reduce the mortality of cancer cases and improve earlier detection and diagnosis	Reduce Stage III & IV lung cancer diagnosis by 10%	158	152	148	142	Earlier detection of lung cancer	Low dose CT screening, Physician education, Utilize EHR reminders	Oncology Service Line	145 (8.2% reduction)
		Increase 5 yr. survival rates for head and neck cancer diagnosis by 5%	Survival 5 yr 65%	66%	68%	Survival 70%	Improve coordination of care for head & neck cancer patients	Create head & neck dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 78%
		Reduce Stage III & IV diagnosis of colon cancer by 10%	45	43	42	41	Earlier detection of colon cancer	Increase colonoscopy screening awareness, provide physician education, utilize EHR reminders	Oncology Service Line	37 (17.7% reduction)
		Increase 5 yr. survival rates for colon cancer by 5%	Survival 5 yr 59%	61%	63%	Survival 5 yr 64%	Improve coordination of care for colon patients	Create colon dx steering, develop clinical pathway, add dedicated navigator to reduce barriers and improve compliance	Oncology Service Line & RN Navigator	Survival 68%

Meritus Health

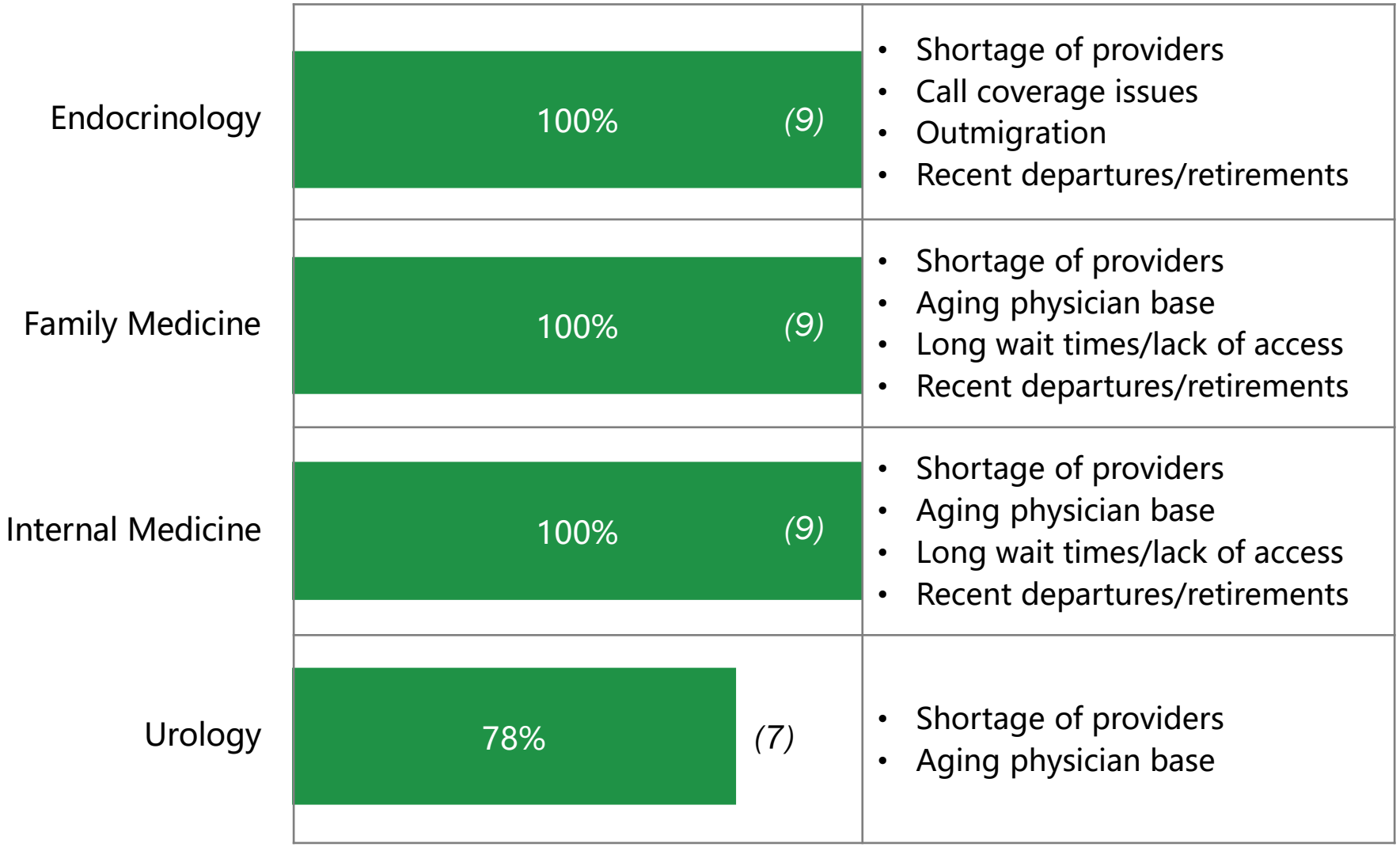
Provider Gap Analysis and Development Plan

July 1, 2019 – June 30, 2022

Local Market Reality Findings

Leadership Interviews

Interviews: Top Areas of Identified Need



3d Health, Inc.

Interviews: Top Areas of Identified Need

Hematology/Oncology	56%	*(5)*	• Shortage of providers • Recent departures/retirements • Outmigration
Neurology	56%	*(5)*	• Shortage of providers • Call coverage issues • Aging physician base • Outmigration
Pediatrics	56%	*(5)*	• Shortage of providers • Aging physician base • Call coverages issues • Outmigration

Local Market Reality Findings

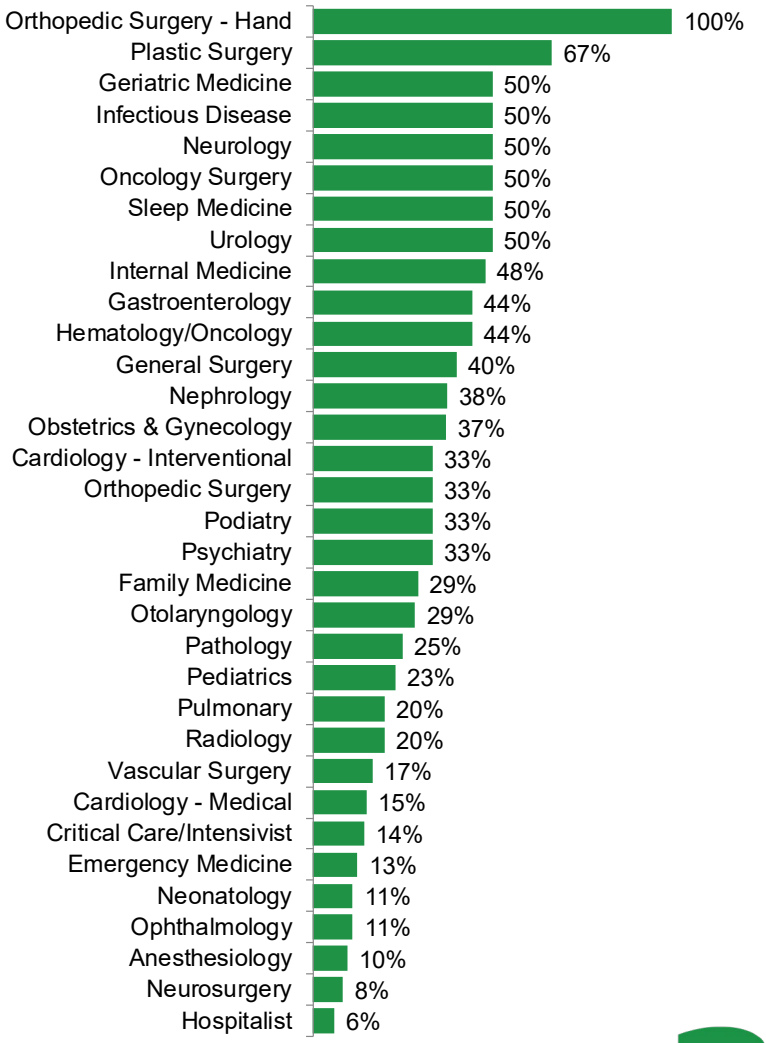
Physician Survey

123 Providers Responded to the Survey

Specialty	Responses	Sent	Response Rate
Primary Care	44	129	34%
Medical Sub-Specialties	22	85	26%
Surgical Sub-Specialties	31	110	28%
Hospital-Based Specialties	26	202	13%
Total, All Specialties	**123**	**526**	**23%**
3d Health Median (Distribution List 400-700)			*18%*

- 123 providers, or 23% of those who received a Survey, responded, which is higher than the 3d Health experience for Surveys with a similar distribution size.

Responses by Specialty

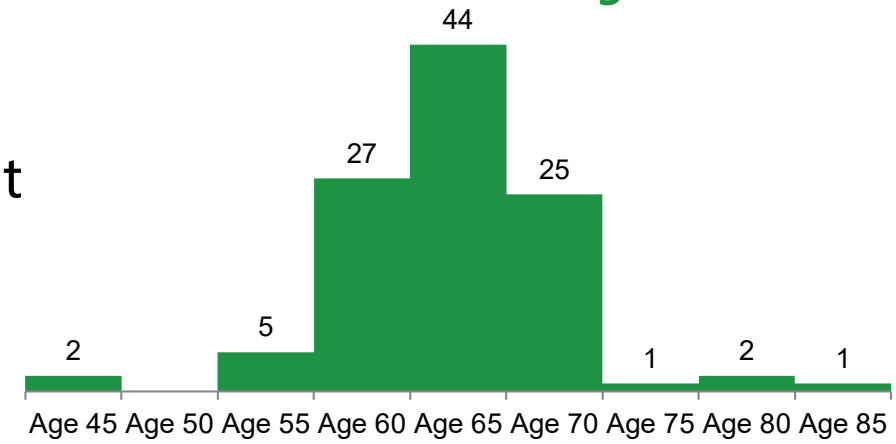


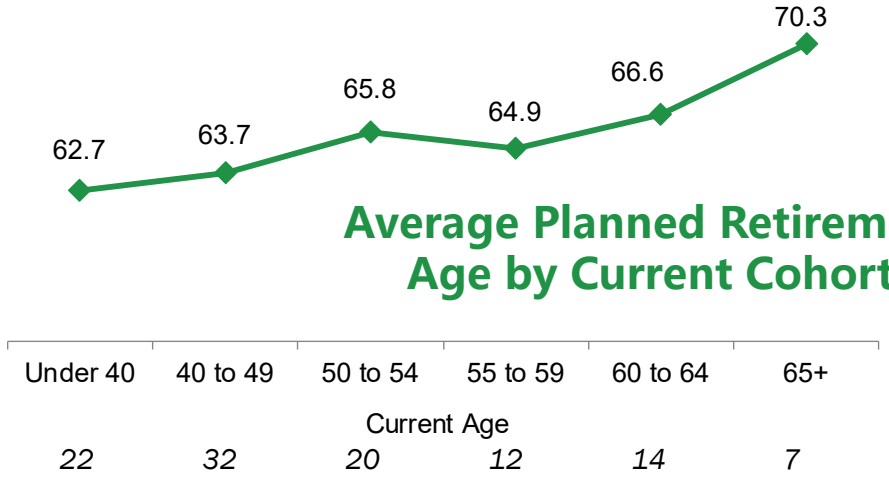
3d Health, Inc.

Average Planned Retirement Age is 64.8 Years Old

- 87%, or 107, of the 123 Survey respondents completed the retirement question.
- The average planned retirement is higher for primary care respondents:
  - Primary Care: 65.1 years
  - Specialist: 64.6 years

Frequency of Planned Retirement Age





Average Planned Retirement Age by Current Cohort

- Average planned retirement generally increases with the age of the respondent. Among physicians currently age 55 or older, the average planned retirement is 66.8 years of age.

3d Health, Inc.

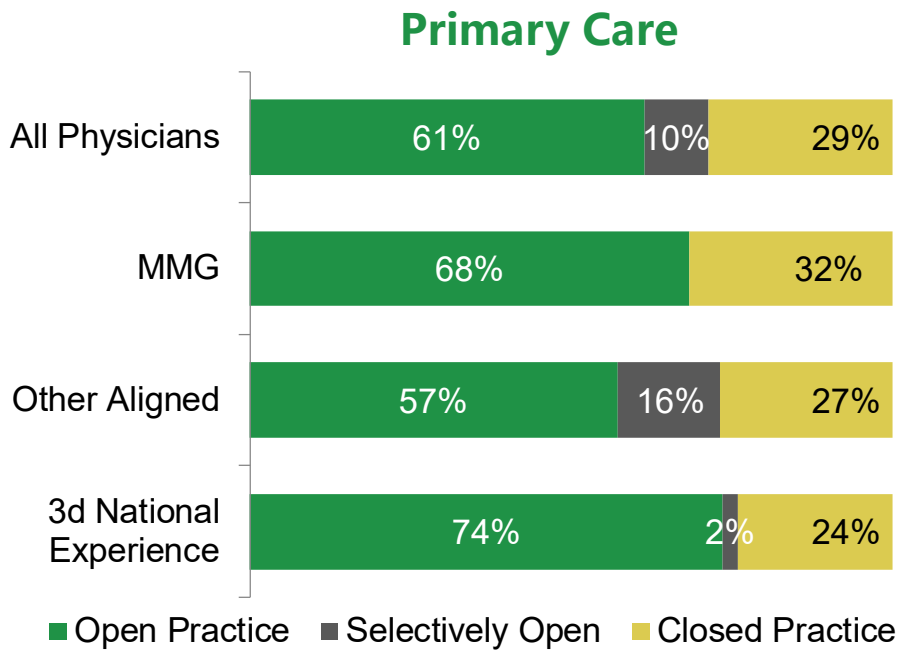
Local Market Reality Findings

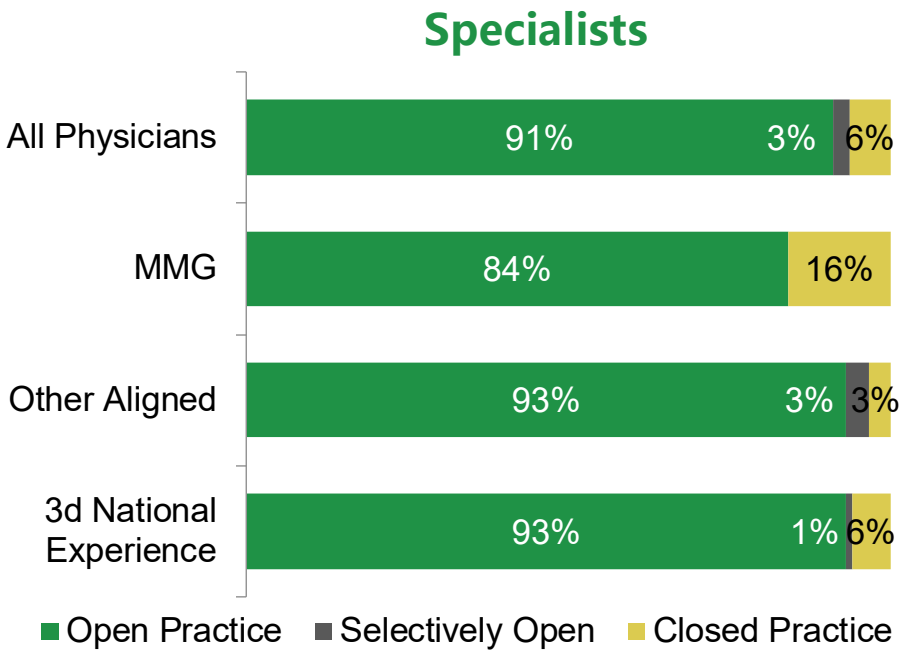
Patient Access Study

Patient Access Study Methodology

- 3d Health completed 195 secret shopper calls to physicians' offices to test whether a physician is open to new commercial patients, as well as wait times for an appointment.
- The calls were completed between June 19th and June 20th.
- For primary care, the caller asked for a patient appointment in order to establish as a new patient.
- For specialists, the caller asked for a consult upon the advice of their primary care physician.
- Medical necessity was purposefully left out of the Study.
- 3d Health documented wait times for next available appointments on a per physician basis.
- Benchmarks used include 3d Health's actual experience across the country as well as two different consumer surveys of over 17,000 people.

Open vs. Closed Physicians



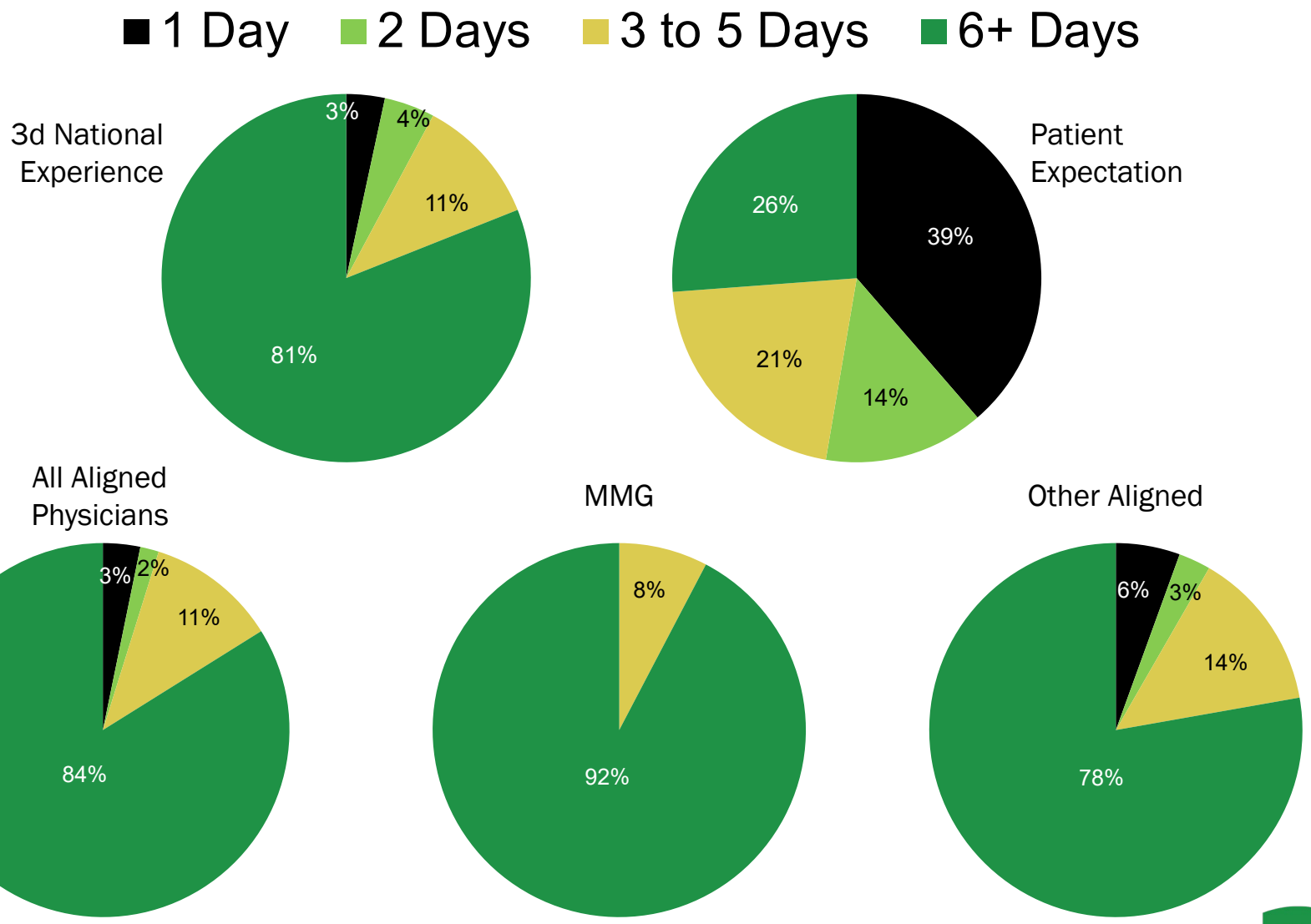


- 27 primary care physicians and 7 specialist physicians aligned with Meritus Health are currently not accepting new commercial patients.
- 15 of the 34 physicians closed to new patients referred us to another physician or ACP.

Note: Selectively Open is defined as a practice that requires the physician's review of the prospective patient's information before determining whether or not they will schedule an appointment.

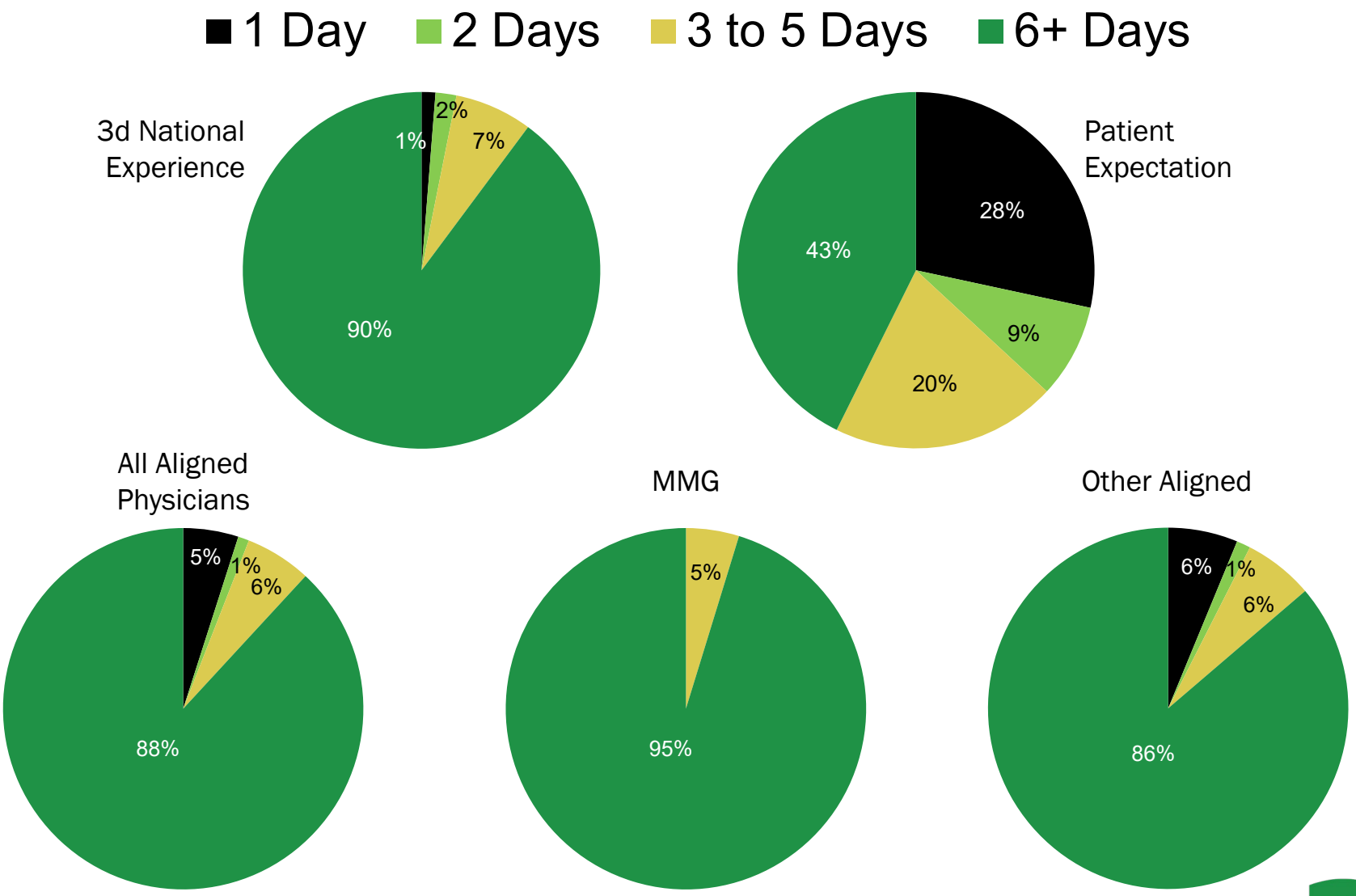
3d Health, Inc.

New Patient Appointment Wait Times: Primary Care



3d Health, Inc.

New Patient Appointment Wait Times: Specialist



3d Health, Inc.

New Patient Appointment Access by Specialty

- The average wait time for the next available, new commercial patient appointment across all specialties is 28 days.
- Average wait times are higher than the 3d Health national experience in 16 specialties, closed or selectively open in another 4 specialties.

	Open Physicians		Wait Time (Days)			National
Specialty	Number	Percent	Average	Max	Min	Average
Allergy & Immunology	1	100%	19	19	19	21
Bariatric Surgery	2	100%	28	28	28	22
Breast Surgery	1	100%	27	27	27	18
Cardiology - Electrophysiology	1	100%	22	22	22	29
Cardiology - Interventional	2	100%	24	26	21	28
Cardiology - Medical	9	90%	25	49	14	26
Endocrinology	-	-	Closed	Closed	Closed	43
Family Medicine	23	58%	39	196	2	22
Gastroenterology	6	100%	31	49	6	29
General Surgery	9	100%	18	28	5	15
Geriatric Medicine	1	100%	15	15	15	26
Hematology/Oncology	5	100%	29	70	2	16
Infectious Disease	2	100%	9	12	6	19
Internal Medicine	17	65%	42	152	5	24
Nephrology	6	100%	30	41	14	31
Neurology	5	100%	34	49	5	39
Neurosurgery - Cranial	2	100%	42	42	42	21
Neurosurgery - Spine	3	100%	42	42	41	26
Obstetrics & Gynecology	11	92%	33	75	8	28
Ophthalmology	3	60%	3	8	-	28
Orthopedic Surgery - General	11	100%	11	21	5	16
Orthopedic Surgery - Hand	1	100%	19	19	19	18
Otolaryngology	5	100%	6	14	1	18
Pain Management	2	100%	64	64	63	28
Pediatrics	10	45%	25	75	1	19
Physical Medicine & Rehab	-	-	Selectively	Selectively	Selectively	27
Plastic Surgery	3	100%	18	28	7	24
Podiatry	4	100%	17	35	6	12
Psychiatry	-	-	Closed	Closed	Closed	34
Pulmonary	5	100%	7	9	6	32
Rheumatology	-	-	Closed	Closed	Closed	44
Sleep Medicine	5	100%	7	9	6	35
Thoracic Surgery	1	100%	14	14	14	17
Urology	5	100%	54	70	36	23
Vascular Surgery	2	100%	31	49	12	19

> *National Average*

Local Market Reality Summary

Specialty	Interviews (% mentioned as a need)	Survey (% "Agree" there is a need)	Patient Access (Average Wait Time)
Family Medicine	100%	66%	39
Geriatric Medicine	-	72%	15
Internal Medicine	100%	62%	42
Advanced Care Provider	-	34%	NA
Nurse Midwife	-	14%	NA
Obstetrics & Gynecology	22%	32%	33
Pediatrics	56%	26%	25
Urgent Care	-	16%	NA
Allergy & Immunology	11%	54%	19
Cardiology - Medical	-	13%	25
Cardiology - Electrophysiology	22%	32%	22
Cardiology - Interventional	-	25%	24
Dermatology	22%	68%	NA
Endocrinology	100%	81%	Closed
Gastroenterology	44%	20%	31
Hematology/Oncology	56%	28%	29
Infectious Disease	-	43%	9
Nephrology	22%	25%	30
Neurology	56%	59%	34
Pain Management	11%	55%	64
Physical Medicine & Rehab	-	36%	Selectively
Psychiatry	22%	72%	Closed
Pulmonary	11%	26%	7
Reproductive Endocrinology	-	41%	NA

Specialty	Interviews (% mentioned as a need)	Survey (% "Agree" there is a need)	Patient Access (Average Wait Time)
Rheumatology	33%	78%	Closed
Sleep Medicine	-	22%	7
Sports Medicine	-	22%	NA
Bariatric Surgery	11%	35%	28
Breast Surgery	-	40%	27
Cardiac Surgery	22%	53%	NA
Colon & Rectal Surgery	22%	41%	NA
General Surgery	44%	26%	18
Maternal Fetal Medicine	-	41%	NA
Neurosurgery - Cranial	33%	42%	42
Neurosurgery - Spine	33%	34%	42
Oncology Surgery	-	52%	NA
Ophthalmology	-	16%	3
Orthopedic Surgery - General	22%	8%	11
Orthopedic Surgery - Hand	-	27%	19
Orthopedic Surgery - Spine	-	31%	NA
Otolaryngology	22%	28%	6
Plastic Surgery	22%	38%	18
Podiatry	-	10%	17
Thoracic Surgery	22%	55%	14
Transplant Surgery	-	45%	NA
Urology	78%	46%	54
Vascular Surgery	11%	41%	31

Identified as a need by 50% or more of the respondents; average wait time greater than the 3d National Experience

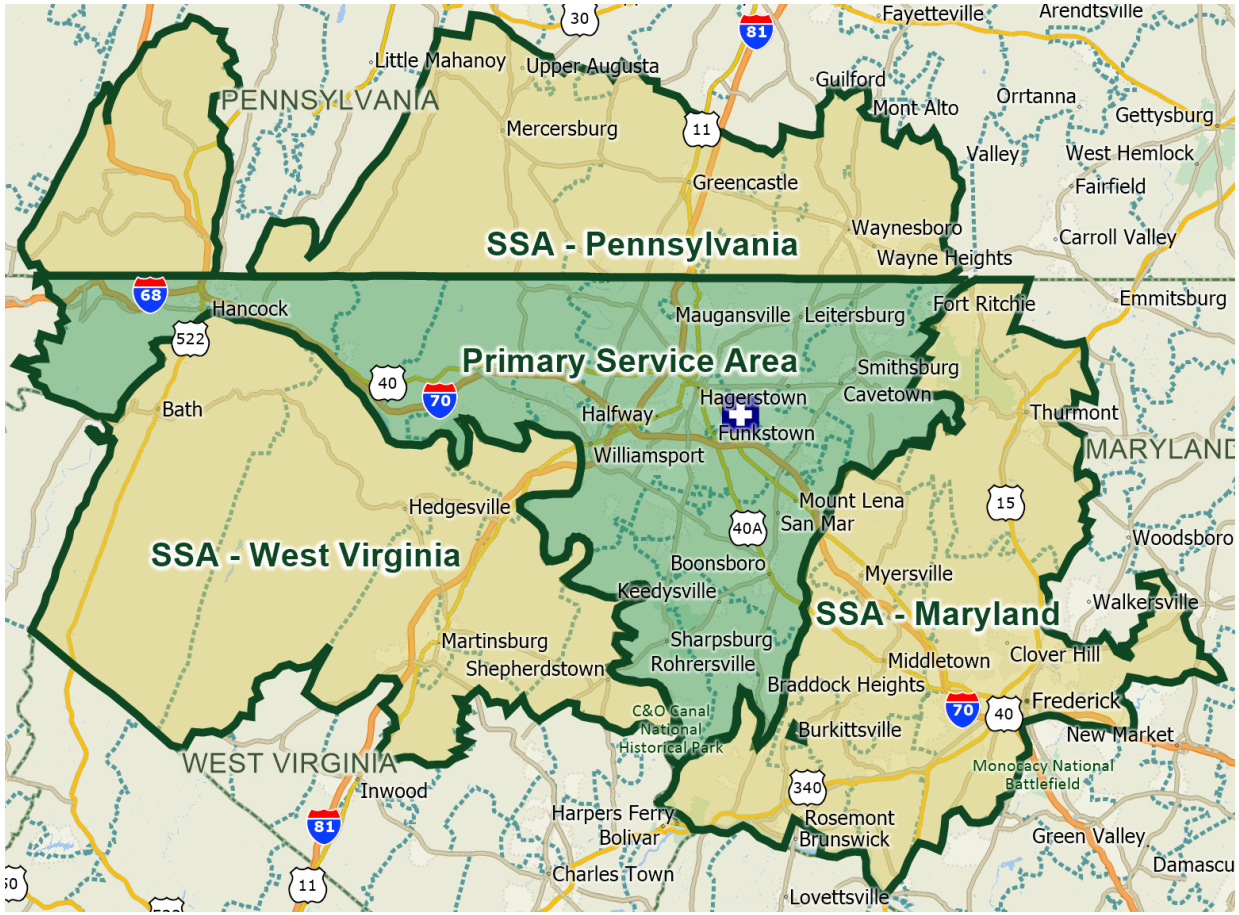
- Family Medicine, Internal Medicine, Endocrinology and Neurology were identified as areas of need, both through the Survey and by the Interview participants.

Market Definition

Meritus Health Planning Service Area

- The Planning Service Area ("Market") was defined by Meritus Health and currently includes 487,080 residents.

Service Area	Population		3 Year % Change
	2019	2022	
PSA	150,681	152,635	1.3%
SSA - MD	161,061	165,460	2.7%
SSA - PA	62,682	63,251	0.9%
SSA - WV	112,656	115,239	2.3%
Total	**487,080**	**496,585**	**2.0%**



3d Health, Inc.

Primary Care Analysis

Current & Projected Market Need

Primary Care Market Surplus/(Deficit)

- The current market surplus/(deficit) includes 100% of supply and demand for physicians within the Service Area, regardless of alignment with Meritus Health.

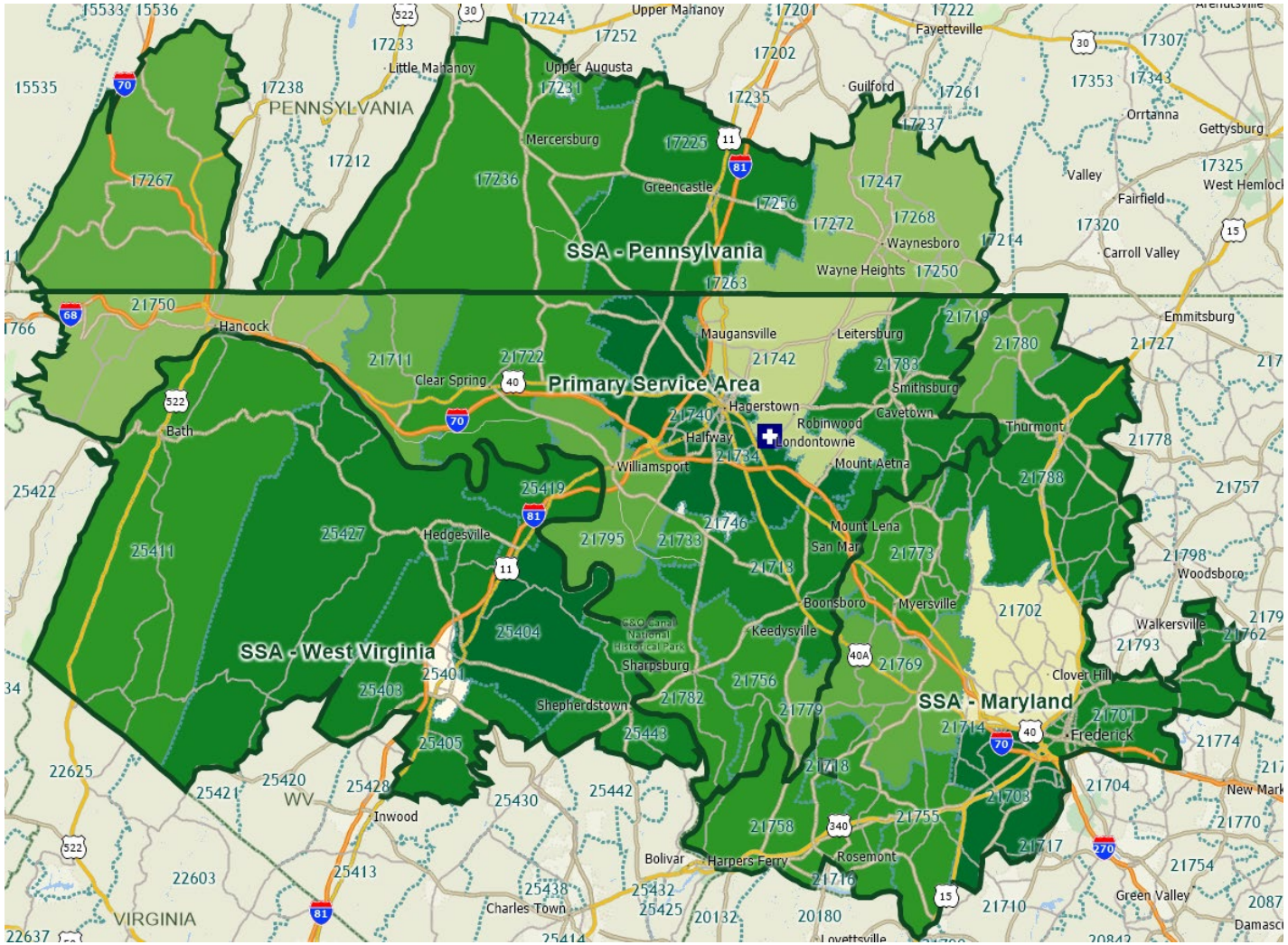
Specialty	Current Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Primary Care							
Family Medicine	*128.7*	*161.5*	*(32.8)*	*(15.1)*	*(4.5)*	*1.0*	*(14.4)*
Internal Medicine	*74.3*	*98.8*	*(24.5)*	*(10.4)*	*(8.1)*	*(6.3)*	*0.3*
Advanced Care Provider	*49.7*	*66.0*	*(16.3)*	*(4.7)*	*(5.9)*	*(2.4)*	*(3.2)*
General Primary Care	252.7	326.3	(73.6)	(30.2)	(18.5)	(7.6)	(17.3)
Geriatric Medicine	1.8	6.8	(5.0)	(0.4)	(2.1)	(1.0)	(1.5)
Nurse Midwife	*3.8*	*1.4*	*2.4*	*3.4*	*(0.5)*	*(0.2)*	*(0.3)*
Obstetrics & Gynecology	*55.0*	*64.9*	*(9.9)*	*0.8*	*(2.7)*	*(3.2)*	*(4.7)*
Obstetrics & Gynecology - Total	58.8	66.3	(7.5)	4.2	(3.2)	(3.4)	(5.1)
Pediatrics	70.2	60.7	9.6	6.3	13.7	(5.1)	(5.3)
Urgent Care	29.0	6.9	22.1	8.8	(1.2)	13.3	1.1
Total Primary Care	**412.5**	**466.9**	**(54.5)**	**(11.3)**	**(11.3)**	**(3.8)**	**(28.0)**

- The projected market surplus/(deficit) includes growth and aging of the population within the demand, and removes all physicians 65 or older from the supply.

Specialty	Projected Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Primary Care							
Family Medicine	*109.2*	*165.1*	*(55.9)*	*(22.2)*	*(12.2)*	*(3.2)*	*(18.3)*
Internal Medicine	*54.8*	*102.9*	*(48.1)*	*(18.8)*	*(9.9)*	*(9.6)*	*(9.8)*
Advanced Care Provider	*49.7*	*68.5*	*(18.8)*	*(5.3)*	*(6.9)*	*(2.6)*	*(3.9)*
General Primary Care	213.7	336.5	(122.9)	(46.4)	(29.0)	(15.5)	(32.1)
Geriatric Medicine	1.3	7.3	(5.9)	(1.1)	(2.2)	(1.0)	(1.6)
Nurse Midwife	*3.8*	*1.4*	*2.4*	*3.4*	*(0.5)*	*(0.2)*	*(0.3)*
Obstetrics & Gynecology	*47.0*	*65.7*	*(18.7)*	*(2.3)*	*(4.2)*	*(3.2)*	*(8.9)*
Obstetrics & Gynecology - Total	50.8	67.1	(16.4)	1.1	(4.7)	(3.4)	(9.3)
Pediatrics	64.2	60.7	3.5	2.3	13.7	(5.1)	(7.4)
Urgent Care	29.0	7.2	21.8	8.8	(1.3)	13.3	1.1
Total Primary Care	**359.0**	**478.9**	**(119.9)**	**(35.4)**	**(23.6)**	**(11.7)**	**(49.3)**

Primary Care Market Need by ZIP Code

City	General PCP Need
Primary Service Area	
Smithsburg	(5.6)
Boonsboro	(5.4)
Hagerstown	(4.9)
Clear Spring	(3.8)
Sharpsburg	(2.9)
Fairplay	(2.8)
Keedysville	(2.7)
Cascade	(1.0)
Maugansville	(0.9)
Williamsport	(0.8)
Big Pool	(0.7)
Rohrersville	(0.7)
Hancock	2.1
Seconary Service Area - MD	
Thurmont	(6.0)
Knoxville	(3.5)
Jefferson	(3.4)
Myersville	(2.7)
Middletown	(1.9)
Sabillasville	(1.1)
Frederick	0.2
Seconary Service Area - PA	
Greencastle	(4.9)
Mercersburg	(3.5)
Warfordsburg	(2.0)
Waynesboro	2.7
Seconary Service Area - WV	
Hedgesville	(8.0)
Shepherdstown	(5.4)
Falling Waters	(5.2)
Berkeley Springs	(2.9)
Martinsburg	4.1



3d Health, Inc.

Primary Care Analysis

Meritus Health Primary Care Served Lives

Meritus Health Primary Care Served Lives Today

Specialty	MMG			Other Aligned			Total		
	Current FTE Supply	Served Lives	% of Market	Current FTE Supply	Served Lives	% of Market	Current FTE Supply	Served Lives	% of Market
Primary Care									
Family Medicine	*13.20*	65,898	13.5%	*16.17*	50,811	10.4%	*29.37*	116,709	24.0%
Geriatric Medicine	*0.67*			*1.17*			*1.84*		
Internal Medicine	*7.80*			*12.80*			*20.60*		
Advanced Care Provider	*7.84*			*5.36*			*13.20*		
Urgent Care	*7.98*			-			*7.98*		
General Primary Care	37.48			35.50			72.98		
Nurse Midwife	*1.40*	38,424	15.7%	*2.40*	25,893	10.6%	*3.80*	64,317	26.3%
Obstetrics & Gynecology	*7.40*			*5.80*			*13.20*		
Obstetrics & Gynecology - Total	8.80			8.20			17.00		
Pediatrics	*2.67*	5,687	5.3%	15.19	26,911	25.0%	17.86	32,598	30.3%

Specialty	Current PSA			Current SSA - MD			Current SSA - PA			Current SSA - WV		
	Current FTE Supply	Served Lives	% of Market	Current FTE Supply	Served Lives	% of Market	Current FTE Supply	Served Lives	% of Market	Current FTE Supply	Served Lives	% of Market
Primary Care												
Family Medicine	*28.07*	97,950	65.0%	*1.30*	3,258	2.0%	-	8,311	13.3%	-	7,190	6.4%
Geriatric Medicine	*1.84*			-			-			-		
Internal Medicine	*19.25*			-			*1.35*			-		
Advanced Care Provider	*13.20*			-			-			-		
Urgent Care	*7.98*			-			-			-		
General Primary Care	70.33			1.30			1.35			-		
Nurse Midwife	*3.80*	52,943	71.4%	-	1,972	2.4%	-	4,131	13.1%	-	5,271	9.2%
Obstetrics & Gynecology	*13.20*			-			-			-		
Obstetrics & Gynecology - Total	17.00			-			-			-		
Pediatrics	17.86	27,358	83.2%	-	910	2.5%	-	2,321	16.8%	-	2,008	8.1%

Projected (FY 2022) Meritus Served Lives

Specialty	Current PSA		Projected (FY 2022) PSA		Current SSA - MD		Projected (FY 2022) SSA - MD	
	Served Lives	% of Market	Served Lives	% of Market	Served Lives	% of Market	Served Lives	% of Market
Primary Care								
Family Medicine	97,950	65.0%	99,220	65.0%	3,258	2.0%	4,137	2.5%
Geriatric Medicine								
Internal Medicine								
Advanced Care Provider								
Urgent Care								
General Primary Care								
Nurse Midwife	52,943	71.4%	54,484	72.5%	1,972	2.4%	2,026	2.4%
Obstetrics & Gynecology								
Obstetrics & Gynecology - Total								
Pediatrics	27,358	83.2%	27,646	84.0%	910	2.5%	910	2.5%

Specialty	Current SSA - PA		Projected (FY 2022) SSA - PA		Current SSA - WV		Projected (FY 2022) SSA - WV	
	Served Lives	% of Market	Served Lives	% of Market	Served Lives	% of Market	Served Lives	% of Market
Primary Care								
Family Medicine	8,311	13.3%	9,045	14.3%	7,190	6.4%	8,067	7.0%
Geriatric Medicine								
Internal Medicine								
Advanced Care Provider								
Urgent Care								
General Primary Care								
Nurse Midwife	4,131	13.1%	4,470	14.0%	5,271	9.2%	5,397	9.2%
Obstetrics & Gynecology								
Obstetrics & Gynecology - Total								
Pediatrics	2,321	16.8%	2,339	17.0%	2,008	8.1%	2,018	8.1%

Projected Meritus Primary Care Need

Specialty	Projected Meritus FTEs		
	Supply	Demand	Surplus / (Deficit)
Primary Care			
Family Medicine	*25.7*	*30.7*	*(5.1)*
Internal Medicine	*13.5*	*21.9*	*(8.5)*
Advanced Care Provider	*13.2*	*14.0*	*(0.8)*
General Primary Care	52.3	66.6	(14.3)
Geriatric Medicine	1.3	2.0	(0.6)
Nurse Midwife	*3.8*	*3.8*	*(0.0)*
Obstetrics & Gynecology	*12.2*	*13.6*	*(1.4)*
Obstetrics & Gynecology - Total	16.0	17.4	(1.4)
Pediatrics	14.7	18.0	(3.4)
Urgent Care	8.0	8.1	(0.1)
Total Primary Care	**92.3**	**112.1**	**(19.9)**

- The Projected Meritus Health Surplus/(Deficit) includes Served Lives targets, growth and aging of the population and removes all physicians 65 or older from the supply.

Specialist Analysis

Market Need

Medical Specialist Market Surplus/(Deficit)

- The current market surplus/(deficit) includes 100% of supply and demand for physicians within the Planning Service Area, regardless of alignment with Meritus Health.

Specialty	Current Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Medical Sub-Specialties							
Allergy & Immunology	5.8	9.4	(3.6)	(2.1)	1.9	(1.2)	(2.2)
Cardiology - Medical	*49.6*	*36.0*	*13.6*	*1.8*	*13.4*	*(0.3)*	*(1.4)*
Cardiology - Electrophysiology	*1.0*	*2.9*	*(1.9)*	*0.1*	*(0.9)*	*(0.4)*	*(0.7)*
Cardiology - Interventional	*2.0*	*4.5*	*(2.5)*	*0.6*	*(1.4)*	*(0.6)*	*(1.1)*
Cardiology - Total	52.6	43.3	9.2	2.4	11.2	(1.3)	(3.1)
Dermatology	12.0	18.1	(6.1)	(5.7)	4.2	(2.4)	(2.2)
Endocrinology	14.3	8.1	6.2	(1.5)	5.4	(0.8)	3.1
Gastroenterology	19.0	22.1	(3.1)	(0.9)	2.9	(2.0)	(3.1)
Hematology/Oncology	21.1	12.3	8.8	1.1	7.5	0.1	0.1
Infectious Disease	3.0	10.9	(7.9)	(1.5)	(2.5)	(1.5)	(2.5)
Nephrology	12.9	14.5	(1.6)	0.2	2.4	(1.9)	(2.4)
Neurology	18.8	19.0	(0.2)	(0.4)	5.2	(2.6)	(2.4)
Pain Management	13.7	4.6	9.1	1.3	4.2	2.4	1.3
Physical Medicine & Rehab	10.0	14.5	(4.5)	1.5	(0.7)	(1.9)	(3.3)
Psychiatry	26.2	27.8	(1.5)	(1.5)	3.8	(3.6)	(0.2)
Pulmonary	8.4	15.4	(7.0)	(1.6)	(4.8)	0.7	(1.4)
Reproductive Endocrinology	2.0	0.5	1.5	(0.2)	1.8	(0.1)	(0.1)
Rheumatology	8.0	6.7	1.3	(0.9)	2.6	(0.9)	0.4
Sleep Medicine	3.8	2.7	1.1	(0.0)	1.9	(0.1)	(0.6)
Sports Medicine	0.5	3.2	(2.7)	(1.0)	(1.1)	0.1	(0.7)
Total Medical Specialties	**232.1**	**233.3**	**(1.2)**	**(10.7)**	**45.8**	**(16.9)**	**(19.4)**

Surgical Specialist Market Surplus/(Deficit)

- The current market surplus/(deficit) includes 100% of supply and demand for physicians within the Planning Service Area, regardless of alignment with Meritus Health.

Specialty	Current Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Surgical Sub-Specialties							
Cardiac Surgery	*-*	*3.0*	*(3.0)*	*(1.0)*	*(0.9)*	*(0.4)*	*(0.7)*
Thoracic Surgery	*2.0*	*4.2*	*(2.2)*	*(0.3)*	*(0.3)*	*(0.6)*	*(1.0)*
Cardio/Thoracic Surgery	2.0	7.3	(5.3)	(1.3)	(1.3)	(1.0)	(1.7)
Bariatric Surgery	*1.8*	*3.4*	*(1.6)*	*(0.3)*	*(1.2)*	*0.7*	*(0.8)*
Breast Surgery	*4.0*	*3.6*	*0.4*	*(0.1)*	*1.9*	*(0.5)*	*(0.8)*
Colon & Rectal Surgery	*-*	*1.9*	*(1.9)*	*(0.6)*	*(0.6)*	*(0.3)*	*(0.4)*
General Surgery	*29.6*	*16.2*	*13.4*	*2.0*	*6.8*	*2.9*	*1.8*
Oncology Surgery	*-*	*0.7*	*(0.7)*	*(0.2)*	*(0.2)*	*(0.1)*	*(0.2)*
Transplant Surgery	*-*	*0.0*	*(0.0)*	*(0.0)*	*(0.0)*	*(0.0)*	*(0.0)*
Vascular Surgery	*10.1*	*4.7*	*5.3*	*1.2*	*4.9*	*(0.7)*	*(0.1)*
General Surgery - Total	45.5	30.5	15.0	2.0	11.5	2.1	(0.6)
Maternal Fetal Medicine	1.0	2.1	(1.1)	(0.6)	0.3	(0.3)	(0.5)
Neurosurgery - Cranial	*3.1*	*2.5*	*0.6*	*(0.3)*	*1.7*	*(0.3)*	*(0.4)*
Neurosurgery - Spine	*3.9*	*7.4*	*(3.5)*	*(0.3)*	*(0.9)*	*(1.0)*	*(1.4)*
Neurosurgery - Total	7.0	10.0	(3.0)	(0.6)	0.8	(1.3)	(1.8)
Ophthalmology	34.8	30.0	4.8	3.9	6.9	(2.5)	(3.5)
Orthopedic Surgery - General	*43.4*	*31.5*	*11.9*	*(0.8)*	*9.8*	*2.1*	*0.7*
Orthopedic Surgery - Hand	*0.6*	*2.0*	*(1.4)*	*(0.3)*	*(0.4)*	*(0.3)*	*(0.5)*
Orthopedic Surgery - Spine	*1.0*	*2.6*	*(1.6)*	*(0.8)*	*0.1*	*(0.3)*	*(0.6)*
Orthopedic Surgery - Total	45.0	36.2	8.8	(1.8)	9.5	1.5	(0.4)
Otolaryngology	16.3	18.0	(1.7)	(0.6)	2.2	(2.1)	(1.2)
Plastic Surgery	7.0	12.5	(5.5)	(0.9)	0.0	(1.7)	(2.9)
Podiatry	44.1	13.8	30.3	11.0	16.2	1.3	1.8
Urology	15.0	14.5	0.5	0.4	2.0	(1.5)	(0.4)
Total Surgical Sub-Specialties	**217.7**	**174.8**	**43.0**	**11.4**	**48.1**	**(5.4)**	**(11.2)**
Total All Sub-Specialties	**449.8**	**408.0**	**41.8**	**0.7**	**93.9**	**(22.3)**	**(30.5)**

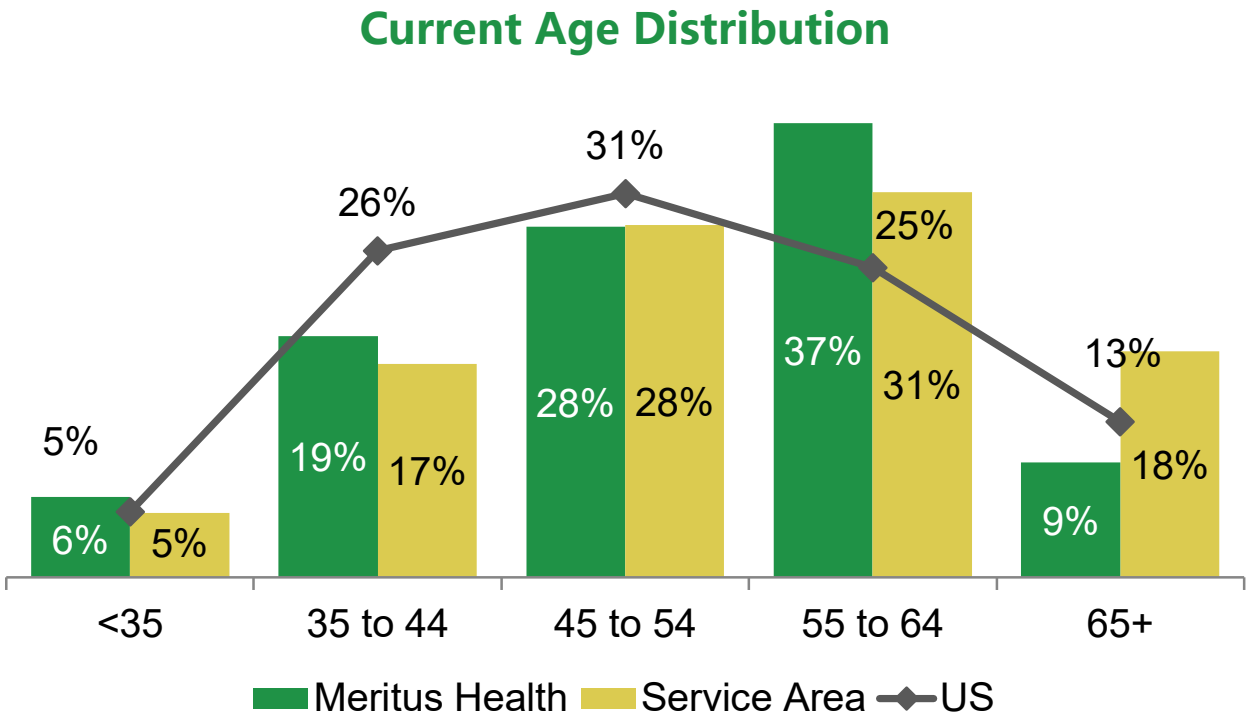
Projected Surgical Specialists in the Market

- The projected market surplus/(deficit) includes growth and aging of the population within the demand, and removes all physicians 65 or older from the supply.

Specialty	Projected Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Surgical Sub-Specialties							
Cardiac Surgery	-	3.2	(3.2)	(1.0)	(1.0)	(0.4)	(0.8)
Thoracic Surgery	1.0	4.4	(3.4)	(1.4)	(0.4)	(0.6)	(1.0)
Cardio/Thoracic Surgery	1.0	7.7	(6.7)	(2.4)	(1.4)	(1.0)	(1.8)
Bariatric Surgery	1.8	3.4	(1.6)	(0.3)	(1.2)	0.7	(0.8)
Breast Surgery	4.0	3.8	0.2	(0.2)	1.8	(0.5)	(0.9)
Colon & Rectal Surgery	-	2.0	(2.0)	(0.6)	(0.6)	(0.3)	(0.5)
General Surgery	28.0	16.7	11.3	1.3	6.5	2.9	0.6
Oncology Surgery	-	0.7	(0.7)	(0.2)	(0.2)	(0.1)	(0.2)
Transplant Surgery	-	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Vascular Surgery	9.7	5.1	4.6	0.7	4.8	(0.7)	(0.2)
General Surgery - Total	43.5	31.7	11.8	0.7	11.0	2.0	(1.9)
Maternal Fetal Medicine	1.0	2.1	(1.1)	(0.6)	0.3	(0.3)	(0.5)
Neurosurgery - Cranial	3.1	2.7	0.4	(0.4)	1.7	(0.4)	(0.5)
Neurosurgery - Spine	3.9	7.7	(3.8)	(0.3)	(1.0)	(1.0)	(1.5)
Neurosurgery - Total	7.0	10.4	(3.4)	(0.7)	0.6	(1.4)	(1.9)
Ophthalmology	33.1	31.8	1.3	3.2	6.2	(3.0)	(5.0)
Orthopedic Surgery - General	40.4	32.7	7.7	(2.0)	9.3	2.0	(1.6)
Orthopedic Surgery - Hand	0.6	2.1	(1.5)	(0.3)	(0.4)	(0.3)	(0.5)
Orthopedic Surgery - Spine	1.0	2.6	(1.6)	(0.8)	0.1	(0.3)	(0.6)
Orthopedic Surgery - Total	42.0	37.4	4.6	(3.1)	9.0	1.4	(2.7)
Otolaryngology	12.3	18.6	(6.3)	(2.8)	1.9	(2.1)	(3.3)
Plastic Surgery	7.0	13.1	(6.1)	(1.1)	(0.2)	(1.7)	(3.1)
Podiatry	39.1	14.4	24.7	7.9	15.9	1.2	(0.3)
Urology	9.5	15.3	(5.8)	(2.8)	1.2	(1.6)	(2.6)
Total Surgical Sub-Specialties	**195.6**	**182.6**	**13.0**	**(1.7)**	**44.4**	**(6.5)**	**(23.2)**
Total All Sub-Specialties	**408.9**	**426.2**	**(17.3)**	**(26.2)**	**85.0**	**(24.3)**	**(51.8)**

Succession Planning

Service Area Physician Age Distribution



Average Physician Age	
Meritus Health	52.2
Service Area	56.1
US	51.1

- Meritus Health has a younger compliment of physicians than the total service area but older than the national average.

3d Health, Inc.

Projected Meritus Health Physician Supply

Potential FTE Physician Retirements *(Assumes Age 65 Retirement)*

Specialty	Current FTEs	Total 3-Year	% of Total	Potential FTE Retirements by Year							Total 10-Year	% of Total
				2023	2024	2025	2026	2027	2028	2029		
Allergy & Immunology	0.3	0.3	100%	-	-	-	-	-	-	-	0.3	100%
Cardiology - Electrophysiology	0.2	0.2	100%	-	-	-	-	-	-	-	0.2	100%
Endocrinology	1.0	1.0	100%	-	-	-	-	-	-	-	1.0	100%
Geriatric Medicine	0.5	0.5	100%	-	-	-	-	-	-	-	0.5	100%
Thoracic Surgery	1.0	1.0	100%	-	-	-	-	-	-	-	1.0	100%
Urology	3.7	1.7	46%	-	-	-	-	-	1.0	-	2.7	73%
Otolaryngology	1.5	0.6	37%	-	-	-	-	-	-	-	0.6	37%
Neurology	2.4	0.8	35%	0.3	-	-	-	-	-	1.3	2.4	100%
Internal Medicine	20.6	7.2	35%	-	2.5	0.6	-	0.4	0.5	-	11.1	54%
Gastroenterology	6.0	2.0	33%	1.0	-	-	-	1.0	-	-	4.0	67%
Nephrology	5.0	1.6	32%	-	-	-	-	-	-	-	1.6	32%
Vascular Surgery	1.4	0.4	29%	-	-	-	-	-	-	-	0.4	29%
Psychiatry	3.7	1.0	27%	-	-	-	0.7	-	-	-	1.7	45%
Hematology/Oncology	3.7	1.0	27%	-	-	0.6	-	-	-	-	1.6	43%
Pediatrics	15.8	3.2	20%	-	1.5	-	-	-	1.5	-	6.2	39%
Family Medicine	29.4	3.7	13%	0.6	1.7	-	-	0.8	3.3	2.0	12.0	41%
Podiatry	2.5	0.3	10%	-	-	-	-	-	-	-	0.3	10%
Obstetrics & Gynecology	11.6	1.0	9%	-	-	-	1.0	-	-	-	2.0	17%
General Surgery	7.0	0.6	9%	0.7	-	1.0	-	-	0.8	0.5	3.5	50%
Orthopedic Surgery - General	6.7	0.4	6%	0.2	-	-	-	1.0	1.2	-	2.8	42%
Neurosurgery - Cranial	0.2	-	-	-	-	-	0.1	0.2	-	-	0.2	100%
Neurosurgery - Spine	1.0	-	-	-	-	-	0.2	0.9	-	-	1.0	100%
Physical Medicine & Rehab	1.0	-	-	-	-	-	-	-	1.0	-	1.0	100%
Plastic Surgery	1.6	-	-	0.6	-	-	-	-	-	0.8	1.3	81%
Cardiology - Medical	3.1	-	-	-	0.2	-	0.7	-	-	0.4	1.3	42%
Pulmonary	3.6	-	-	0.7	-	-	-	-	0.7	-	1.4	40%
Sleep Medicine	0.9	-	-	0.2	-	-	-	-	0.2	-	0.4	40%
Bariatric Surgery	0.8	-	-	-	-	-	-	-	0.3	-	0.3	33%
Urgent Care	3.7	-	-	-	0.9	-	-	-	-	-	0.9	24%
Ophthalmology	1.8	-	-	-	-	-	-	-	-	0.4	0.4	23%
All Other Specialties	7.2	-	-	-	-	-	-	-	-	-	-	-
Total	**148.7**	**28.4**	**19%**	**4.1**	**6.8**	**2.2**	**2.6**	**4.2**	**10.3**	**5.4**	**63.9**	**43%**

Market Demand Calculation

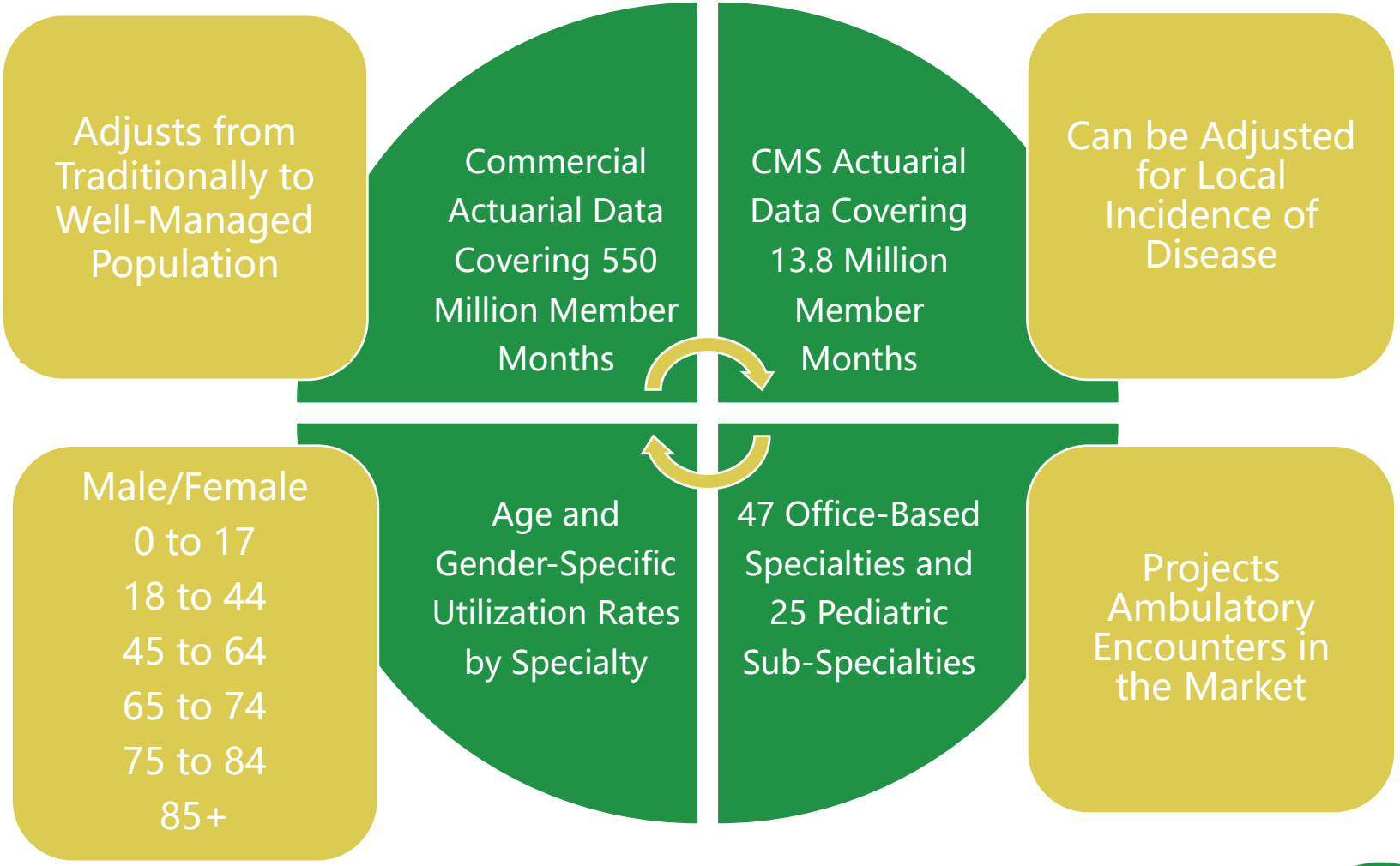
Specialty	Gender	Age Cohort	Population		Use Rate		Encounters		AMGA Median Office Encounters		FTE Demand
Family Medicine	Female	Under 18	52,546	X	0.7334	=	38,539	/	3,652	=	10.55
		18 - 44	80,074		1.3211		105,784				28.97
		45 - 64	67,212		1.6954		113,952				31.20
		65 - 74	25,710		1.5050		38,693				10.60
		75 - 84	12,967		1.7595		22,815				6.25
		85 or Older	6,312		1.8343		11,578				3.17
	Male	Under 18	54,917		0.6990		38,384				10.51
		18 - 44	84,464		0.8842		74,679				20.45
		45 - 64	66,269		1.4131		93,646				25.64
		65 - 74	23,071		1.2877		29,710				8.14
		75 - 84	10,155		1.5835		16,081				4.40
		85 or Older	3,383		1.7424		5,895				1.61

Total ***487,080***

Total Family Medicine FTE Demand **161.49**

Physician Demand Methodology

3d Health's Actuarial Demand Model:



DEPARTMENT:	Patient Financial Services
POLICY NAME:	Financial Assistance
POLICY NUMBER:	0436
ORIGINATOR:	Patient Financial Services
EFFECTIVE DATE:	8/97
REVISION DATE(s):	03/99, 03/00, 03/03, 02/04, 03/04, 06/04, 10/04, 6/05, 3/06, 2/07, 3/07, 1/08, 3/09, 8/10, 2/11, 1/12, 1/14, 11/15, 1/18, 7/19, 2/20, 11/20
REVIEWED DATE:	12/00, 2/03, 3/04

SCOPE

This policy applies to all patients seeking emergency or other medically necessary care at Meritus Medical Center. This policy also applies to patients seeking treatment at any Meritus owned physician practice. These entities are hereinafter collectively referred to as "Meritus."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom outstanding "self-pay" balances exceed their own ability to pay. The underlying theory is that a person, over a reasonable period of time can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as financial assistance.

PURPOSE

Meritus is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, sex, age, color, national origin, creed, marital status, sexual orientation, gender identity, or disability. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment. The procedures describe how applications for financial assistance should be made, the criteria for eligibility, and the steps for processing applications.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and has been adopted by Meritus' Board of Directors.

POLICY

A. OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within thirty (30) days.
    a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a discount to qualifying patients.

b. A list of our health care service providers is available at www.meritushealth.com/financialassistance. Only providers employed by Meritus are covered under this policy and are indicated on the provider list.

c. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.

2. Notice of the Availability of Financial Assistance:

   a. Meritus will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within Meritus locations.

   b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.

   c. A statement on the availability of financial assistance will be included on patient billing statements.

   d. A Plain Language Summary of Meritus' Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.

   e. Meritus' Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at Meritus, through mail (postal service), and on Meritus' website at www.meritushealth.com/financialassistance.

   f. Meritus' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.

      i. On an annual basis, Meritus shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: Meritus retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

   a. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

   b. All patients presenting for emergency services will be treated regardless of their ability to pay.

      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

a. Meritus' rate structure is governed by the HSCRC rate setting authority. As an "all-payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

b. Charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

B. PROGRAM ELIGIBILITY

1. Meritus strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Meritus reserves the right to grant financial assistance without formal application being made by patients. These patients may include the homeless or individuals with returned mailed and no forwarding address.

2. Patients who are uninsured, underinsured, ineligible for a government programs, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for Meritus' Financial Assistance Program.

3. All residents of Meritus' service area will be considered for financial assistance regardless of United States immigration status. Financial assistance consideration is available to non-service area residents requiring emergency services at Meritus.

4. For non-emergent services for patients residing outside of Meritus' service area, including patients traveling to the United States to obtain health care services, Meritus reserves the right to screen patients for insurance coverage and ability to pay. Meritus may only offer financial assistance to non-service area residents for non-emergency services on a case-by-case basis.

5. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:

   a. Emergency medical services provided in an emergency room setting;

   b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual;

   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

   d. Medically necessary services.

      i. A medically necessary service is one which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which: (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.

      ii. A service or item is not medically necessary if there is another service or item that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all.

iii. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary.

6. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance Program include the following:
   a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
      1) Exceptions to this exclusion may be made, in Meritus' sole discretion, considering medical and programmatic implications.
   b. Unpaid balances resulting from cosmetic or other non-medically necessary services; and
   c. Patient convenience items.
7. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:
   a. After being notified by Meritus, for refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).
   b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance program that denies access to Meritus due to insurance plan restrictions/limitations.
   c. Failure to pay co-payments as required by the Financial Assistance Program.
   d. Failure to keep current on existing payment arrangements with Meritus.
   e. Failure to make appropriate arrangements on past payment obligations owed to Meritus (including those patients who were referred to an outside collection agency for a previous debt).
   f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless Meritus can readily determine that the patient would fail to meet the eligibility requirements.
8. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
9. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section C.2. below).
   a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Meritus' Senior Finance Executive for approval.
   b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

10. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in ***Appendix 1.***

C. PRESUMPTIVE ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance Application and/or supporting documentation on file. Often there is adequate information, provided by the patient or other sources, that is sufficient for determining financial assistance eligibility.
    a. In the event there is no evidence to support a patient's eligibility for financial assistance, Meritus reserves the right to use outside agencies or propensity to pay modeling in determining financial assistance eligibility.
    b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service.
2. Presumptive eligibility will be determined on the basis of individual life circumstances that may include:
    a. Active Medical Assistance pharmacy coverage;
    b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
    c. Homelessness;
    d. Maryland Public Health System Emergency Petition patients;
    e. Participation in Women, Infants and Children Programs ("WIC");
    f. Food Stamp eligibility;
    g. Eligibility for other state or local assistance programs;
    h. Deceased patient with no known estate; and
    i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.
3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
4. Exclusions from consideration for presumptive eligibility include:
    a. Purely elective procedures (e.g., cosmetic procedures).
    b. Uninsured patients seen in the Emergency Department under Emergency Petition unless and until the Maryland Behavioral Health Administration (BHA) has been billed.

5. All Amish and Mennonite patients will be extended a 25% reduction to charges. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health coverage.

D. FINANCIAL MEDICAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Medical Hardship Program.
    a. Patients may qualify under the following circumstances:
        1) Combined household income less than 500% of the current federal poverty level; or
        2) Having incurred collective family hospital medical debt at Meritus exceeding 25% of the combined household income during a 12-month period.
            (a) Medical debt excludes co-payments, co-insurance, and deductibles.
2. Meritus applies the criteria above to a patient's balance after any insurance payments have been received.
3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of the sliding scale is included in ***Appendix 1*****.**
4. If determined eligible, patients and their immediate family qualify for reduced-cost, medically necessary care for a 12-month period effective on the date the medically necessary care was initially received.
5. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Program, Meritus is to apply the greater of the two discounts.
6. The patient is required to notify Meritus of their potential eligibility for reduced cost-care due to financial medical hardship.

E. ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES: Meritus reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management level review and approval.

F. ASSET CONSIDERATION

1. Assets are generally not considered as part of the financial assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.

2. The following assets are excluded from consideration:
   a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families;
   b. Up to $150,000 in primary residence equity;
   c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal;
   d. One motor vehicle used for the transportation needs of the patient or any family member of the patient;
   e. Any resources excluded in determining financial eligibility under Maryland Medicaid; and
   f. Prepaid higher education funds in a Maryland 529 Program account
3. Monetary assets excluded from the determination of eligibility shall be adjusted annually for inflation in accordance with the Consumer Price Index.

G. APPEALS

1. Patients whose Financial Assistance Applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Meritus Medical Center, 11116 Medical Campus Road, Hagerstown, Maryland 27142 Attn: Financial Counseling Team.
2. Upon denial, patients shall be informed that the Maryland Health Education and Advocacy Unit (HEAU) is available to assist patients in filing and mediation of a reconsideration request. The HEAU contact information is:

   HEAU Hotline:
   Mon-Fri 9am-4:30pm
   410-528-1840
   Toll free: 1-877-261-8807
   FAX: 410-576-6571
   heau@oag.state.md.us

   https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx
3. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
4. Appeals are documented and reviewed by the next level of management above the representative who denied the original application.
5. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
6. Appeals can be escalated up to the Chief Financial Officer, who will render the final decision.
7. Patients who have formally submitted an appeal will receive a letter of the final determination.

8. If a patient, or a patient's representative, feels Meritus is in violation of the financial assistance requirements as detailed in Maryland Code, Health-General §19-214.1 and §19-214.3, they may file a complaint with the Health Services Cost Review Commission (HSCRC) by emailing hscrc.patient-complaints@maryland.gov.

H. PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under Meritus' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where Meritus' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for financial assistance after Meritus has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, Meritus will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

I. OPERATIONS

1. Meritus will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        1) To facilitate this process, each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. Meritus will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
        1) Patients may be required to submit the following documentation with their completed application:
            (a) A copy of their 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);
            (b) Proof of disability income (if applicable);
            (c) A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;

(d) Proof of social security income (if applicable);

(e) A Medical Assistance Notice of Determination (if applicable);

(f) Reasonable proof of other declared expenses; and

(g) If unemployed, reasonable proof of unemployment, such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance Application or any required supporting documentation within 30 days after a formal application request, a letter will be sent reminding the patient that financial assistance is available and informing the patient of the collection actions that may be taken if no documentation is received.
   a. A deadline for submission, prior to initiation of extraordinary collection actions, will be included in the letter. Such deadline may not be earlier than 30 days after the date on which the reminder letter is sent.
   b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).
   c. If documentation is received after collection actions have been initiated, but within 240 days after patient receipt of the first post discharge billing statement, Meritus shall cease all collection actions and determine whether the patient is eligible for financial assistance.
4. A Plain Language Summary of this policy shall be included with the letter and Meritus staff shall make a reasonable effort to orally notify the individual of Meritus' Financial Assistance Program.
5. Once a patient has submitted all the required information, appropriate personnel will review the application and forward it to the Patient Financial Services Department for final determination of eligibility based on Meritus guidelines.
   a. For complete applications, the patient will receive a letter notifying them of approval/denial within 14 days of submitting the completed applications.
   b. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information.
   c. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
   d. If a patient is determined to be ineligible after receiving services, a payment arrangement may be obtained, subject to Meritus approval, on any balance due by the patient.
6. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective as of the date treatment is received and the following six (6) calendar months.

a. For those who qualify for reduced-cost care due to medical hardship, such qualification will apply for a twelve (12) month period.

b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

7. The following may result in the reconsideration of financial assistance approval:

   a. Post approval discovery of an ability to pay; and

   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to Meritus.

8. Meritus will track patient qualification for financial assistance or medical hardship. However, it is ultimately the responsibility of the patient to inform Meritus of their eligibility status at the time of registration or upon receiving a statement.

J. CREDIT & COLLECTIONS POLICY

1. Meritus maintains a separate Credit & Collections Policy that outlines what actions Meritus may take in the event a patient fails to meet their financial responsibility.
2. A copy of this policy may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

K. PROVIDER LIST

1. Meritus maintains a list of all Meritus and non-Meritus providers who may care for patients while at Meritus. This list indicates whether the provider is covered by this policy. Non-Meritus providers are not covered and bill separately for their services.
2. A copy of this list may be obtained by requesting a copy from Meritus staff or by visiting Meritus' website at www.meritushealth.com/financialassistance.

RESPONSIBILITY
Vice President, Revenue Cycle and Clinical Support Services

REFERENCES
I.R.C. § 501(r) (2015).
26 C.F.R. § 1.501(r)-4 (2015).
Md. Code Regs. 10.37.10.26.

RELATED POLICIES
Meritus Policy 0444, Credit & Collections

Sliding Scale

US Federal Poverty guidelines are updated annually by the Department of Health and Human Services. Below is an example of the sliding scale Meritus shall use to determine patient eligibility for financial assistance or medical hardship.
https://aspe.hhs.gov/poverty-guidelines

Size of Family Unit*	2020 FPL Income	% of Federal Poverty Level Income					
		200%	250%	300%	350%	400%	500%
		Approved % of Financial Assistance					
		100%	**80%**	**60%**	**40%**	**20%**	**0%**
1	$12,140	$25,520	$31,900	$38,280	$44,660	$51,040	(3) $63,800
2	$16,460	$34,480	$43,100	(2) $51,720	$60,340	$68,960	$86,200
3	$20,780	$43,440	$54,300	$65,160	$76,020	$86,880	$108,600
4	$25,100	(1) $52,400	$65,500	$78,600	$91,700	$104,800	$131,000
5	$29,420	$61,360	$76,700	$92,040	$107,380	$122,720	$153,400
6	$33,740	$70,320	$87,900	$105,480	$123,060	$140,640	$175,800
7	$38,060	$79,280	$99,100	$118,920	$138,740	$158,560	$198,200
8	$42,380	$88,240	$110,300	$132,360	$154,420	$176,480	$220,600

Example # 1	**Example # 2**	**Example # 3**
1. Patient earns $57,000 per year. 2. There are 4 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 80% (they earn more than $52,400 but less than $65,500)	1. Patient earns $54,000 per year. 2. There are 2 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 40% (they earn more than $51,720 but less than $60,340)	1. Patient earns $61,000 per year. 2. There is 1 person in the patient's family. 3. The balance owed is $20,000. 4. If the patient qualifies for Hardship coverage, they would owe $15,250 (25% of 61,000).

* Family unit includes spouse, biological, adopted, or step-children, and anyone for whom patient claims a personal exemption in a state or federal tax return; if patient is a child, family unit includes biological, adopted, or step-parents or guardians; biological, adopted, or step-sibling, and anyone for whom the patient's parents or guardians claims a personal exemption in a state or federal tax return

From: Allen Twigg
To: Hilltop HCB Help Account
Subject: FW: Clarification Required - FY 22 Meritus Medical Center Narrative
Date: Tuesday, March 14, 2023 5:10:41 PM
Attachments: Meritus FY22 Community Benefit Data Collection Tool_Draft_15Dec2022.xlsx
Meritus Medical Center_HCBNarrative_FY2022_20221215.pdf

Hilltop,

Thank you for the opportunity to correct the omissions and clarify our initial responses. Please find the detailed response to your questions below in red.

If there are any further questions please don't hesitate to contact us.

Thank you, Allen

Allen L. Twigg LCPC FACHE
Executive Director
Behavioral & Community Health
Phone | 301-790-8263

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, March 8, 2023 1:06 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Allen Twigg <Allen.Twigg@meritushealth.com>
Subject: RE: Clarification Required - FY 22 Meritus Medical Center Narrative

---

Apologies again! Please disregard the attachment in the previous message; it was your hospital's narrative submission from FY 2021. The narrative for FY 2022 is attached. We appreciate your patience and understanding.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, March 8, 2023 12:59 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; allen.twigg@meritushealth.com
Subject: RE: Clarification Required - FY 22 Meritus Medical Center Narrative

The previous message was mistakenly sent without your hospital's narrative report attached. Please find the report attached for your reference as you review the clarification requests. Thank you.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, March 8, 2023 12:55 PM
To: allen.twigg@meritushealth.com; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: Clarification Required - FY 22 Meritus Medical Center Narrative

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative report for Meritus Medical Center. In reviewing the narrative, we encountered several items that require clarification:

- Question 61 on page 13 was left blank. Please provide a response. None
- For Question 79 on pages 15-16, there were discrepancies between the physician subsidies indicated on the narrative report and financial report (the physician subsidies should align between the two reports). Please clarify.
  - The provider types listed below were only present on the community benefit financial report. Please clarify a provider type and subsidy type for each using the categories in Question 79.
    - Intensivist Physician Recruitment to Meet Community Need
    - Anesthesiologist Non-Resident House Staff and Hospitalists
    - UPMC Stroke Program Physician Recruitment to Meet Community Need
    - Trauma On-Call Coverage of Emergency Department Call
    - MMC Physical Medicine and Rehab Physician Recruitment to Meet Community Need
    - MMC Gynecology Oncology Specialists Physician Recruitment to Meet Community Need
    - MMC Psych Practice Physician Recruitment to Meet Community Need
    - MMC Wound Cntr-Phys Physician Recruitment to Meet Community Need
    - Physician Recruiting Expense Physician Recruitment to Meet Community Need
  - Please also provide a description for how it was determined that a subsidy was needed for each of the physician types listed above per the instructions in Question 80 on page 16.

Clarifications added to original response in red:

Meritus Medical Center subsidizes the Hospitalist and Anesthesiology programs in response to a community need for these services. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured population necessitated the need for Hospitalist and Anesthesia services to be subsidized by the Hospital to ensure availability. Meritus Medical Center subsidizes the Emergency On-call and Trauma On-Call services in response to a community need for timely access and response to emergent care. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with higher volumes of uninsured/underinsured population in the Emergency Department has necessitated the need for an Emergency On-call program subsidized by the Hospital. Supporting data includes increased Charity Care expense for FY2022. Additional physician subsidies were necessary to provide physician specialty services necessary to meet community needs including: the Intensivists, the UPMC Stroke Program, Physical Medicine and Rehab, Gynecology, and Psychiatry. Subsidies were used in part for physician recruitment for all of these specialties as evidenced by the shortages identified in the most recent physician gap assessment (please see Q. 81).

    - The subsidy type selected for hospitalists in the narrative report was “Non-resident house staff and hospitalists”, while the subsidy type for hospitalists in the financial report was “Physician Recruitment to Meet Community Need”. Please clarify which of these is the correct subsidy type. Non-Resident House Staff and Hospitalists

- For Question 87 on page 17 no lower bound was selected for the percentage of FPL for which your hospital offers reduced-cost care. Please verify that this was left blank intentionally, or clarify the lower bound. The lower FPL bound is 200%

Please provide your clarifying answers as a response to this message.