COMMUNITY BENEFIT NARRATIVE REPORT

FY2013

Western Maryland Regional Medi

BACKGROUND

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

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	**Inpatient Admissions:**	**Primary Service Area Zip Codes**	**All Other Maryland Hospitals Sharing Primary Service Area:**	**Percentage of Uninsured Patients, by County:**	**Percentage of Patients who are Medicaid Recipients, by County:**
247 Beds 20 Bassinets	Adults: 13,029 Nursery: 1,004 Total: 14,033	21502 21532 21539 21562 21536	Garrett Memorial Hospital	13%	21.9%

2. For purposes of reporting on your community benefit activities, please provide the following information:
   a. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary). Some statistics may be accessed from:
      - The Maryland State Health Improvement Process. http://dhmh.maryland.gov/ship/
      - The County Health Profiles 2013 http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx
      - The Maryland Vital Statistics Administration. http://vsa.maryland.gov/html/reports.cfm
      - The Maryland Plan to Eliminate Minority Health Disparities (2010-2014). http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf
      - Maryland ChartBook of Minority Health and Minority Health Disparities 2nd Edition http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)	Allegany County, MD: 75,087 By sex •51.7% Male •48.3% Female By race & ethnicity •89.2% White •8% Black/African Am. •0.1% Native American •0.8% Asian •1.4% Hispanic or Latino Average age •40.9 years •(4.7% under age 5 and 17.8% 65 yrs and over) Mineral County, WV: 28,212 By sex •49.6% Male •50.4% Female By race & ethnicity •95.3% White •2.8% Black/African Am. •0.1% Native American* •0.4% Asian •0.7% Hispanic or Latino Average age •40.7 years •(5.4% under age 5 and 17.3% 65 yrs and over) Source: US Census 2010
Median Household Income within the CBSA	Allegany County: $37,952 Mineral County, WV:$36,571 Source: US Census 2010
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Allegany County: 15.2% households Source: American Community Survey 2008-2010 Mineral County, WV:16.1% of people with incomes below FPL Source: ACS 2006-2010
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Allegany County: 13% Mineral County, WV:17% Source: County Health Rankings –Univ. of Wisconsin 2013 Report
Percentage of Medicaid recipients by County within the CBSA.	Allegany County: 21.9% Mineral County, WV:16.3% Source: HRSA Area Resource File 2012
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).See SHIP website: http://dhmh.maryland.gov/ship/SitePages/objective1.aspxand county profiles:http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Allegany County: 77.2 White 80.0 Black Source: SHIP County Profile 2012 Mineral County, WV:75.2 Source: CHIS (DHHS-2009)
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Allegany County: 7,375 per 100,000 age adj Mineral County, WV: 8,106 per 100,000 age adj Source: County Health Rankings –Univ. of Wisconsin 2013 Report

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health statusby County within the CBSA. (to the extent information is available from localor county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information:http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Limited Access to healthy food. Allegany County: 17% Mineral County, WV:26% Source: County Health Rankings 2012 Report Transportation-Percentage of households without access to vehicles Allegany County: 11% Mineral County, WV:9% Source: American Community Survey 2005-2009 5 yr est. Illiteracy Allegany County: 11.3% Mineral County, WV:13.4% Source: County Health Rankings 2012 Report Pop. 25+ With Bachelor's Degree or Above % Allegany County: 15.9% Mineral County, WV:14.1% Source: American Community Survey (2008-2010) Children living in Single Parent Households % Allegany County: 35% Mineral County, WV:32% Source: County Health Rankings 2013 Report
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	Allegany County, MD: 75,087 By race & ethnicity •89.2% White •8% Black/African Am. •0.1% Native American •0.8% Asian •1.4% Hispanic or Latino Mineral County, WV: 28,212 By race & ethnicity •95.3% White •2.8% Black/African Am. •0.1% Native American* •0.4% Asian •0.7% Hispanic or Latino Source: US Census 2010 Language Other Than English spoken at home % Allegany County: 3.8% Mineral County, WV:1.5% Source: US Census 2010
Other	Population to Primary Care Provider Ratio Allegany County: 1746:1 Mineral County, WV:2822:1 Source: County Health Rankings 2013 Report Adults who currently smoke % Allegany County: 24%

	Mineral County, WV:16% Source: BRFSS 2008-2010 and County Health Rankings 2013 Report Inadequate Social Support % Allegany County: 19% Mineral County, WV:16% Source: County Health Rankings 2013 Report

b. Please use the space provided to complete the description of your CBSA. Provide any detail that is not already stated in Table II (you may copy and paste the information directly from your CHNA).

The Western Maryland Health System provides primary and secondary acute care services for a six county region covering: Upper Potomac region of Maryland, Eastern West Virginia, and Southwestern Pennsylvania. With the majority of patients residing in Allegany County, Maryland (72.5%), that is where WMHS focuses its community benefit efforts. However, with almost 14% of the patients residing in Mineral County WV, the demographics and input from residents of this area are incorporated into our Community Benefit Service Area planning.

Located in rural Western Maryland, Allegany County is part of the Appalachian region with low education levels, limited racial diversity, a large elderly population, and low household incomes. The average household size is 2.25, and along with a higher percentage of single parent households, there is a higher percentage of grandparents living with, and responsible for, their grandchildren under age 18 (54.2%) compared to Maryland (36.7%) or the U.S. (33.4%).

According to Catholic Healthcare West and Thomson Reuters' Community Needs Index (CNI), four of the zip codes in Allegany County with the greatest need are within WMHS' primary service area. These include, 21502 (Cumberland) with a CNI of 3.8, as well as 21562 (Westernport), 21539 (Lonaconing), and 21532 (Frostburg) all at 3.6. The closer to 5 the more community need there is in a zip code. A comparison of CNI scores to hospitalization shows a strong correlation between high need and high use. In fact, admission rates for the most highly needy communities are over 60% higher than communities with the lowest need.

High rates of poverty are a significant contributor to the poor health status in Allegany County. Social determinants associated with poverty including limited transportation, unstable/unsafe housing, and limited access to healthy foods affect health outcomes which are reflected in our high rates of chronic disease. Health literacy is another significant barrier in Allegany County, and disproportionately impacts lower socioeconomic groups. Providing information in a way that is understood by patients, and developing trusting relationships between patients and providers are important to address these needs.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscalyear 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, the IRS defines a CHNA as a:

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

The written document (CHNA) must include the following:

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

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

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons

(whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP) (http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) The Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) Local Health Departments (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);

(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNAinvolving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

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

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need; or
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

X Yes
_ No

Provide date here.1/26/2012

If no, please provide an explanation

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

http://alleganyhealthplanningcoalition.com/pdf/ACHD%20Community%20Health%20Needs%20Assessment.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

X Yes
_ No

If no, please provide an explanation

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

http://www.wmhs.com/community-health-assessment.html and http://alleganyhealthplanningcoalition.com/

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?
    a. Is Community Benefits planning part of your hospital's strategic plan?

X Yes
_ No

If no, please provide an explanation

    b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB processand provide additional information if necessary):

i. Senior Leadership

1.X CEO
2.X CFO
3.X Other (Please Specify)
All members of WMHS System Administration (COO, CNO, and all VPs)

ii. Clinical Leadership

1.X Physician

2.X Nurse
3.X Social Worker
4.X Other (Please Specify)
Allied Health Professionals

iii.Community Benefit Department/Team
1._ Individual (please specify FTE)
2.X Committee (please list members)
Scott Lutton, Nancy Forlifer, Kathy Rogers, and Kim Repac
3._ Other (Please Specify)

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

Spreadsheet X Yes _ No
If you answered no to this question, please explain why?

Narrative X Yes _ No
If you answered no to this question, please explain why?

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

Spreadsheet X Yes _ No
If you answered no to this question, please explain why?

Narrative X Yes _ No
If you answered no to this question, please explain why?

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on

the measured outcomes, and the current FY costs associated with each initiative. Please be sure these initiatives occurred in the FY in which you are reporting.

For example for each principal initiative, provide the following:

a Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)

d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

e. Key Partners in Development/Implementation: Name the partners(community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

f. How were the outcomes of the initiative evaluated?

g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

h. Continuation of Initiative: Will the initiative be continued based on the outcome?

i Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

Initiative 1

Identified Need	Obesity Only 28% of adults in Allegany County are at a healthy weight
Hospital Initiative	Worksite Wellness-promotion of increased physical activity and healthier nutrition choices Change to Win-weight management program
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To increase the percentage of healthy weight adults and reduce obesity, the worksite wellness initiative focused on promotion of physical activity and healthier nutrition choices using e-mail blasts, newsletter, mini-grants, presentations and challenges. Metrics include: # worksites reached, # physical activity and/or nutrition strategies implemented at worksites, # employees reached at worksites, and # environment or policy changes made. Change to Win is a 10 week program also intended to increase the percentage of healthy weight adults by aiding participants in making healthy lifestyle choices that lead to permanent weight loss. Metrics are: # participants completing and % of participants with healthy BMI or losing 5 or more pounds.
Single or Multi-Year InitiativeTime Period	Multi-year- since 2011
Key Partners and/or Hospitals in initiative development and/or implementation	WMHS, Make Healthy Choices Easy (partnership that includes YMCA, ACHD, fitness centers, Board of Education, UM Extension, Family Junction, Western MD. AHEC, Maryland Physicians Care ,and several others), Allegany County Chamber of Commerce, and Allegany County Health Planning Coalition.
How were the outcomes evaluated?	Monthly tracking of occurrences in CBISA Worksite and participant feedback Post session attendance and weights reviewed Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan.
Outcome (Include process and impact measures)	-439 worksites reached -9 physical activity and/or nutrition strategies implemented at worksites -7438 employees reached at worksites -1 environmental or policy change made -8% of employees reported increasing physical activity or making a healthier nutrition choice

	4 (10 week sessions) of Change to Win held in FY13 resulting in: -51 community members participating (does not include WMHS employees) -64% of participants attending 80% or more of classes and either maintaining a healthy BMI or losing 5 or more pounds - 483 pounds were lost
Continuation of Initiative	Adjustments being made to worksite wellness in FY14. Will increase tracking of outcomes. Change to Win is ongoing.
Cost of initiative for current FY?	Worksite Wellness: $3,386 Change to Win: $2,298

Initiative 2

Identified Need	Access to Care 13% of persons under age 65 in Allegany County are uninsured 15.2% of Allegany County households are living below the federal poverty level 25% of individuals surveyed reported missing medical appointments due to transportation
Hospital Initiative	Community Health Access Program (CHAP)-safety net program Transportation Support
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	For low income, uninsured adults, CHAP increases access to primary care, diagnostic services, care coordination, and support with specialty care. Connects eligible individuals with public or private insurance. Coordinates services with community agencies to address needs including prescriptions, utilities, transportation etc. Facilitates gap services and support for adults in PAC. To decrease the percentage of uninsured adults and increase access to appropriate care, metrics include: # people assisted with enrollment in insurance, and reduction in non-emergent ED visits post intake into CHAP. In addition to providing taxi/bus vouchers for patients/families when a need arises, WMHS facilitated meetings with community partners to identify barriers and potential solutions to address the transportation needs. Metrics of success will be pursuit of a solution.
Single or Multi-Year InitiativeTime Period	CHAP-Multi-year, Since 2001, Transportation- Multi-year, 2012-2014
Key Partners and/or Hospitals in initiative development and/or implementation	CHAP is joint venture of WMHS and Allegany Health Right, with support from area physician offices, Tri-State Community Health Center. Coordinated under Wkgrp on Access to Care including Associated Charities, Dept. Social Svs, AHEC,ACHD,

	UMExtension , Carver Ctr, and Managed Care Organizations. Transportation has involved the Allegany County Health Planning Coalition including WMHS, Allegany County Health Dept., Human Resource Development Commission, human service providers, and transportation vendors.
How were the outcomes evaluated?	CHAP and supported PAC patients are monitored in the CAP Management Information System. Insurance enrollments are reported monthly in CBISA and ED usage is checked quarterly via CAP MIS. Meeting notes identify progress made with transportation. Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management via dashboard.
Outcome (Include process and impact measures)	At the end of FY13, there were: - 741 uninsured adults participating in CHAP/PAC-FAP having: -4049 encounters with the care coordinator and -30% reduction in non-emergent ED visits post intake into CHAP. -138 uninsured adults were transitioned into public or private insurance 1137 people were assisted with transportation in FY13 Held 6 meetings with partners and developed proposed plan for addressing transportation need. With the Allegany County Health Planning Coalition, applied for and at year end was awarded grant funding for a part time mobility manager and transportation voucher pilot.
Continuation of Initiative	CHAP-Ending December 31, 2013 (based on ACA and Exchange) Transportation-Ongoing based on success of grant funded pilot and sustainability of partnership.
Cost of initiative for current FY?	CHAP: $94,416 Note: This cost does not include the charity care provided to the participants in this program, but the financial support of physicians assisting with care to the uninsured. Transportation: $13,934

Initiative 3

Identified Need	Emotional and Mental Health 6846.8- Rate of behavioral health related ED visits per 100,000 population Poor Mental Health Days-Average 3.9 reported in past 30 days age adjusted Severe depression is 6th leading cause of hospital admissions at WMHS
Hospital Initiative	Parish Nursing Community Support Grants Mental Health First Aid-training
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Parish Nursing, Community Support Grants, and Mental Health First Aid Training are designed to increase social connectedness and provide support for the emotional & mental health needs in our community thereby reducing the number of poor mental health days and unnecessary ED visits for behavioral health. Parish Nurse Coordinator provides information, support and resources to volunteers in faith-based communities promoting health and wellness for mind, body and spirit. Metrics include: # engaged faith based communities and #encounters with people. Community Support Grants are awarded to promote development of positive, non-abusive relationships and to enhance social connectedness. Metrics include: # new programs offered providing support or enhanced connectedness and # of people supported through these programs. Mental Health First Aid is designed to train community members about how to help someone developing a mental health problem or in a mental health crisis before professional help arrives. Metric will be the # of participants trained successfully.
Single or Multi-Year InitiativeTime Period	Multi-year programs. Parish Nursing since 1997, Community Grants as of 2013, MHFA began 2012
Key Partners and/or Hospitals in initiative development and/or implementation	WMHS, Allegany County Health Planning Coalition, Allegany County Health Dept.-Mental Health Systems Office, Faith Based Communities, Cumberland Ministerial Assn., Western Correctional Institute, Family Crisis Resource Center, Hope Station and Bruce Outreach Center.
How were the outcomes evaluated?	Tracking sheets and monthly dashboards are used to track Parish Nursing. Community grant recipients submit reports on the outcomes achieved. MHFA Trainers track attendance, participation and determine if participants receive a certificate.

	ED data is tracked by the hospital. Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan.
Outcome (Include process and impact measures)	Parish Nursing engaged 42 faith based communities and had 38,893 encounters. Through the community grants, 5 new programs were started and are continuing to provide support and enhance connectedness. 96 people were supported through these programs. In addition, the Wellness and Recovery Center reported increased use, 158 hot line calls were answered, and those engaged in one of the programs have offered to help others. Of those surveyed by one of the programs, 39% reported making a connection with a person or resource and 97% felt the program was helpful. 26 people successfully completed the Mental Health First Aid Training and additional sessions have been scheduled based on demand. ED visits for behavioral health per 100,000population have decreased.
Continuation of Initiative	Parish Nursing- Ongoing Community Support Grants- Plan to continue. MHFA Training-Plan to continue in FY14 with addition of Youth training.
Cost of initiative for current FY?	Parish Nursing: $56,582 Community Support Grants: $2578 MHFA Training: $249

Initiative 4

Identified Need	Substance Abuse & Barriers related to health literacy Reduce illegal sales of prescription drugs in the community 80% of medication lists had discrepancies between hospital and provider acquired versions 20% of patients do not bring a medication list or medications with them to the hospital
Hospital Initiative	Just Bring It-community outreach and education tools for medication safety and patient engagement
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To increase patient understanding of medications (use and disposal) and engagement in the reconciliation process, Just Bring It included community outreach and wide spread use of standard tools. These efforts were also coordinated with the

	establishment and promotion of community collection sites, which help decrease the illegal sale of prescription drugs. Metrics include: # bags/magnets and medication lists distributed, # prescription medication containers collected at disposal sites, % of patients bringing medication lists or medications to the hospital ,and % completing the medication reconciliation process.
Single or Multi-Year InitiativeTime Period	Multi-year starting in 2012
Key Partners and/or Hospitals in initiative development and/or implementation	WMHS, Western Maryland Insurance Captive, Allegany County Health Dept. Associated Charities, Pharmacies, various Community Organizations, Physician offices, and the Allegany County Health Planning Coalition.
How were the outcomes evaluated?	Medication Reconciliation data was collected through facility wide regulation data assessments and reviewed by an internal WMHS committee. Outreach efforts were also tracked and reported to this committee on a quarterly basis. Collection sites are located with law enforcement and their data is reported to the health department monthly. Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress.
Outcome (Include process and impact measures)	In Fy13, 4453 people received Just Bring It magnets or bags with the standardized medication list at 40 different sites. -3976 prescription medication containers were collected in FY13 Between July 2012 to June 2013, the percentage of patients completing the overall medication reconciliation process increased from 76% to 95% and the percentage of patients with home medication lists addressed upon admission increased from 63% to 97%.
Continuation of Initiative	Use of tools and collection sites will be maintained.
Cost of initiative for current FY?	$1177

Initiative 5

Identified Need	Chronic Diseases 231.6 Rate of ED visits for hypertension per 100,000 population in Allegany County 385.6 Rate of ED visits for diabetes per 100,000 population in Allegany County 259.8 age adjusted death rate for heart disease in Allegany County
Hospital Initiative	Screening and Outreach Disease Management Clinics- Center for Diabetes Management and CHF Clinic
Primary Objective of the Initiative/Metrics	By promoting recommended screenings and

that will be used to evaluate the results	providing expanded disease management support including self management strategies, the intent is to increase awareness of chronic disease risk and reduce inappropriate use of the ED and hospital readmissions. Metrics include: # educated about screening and chronic disease risks, # screened and provided with follow up when risk identified, # particpants in disease management programs, and % change in ED, Observation & Inpatient visits 12 months pre/post intake into disease management program and related cost savings.
Single or Multi-Year InitiativeTime Period	Multi year initiated in FY13
Key Partners and/or Hospitals in initiative development and/or implementation	WMHS, Allegany County Health Planning Coalition, EMT, and physician offices.
How were the outcomes evaluated?	Education and outreach occurences are tracked in CBISA. Screening results are assessed by an approved provider. Data related to heart disease is tracked by the cardiology department and reviewed regularly. A team from Finance and Quality Improvement at WMHS compile the visit data and cost savings for the patients in the disease management programs. This data is monitored by System Management and used to make improvements. Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress.
Outcome (Include process and impact measures)	Rack cards were created to educate the community about the screenings recommended by the US Preventive Services Task Force. To increase awareness of heart attack signs and the advantages of calling 911, another rack card was created in conjunction with the EMS and Allegany County Health Planning Coalition. -175 people were educated about screening and chronic disease risks -1563 screened and provided with follow up when risk identified -916 participants in disease management programs (Diabetes and CHF) Of the patients fully managed in the disease management programs, the following results were reported as of March 31, 2013. Diabetes (84 patients) Visits to ED, OBS and Inpatient were reduced by 19.4% for a cost savings of $137,152 CHF (61 patients) Visits to ED, OBS and Inpatient were reduced by 34.5% for a cost savings of $559,352
Continuation of Initiative	With coverage of preventive screenings under the ACA, the strategy for community outreach is being evaluated but promotion of prevention and chronic disease risk will be continued in some manner.

	Based on the initial results, the disease management programs will be expanded.
Cost of initiative for current FY?	Screening & Outreach: $9,878 Disease Management Clinics: $427,419

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

There were no primary community health needs identified through the CHNA that were not addressed by the local health action plan (implementation strategy).Due to the extent of the identified needs, implementation will be spread over multiple years and partnerships with various sectors of the community will be critical. For example, to address overarching issues like poverty that directly impact community health, WMHS will continue to collaborate with entities in education and economic development.

V. PHYSICIANS

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

Our area is designated a health professional shortage area (HPSA) for low income populations needing primary care and dental care, and a HPSA in mental health for Medical Assistance eligible residents. According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 1067 people, Allegany County comes closest with 1746:1 and Mineral County is off target at 2822:1.

The most recent assessment in compliance with Stark regulations, found the top needs for WMHS is primary care (4.8FTE)). In addition there is a lesser need (<2 FTE) for specialists in the areas of Vascular Surgery and Urology. The average net need is based on the current supply and calculated demand, based on population needs, causes of death, age of physicians and more.

Based on the specialty referrals for uninsured clients in the safety net program, it seems the greatest gaps are in the following specialties: Orthopedics, Neurology, Gastroenterology, and Nephrology. Dental care for adults has also been identified as a significant need and results in inappropriate use of the emergency department.

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

recruitment to meet community need.

Based on the community health needs assessment and Medical Staff Development Plan, Western Maryland Health System has included physician subsidies in the following categories:

With a growing number of area physicians electing to concentrate on their office practice and not admit their patients to the hospital, WMHS needed to expand the Hospitalist program to respond to community need.

Physician shortages were identified in primary care, psychiatry and obstetrics and WMHS responded by recruiting and maintaining practices in these areas. These needs were not being met by other agencies in the community and based on the demographics and health indicators in the area, were much needed services. As a WMHS practice these physicians align with the WMHS Financial Assistance Policy, and help ensure that more patients will be provided with care in the most appropriate setting. With the shortage of providers, particularly some specialists, WMHS offered some financial support to providers for consulting with and caring for low income uninsured people in the CHAP and PAC-FAP program.

Appendix I - Describe FAP

Appendix 1- Description of Financial Assistance Policy
Western Maryland Health System FY13

Description of the Financial Assistance Policy

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

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

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

Patients' Rights:

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

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

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

Patients' Obligations:

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

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

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

• If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

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

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

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

Physician Services

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. This includes the fees for emergency department physicians, primary care physicians, surgeon, cardiologist, radiologist, and other physicians who provide care during your stay.

Appendix II - Hospital FAP

WESTERN MARYLAND HEALTH SYSTEM DEPARTMENTAL Policy Manual	**Department\Division:** Business Office	**Policy Number:** 400-04
	Effective Date: November 12, 2010	**Reviewed/Revised:** 4/11, 12/11, 5/12, 10/12, 8/13

FINANCIAL ASSISTANCE POLICY

PURPOSE:
To provide a process for patients to receive financial assistance for their medical care debt.

POLICY:
Western Maryland Health System is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual situation. A patient can qualify for Financial Assistance either through lack of sufficient insurance or financial hardship due to excessive medical debt.

It is the policy of Western Maryland Health System to provide Financial Assistance based on indigence or excessive medical debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

Western Maryland Health System will post notices of availability at patient registration sites, Admissions, Patient Accounting Department and at the Emergency Department. Notice of availability will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients via the Admission Handbook given to every admitted patient. This is provided to patients prior to discharge and is also available to all patients upon request.

This policy covers Western Maryland Health System and Physician Clinics and Practices owned by the Western Maryland Health System.

DEFINITIONS:
Medical Debt-Out-of-Pocket Expenses: Medical expenses excluding co-payments, co-insurance, and deductibles, for medical costs billed by a hospital.

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

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

Supporting Documentation: Pay stubs, workers compensation, Social Security or Disability award letters, bank or brokerage statements, tax returns, Explanation of Benefits to support medical debt.

Financial Hardship: Medical debt incurred by a family over a 12 month period that exceeds 25% of family income and the patient's income is under 500% of the Federal Poverty Level. (See Medical Debt definition)

Medically Necessary: For this policy does not include cosmetic procedures.

Free Care: Available to patients in households between 0% and 200% of Federal Poverty Level (FPL)

Reduced-Cost Care: Available to patients in households between 200% and 300% of Federal Poverty Level (FPL).

PROCEDURE;

1. Evaluation for Financial Assistance can begin in a number of ways. A patient may present to a hospital service area seeking medical care and inquire about financial assistance; a patient may notify Patient Accounting personnel/ financial counselor that he/she cannot afford to pay a bill and requests assistance, or any health care provider referral. All hospital registration sites, outpatient diagnostic centers, and system owned clinics and practices have financial assistance applications to offer to patients. Registrars are trained to offer financial assistance applications to self pay patients. Western Maryland Health System will use the Maryland State Uniform Financial Assistance Application.

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

3. Determination should be made that all forms of insurance are not available to pay the patient's bill. All insurance benefits must have been exhausted. Patients must follow participating provider guidelines and seek medical care from their provider network. WMHS will not grant assistance to patients that violate their provider network regulations.

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

5. Determination of income will be made after review of all required documents. The following supporting documents must be provided with the application:

    a. Most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations.)
    b. A copy of the four (4) most recent pay stub (if employed) or other evidence of income of any person whose income is considered part of the family income as defined by Medicaid regulations.
    c. Proof of disability income (if applicable)
    d. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, or statement from current source of financial support, etc.
    e. Bank statement.

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

6. When calculating total income for purposes of financial assistance, the following will be considered in the calculation of total income;
    Earned Income
    Social Security
    Pension Income
    Unemployment Compensation

Business or Farm Income less Business or Farm Expenses
Any other income such as rents, royalties, etc.

7. Presumptive Financial Assistance Eligibility: These are instances when a patient qualifies for financial assistance based on the enrollment in the following government programs. In these instances the application process is abbreviated. The application must be completed and the only additional required document is proof of acceptance and participation in one of the following programs.
   a. Food Stamps
   b. Women's, Infants and Children (WIC Program)
   c. Households with children in the free and reduced lunch program
   d. Primary Adult Care Program (PAC)
   e. Energy assistance
   f. Out of state medical assistance
   g. Unemployment under federal poverty guidelines and applicant is sole provider in the household.
   h. Patients eligible for out of state medical assistance and WMHS is not enrolled with participating provider credentials to file the claim

   Homeless patients and members of a recognized religious organization who have taken a vow of poverty are also considered eligible for Presumptive Financial Assistance. Patients unable to provide sole support and relying on someone else for support may provide a "Letter of Support" for consideration. Other documentation may be required and considered on a case by case basis.

   Presumptive Financial Assistance is valid 6 months from date of application.

8. The application, with supporting documents, should be completed by the applicant and returned to the Collections Department within ten business days. If partial information is returned, the applicant will be given additional time to provide the required documents. If the applicant does not respond, the applicant is considered not interested.

9. By using the Federal poverty guidelines published annually in the Federal Register, a patient may be found to receive 100% Free Care or Reduced Cost Care which is based on a percentage of their bill according to their income and number of dependents. The patient's responsibility may be capped based on a percentage of their income. In such cases, a percentage of the bill is charged to the Financial Assistance Program and the patient /guarantor is required to pay the remainder not charged to the Financial Assistance Program. Financial counselors will use WMHS Charity Calculation form to determine level of financial assistance.

10. Decisions on eligibility will be made within fifteen business days of application. In the event a patient has medical services scheduled and a financial assistance decision/approval is needed quickly, all measures will be taken for a speedy decision. The applicant will be notified in writing by the WMHS financial counselor.

11. The Financial Assistance application, when approved, is backdated for services rendered 12 months prior to approval and valid 12 months after approval.

12. If within a two year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25.00. If documentation demonstrates lack of cooperation in patient/guarantor in providing information to determine eligibility for free care, the two year period may be reduced to 30 days from the date of initial request for information.

13. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency will be notified and the account

will be placed on hold pending the completion of the application within ten business days. In the event the application is not completed by the patient, the patient will be deemed uncooperative and the account will be returned to the collection agency.

14. If the application is denied, the patient has the right to request the application be reconsidered. The financial counselor will forward the application to the Director of Business Operations for final evaluation and decision.

15. Applications under $2,500 will be approved by the Director, Business Operations or designee. The Vice President, Revenue Cycle will approve all applications over $2,500. The Director and Vice President have the privilege to make exceptions, as circumstances deem necessary.

APPROVAL

_____ _____

Director, Business Operations Date

_____ _____

Vice President, Revenue Cycle Date

2013 SLIDING SCALE ADJUSTMENTS (Based on FPL)

WMHS Financial Assistance Program (Charity Care) and Community Health Access Program

PATIENT RESPONSIBILITY PERCENTAGES

Size of family unit	**0%** **(PAC-FAP-unless exception noted)**	**10%**	**20%**	**30%**	**40%**
1	0 ($11,490) - $23,094	$23,095-$25,852	$25,853-$28,724	$28,725-$31,597	$31,598-$34,470
2	0 ($15,510) - $31,174	$31,175-$34,897	$34,898-$38,774	$38,775-$42,652	$42,653-$46,530
3	0 ($19,530) - $39,254	$39,255-$43,942	$43,943-$48,824	$48,825-$53,707	$53,708-$58,590
4	0 ($23,550) - $47,335	$47,336-$52,987	$52,988-$58,874	$58,875-$64,762	$64,763-$70,650
5	0 ($27,570) - $55,415	$55,416-$62,032	$62,033-$68,924	$68,925-$75,817	$75,818-$82,710
6	0 ($31,590) - $63,495	$63,496-$71,077	$71,078-$78,974	$78,975-$86,872	$86,873-$94,770
7	0 ($35,610) - $71,575	$71,576-$80,122	$80,123-$89,024	$89,025-$97,927	$97,928-$106,830
8	0 ($39,630) - $79,655	$79,656-$89,167	$89,168-$99,074	$99,075-$108,982	$108,983-$118,890
FPL range	**Thru 200%**	**201% -224%**	**225% - 249%***	**250% - 274%**	**275%-300%**

Each additional person, add $4,020 to base FPL.

***CHAP- stops at 250% FPL**

MEDICAL HARDSHIP FINANCIAL GRID

	Upper Limits of Family Income for Allowance Range		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	$32,490	$43,320	$54,150
2	$43,710	$58,280	$72,850
3	$54,930	$73,240	$91,550
4	$66,150	$88,200	$110,250
5	$77,370	$103,160	$128,950
6	$88,590	$118,120	$147,650
7	$99,810	$133,080	$166,350
8*	$111,030	$148,040	$185,050
Allowance to Give:	50%	35%	25%

*For family units with more than 8 members, add $11,220 for each additional person at 300% of FPL, $14,960 at 400% at FPL; and $18,700 at 500% of FPL.

Appendix III - Patient Information Sheet

Hospital Financial Assistance

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

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Patients' Rights and Obligations

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discuss this matter. (See contact information below).

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

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

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

Important Billing Information

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

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

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

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

Appendix VI - Mission, Vision, Value Statement

Mission, Vision & Values

Mission Statement

Superior care for all we serve

Vision Statement

Demonstrated leader in the delivery of exceptional healthcare services throughout the tri-state region

Core Values – i2care

Integrity – Demonstrate honesty and straightforwardness in all relationships

Innovation – Pursue continuous improvement through creative new ideas, methods, and practices

Compassion – Show care and kindness to all we serve and with whom we work

Accountability – Ensure effective stewardship of the community's trust

Respect – Demonstrate a high regard for the dignity and worth of each person

Excellence – Strive for superior performance in all that we do

Section II Attachments

Allegany County Community Health Needs Assessment

Western Maryland Health System and Allegany County Health Department
November 2011

Background

National Prevention Strategy

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act (known together as the Affordable Care Act) mandate the development of a National Prevention and Health Promotion Strategy and require non-profit hospitals to conduct a community health needs assessment in conjunction with public health entities.

The vision of the National Prevention Strategy is "Working together to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness." The goal is to increase the number of Americans who are healthy at every stage of life.

The National Prevention Strategy recognizes that social, economic, and environmental factors all influence health. Many of the strongest predictors of health and wellbeing fall outside of the healthcare setting. State and local government, businesses, community organizations, and community members are encouraged to partner on the Strategy.

Maryland Health Care Reform Coordinating Council

The Maryland Health Care Reform Coordinating Council (HCRCC) was created to advise the State government on efficient and effective implementation of federal health care reform. HCRCC directed the Maryland Department of Health and Mental Hygiene to develop a State Health Plan in coordination with hospitals under the Health Services Cost Review Commission.

HCRCC recommended development of interconnected state and local strategic plans to achieve improved health outcomes. Maryland's Health Improvement Plan 2011-2014 will provide a framework to support improvements in the health of Marylanders and their communities. Improving the health of all Marylanders through population planning requires committed local partnerships that include hospitals, local health departments, community organizations, and the private sector.

National and State Priorities

National and State plans include engaging partners, aligning policies and programs, utilizing evidence-based research and best practices, and ensuring accountability. National priorities are: tobacco-free living, preventable drug abuse and excessive alcohol use, healthy eating, active living, injury and violence free living, reproductive and sexual health, and mental and emotional wellbeing. Maryland vision areas are: reproductive healthcare and birth outcomes, social environments that are safe and support health, physical environments that are safe and

support health, prevent and control infectious disease, prevent and control chronic disease, and all Marylanders receive needed healthcare.

Allegany County Community Health Needs Assessment

The community health needs assessment will guide decision making for the community and allow Allegany County to engage effectively with state and federal initiatives. The community health needs assessment will be used to develop a Local Health Improvement Plan.

The Allegany County Health Department and the Western Maryland Health System (WMHS) led community health needs assessment efforts. The Allegany County Health Department works to promote health in Allegany County and WMHS is a Total Patient Revenue hospital and the only hospital in the county, providing a unique opportunity to impact community health. 72.5% of WMHS patients are Allegany County residents.

Management teams from the Allegany County Health Department and WMHS collected and analyzed data from an array of sources to assist in identifying health needs in Allegany County (see Appendix). Criteria to identify the most significant health issues included magnitude, severity compared to target, and level of need for vulnerable populations.

Data were presented to a wide variety of local organizations and community members who gave input and ranked community health priorities (see Community Input). WMHS, Allegany County Health Department, and community partners will develop a Local Health Improvement Plan with evidence-based strategies to address the top 13 health priorities.

Tasks	Jan-Mar 2011	Apr-Jun 2011	July-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	July-Sept 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	July-Sept 2013+
Data Collection & Analysis											
Presentations & Priorities											
Service Line Coordination											
Summary of Needs, Gaps & Resources											
Priorities, Best Practices & Partners											
Approve Action Plan & Metrics											
Community Benefit Report											
Report to Public											
Implement Plan & Report Quarterly											
Update Timeline for Next 3 yr. cycle											

Allegany County Overview

Demographics

Allegany County is located in rural Western Maryland and has a population of 72,598. The county is part of the Appalachian region and has low education levels, limited racial diversity, a large elderly population, and low household incomes.

Allegany County is 50.3% male and 49.7% female. A smaller percent of the population is under 5 years old (4.6%) than in Maryland (6.7%) or the U.S. (6.9%). A larger percent of the population is 65 years and older (18.1%) than in Maryland (11.8%) or the U.S. (12.6%). There is less racial diversity in Allegany County than in the U.S.; 91.4% of the population is white, 6.2% is black, 1.1% is Hispanic or Latino, and 1.1% is two or more races.

In Allegany County, the average household size is 2.25. The county has a larger percentage of single parent households (33%) than the U.S. benchmark (20%). Of the grandparents living with their grandchildren under age 18, there is a higher percentage responsible for their grandchildren (54.2%) than in Maryland (36.7%) or the U.S. (33.4%). More households in Allegany County are without a vehicle (11%) than in the U.S. (9%).

The median household income in Allegany County is well below the U.S. median ($36,810 v. $51,425), and 14.2% of individuals are living below the poverty line compared to 13.5% in the U.S. The unemployment rate is 8.9% in Allegany County compared to 6.6% in Maryland. The percentage of Allegany County children living in poverty (19%) is higher than the Maryland rate (10%) and the U.S. benchmark (11%).

While Allegany County has the same percentage of adults with a high school education as the U.S. (85%), the county has only 15.2% of adults with a bachelor's degree or higher compared to 35.2% in Maryland and 27.5% in the U.S. In addition, 11% of Allegany County residents age 16 and over are illiterate.

Community Needs Index

Catholic Healthcare West and Thomson Reuters developed the nation's first standardized Community Needs Index (CNI). It identifies the severity of health disparity in every zip code in the U.S. and demonstrates a link between community need, access to care, and preventable hospitalizations. CNI gathers data about the community's socio-economy including barriers related to income, culture/ language, education, insurance, and housing. A score of 1.0 indicates a zip code with the lowest socio-economic barriers and 5.0 represents a zip code with the most socio-economic barriers. The closer to 5 the more community need there is in a zip code. A comparison of CNI scores to hospitalization shows a strong correlation between high need and high use. In fact admission rates for the most highly needy communities are over 60% higher than communities with the lowest need.

In Allegany County, the area of highest need is 21502 (Cumberland) with a CNI of 3.8. Other high need areas include 21562 (Westernport), 21539 (Lonaconing), and 21532 (Frostburg) all at 3.6. The area with the lowest need is 21557 (Rawlings) with a CNI of 2.2.

County Health Rankings

Recent population-based health information was received from the University of Wisconsin Population Health Institute through a study funded by the Robert Wood Johnson Foundation. The results show that Allegany County ranks 21st out of 24 Maryland jurisdictions on health outcomes and 20th out of 24 on health factors. Breaking down the health factors, the study shows that Allegany is 18th in health behaviors and social and economic factors, 24th in clinical care, and 8th in physical environment.

Lifestyle and Environment

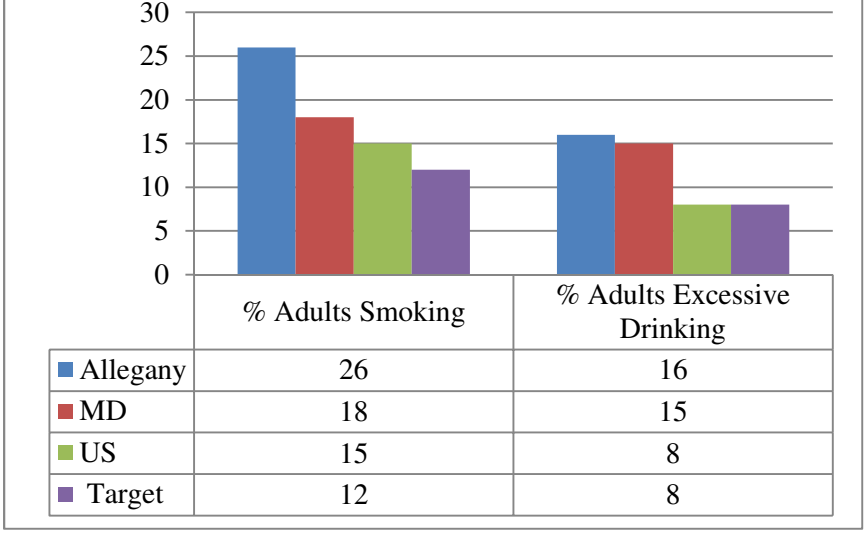
Health Behaviors

Lifestyle and behavioral risk factors substantially contribute to health. According to the Community Health Status Reports from the U.S. Department of Health and Human Services, half of all deaths can be attributed to these factors. Tobacco use accounts for 19% of all U.S. deaths, poor diet and inactivity account for 14%, alcohol use accounts for 5%, and 12% are related to factors including microbes, toxins, firearms, sexual behavior, motor vehicles and drug use. In Allegany County unhealthy behaviors including tobacco use, substance abuse, and low levels of physical activity contribute to poor health outcomes.

Tobacco and Alcohol Use

The Healthy People 2020 goal for adult smoking is 12% or less. In Allegany County, 26% of adults smoke, a larger percentage than in Maryland (18%) and well above the U.S. benchmark (15%). According to the Centers for Disease Control and Prevention, the highest smoking rates are found among vulnerable populations, including people with lower levels of educational attainment. In the U.S. in 2008, 41% of people with a General Education Development certificate smoked cigarettes, compared to 6% of people with a graduate degree.

The U.S. benchmark for excessive drinking is 8% and 16% of adults drink excessively in Allegany County. 13.1% of fatal motor vehicle crashes in Allegany County are alcohol related.

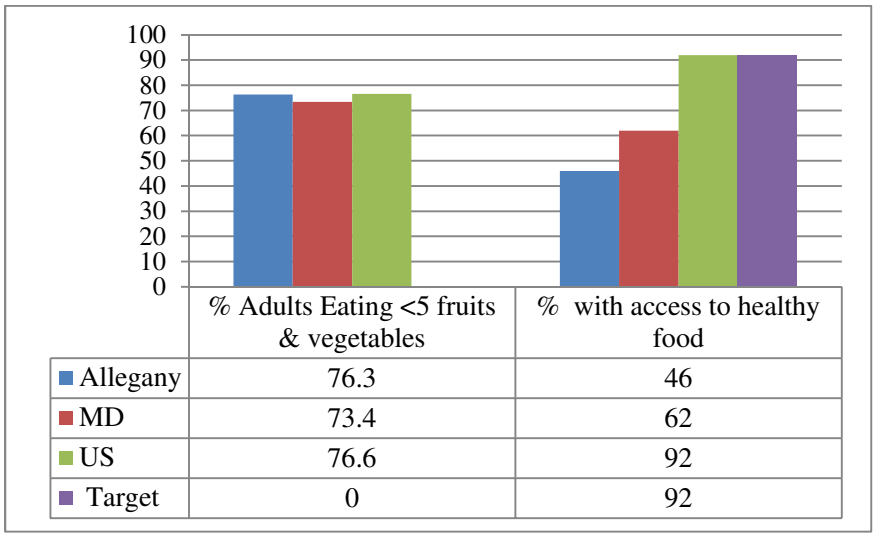


	% Adults Smoking	% Adults Excessive Drinking
Allegany	26	16
MD	18	15
US	15	8
Target	12	8

County Health Ranking 2011 (University of Wisconsin)

Food Choices and Access

76.3% of Allegany County adults report eating fewer than five servings of fruits and vegetables a day compared to 73.4% in Maryland and 76.6% in the U.S. The U.S. benchmark is for 92% of the population to have access to healthy foods but in Allegany County, only 46% of residents have access to healthy foods. The large number of households without vehicles and limited public transportation options also hinder access to healthy foods in Allegany County. Low-income rural areas are more often affected by limited access to healthy foods than higher-income communities.



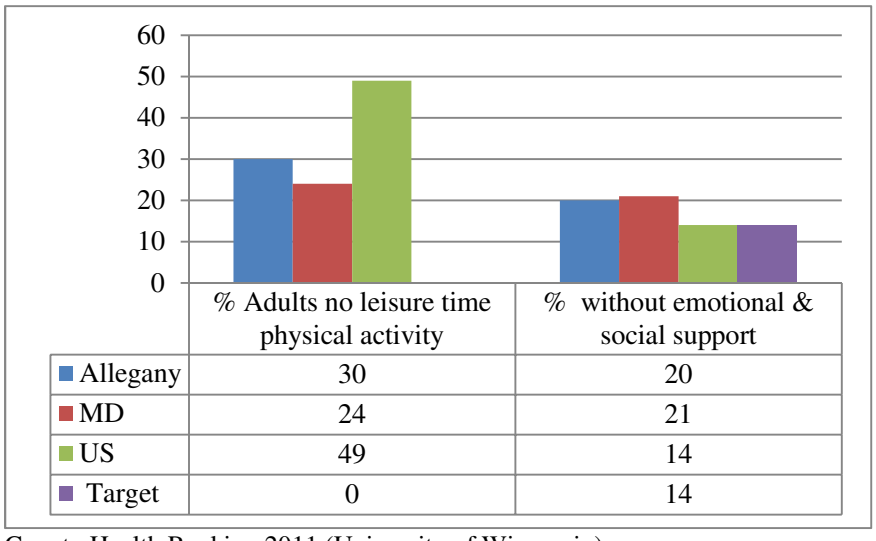
	% Adults Eating <5 fruits & vegetables	% with access to healthy food
Allegany	76.3	46
MD	73.4	62
US	76.6	92
Target	0	92

County Health Ranking 2011 (University of Wisconsin) and Health Indicator Warehouse

Physical Activity and Social Support

In Allegany County, 30% of adults are not engaging in any leisure time physical activity, compared to 24% of adults in Maryland and 49% of adults in the U.S. Allegany County has more than 19 recreational facilities per 100,000 population, above the U.S. benchmark of 17.

20% of adults in Allegany County are without social and emotional support compared to the U.S. benchmark of 14%.



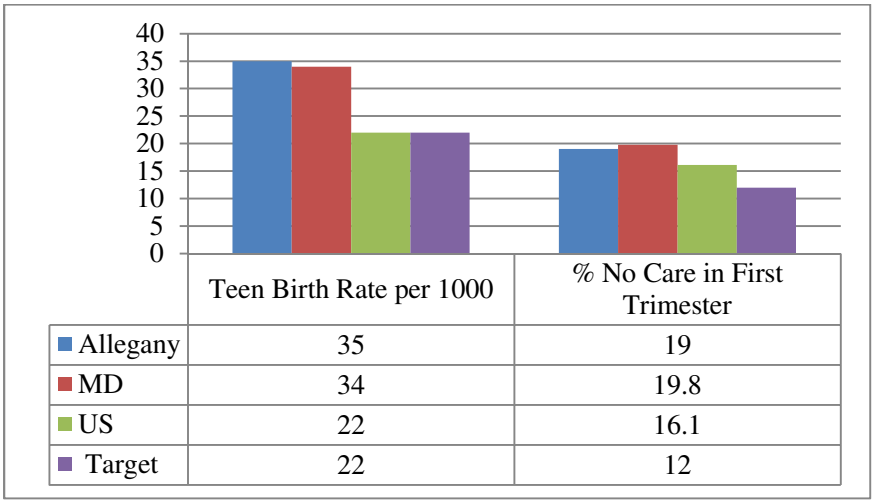
	% Adults no leisure time physical activity	% without emotional & social support
Allegany	30	20
MD	24	21
US	49	14
Target	0	14

County Health Ranking 2011 (University of Wisconsin)

Health Needs and Disease Status

Birth Measures

The teen birth rate in Allegany County (35 per 1,000 births) is above the Maryland rate (34 per 1,000) and U.S. benchmark (22 per 1,000). Allegany County has a high percentage of unmarried women giving birth at 42.7%. In Allegany County, 19% of mothers do not receive prenatal care in the first trimester compared to 19.8% in Maryland and 16.1% in the U.S.



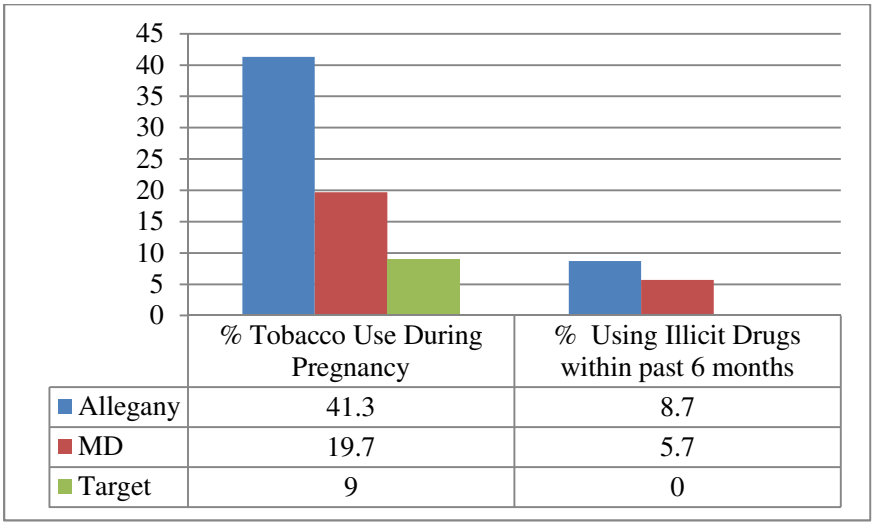
	Teen Birth Rate per 1000	% No Care in First Trimester
Allegany	35	19
MD	34	19.8
US	22	16.1
Target	22	12

Kids Count 2005-2011 and Maryland Vital Statistics

Tobacco and Drug Use during Pregnancy

In Allegany County, 41.3% of Medicaid eligible pregnant women report using tobacco during pregnancy. This is more than double the Maryland rate (19.7%) and well above the target level of less than 9%.

In Allegany County, 8.7% of Medicaid eligible pregnant women report using illicit drugs during pregnancy compared to 5.7% in Maryland. In 2010, of the 1,058 deliveries at Western Maryland Health System, 102 infants (9.6%) were drug exposed and 25 (2.4%) were drug addicted.



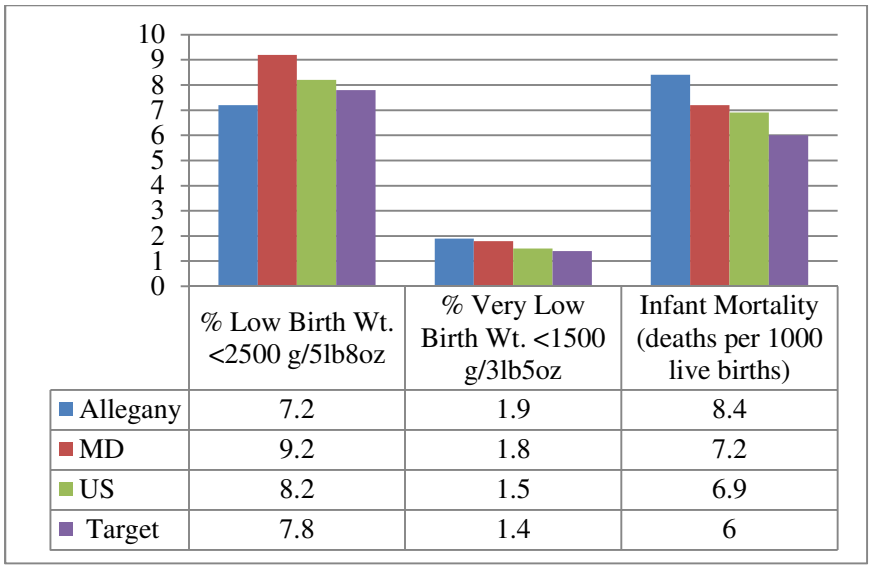
	% Tobacco Use During Pregnancy	% Using Illicit Drugs within past 6 months
Allegany	41.3	8.7
MD	19.7	5.7
Target	9	0

Maryland Prenatal Risk Assessment FY10

Birth Weight and Infant Mortality

In Allegany County, 7.2% of infants are considered low birth weight, weighing less than 2500 grams. This is lower than the Maryland (9.2%) and U.S. (8.2%) rates. However, 1.9% of infants in Allegany County are very low birth weight at less than 1500 grams. This is higher than the Maryland (1.8%) and U.S. (1.5%) rates.

The infant mortality rate in Allegany County is 8.4 per 1,000 live births, higher than both the Maryland (7.2) and U.S. (6.9) rates.



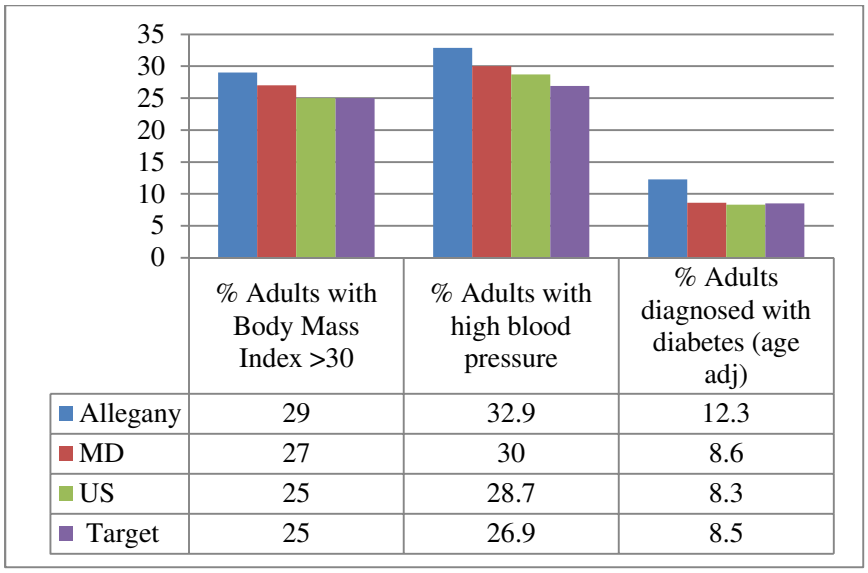
	% Low Birth Wt. <2500 g/5lb8oz	% Very Low Birth Wt. <1500 g/3lb5oz	Infant Mortality (deaths per 1000 live births)
Allegany	7.2	1.9	8.4
MD	9.2	1.8	7.2
US	8.2	1.5	6.9
Target	7.8	1.4	6

Kids Count 2005-2011 and Maryland Vital Statistics

Chronic Disease Risk Factors

The Centers for Disease Control and Prevention (CDC) define obesity as adults with a body mass index of 30 or above. By this measure, 29% of Allegany County adults are obese compared to 27% of Maryland adults and the U.S. benchmark of 25%. Obesity is associated with increased risk of heart disease, stroke, type 2 diabetes, and certain types of cancer.

Allegany County has a higher percentage of adults with high blood pressure (32.9%) than Maryland (30%) and the U.S. (28.7%). In addition, a higher percentage of Allegany County adults have been diagnosed with diabetes (12.3%) than in Maryland (8.6%) or the U.S. (8.3%).

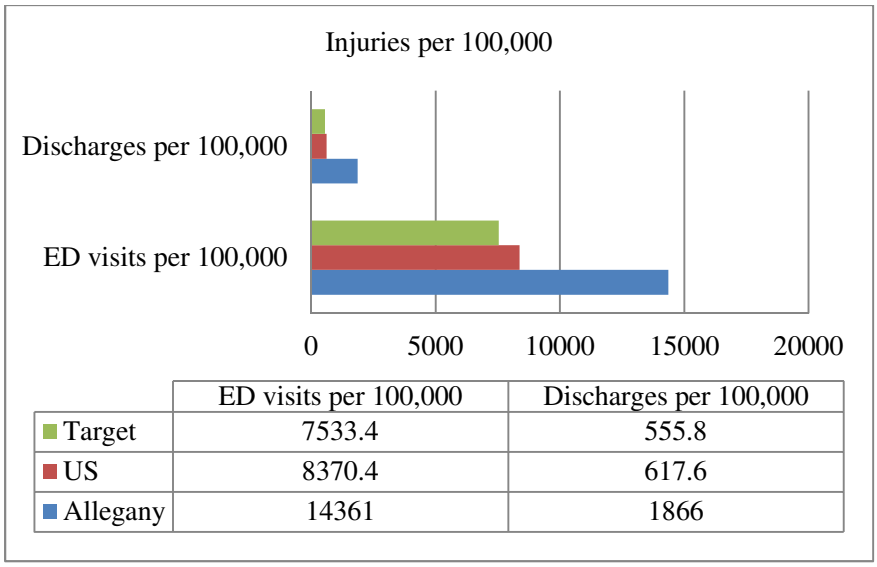


	% Adults with Body Mass Index >30	% Adults with high blood pressure	% Adults diagnosed with diabetes (age adj)
Allegany	29	32.9	12.3
MD	27	30	8.6
US	25	28.7	8.3
Target	25	26.9	8.5

County Health Ranking, 2008 CDC Trends, and Community Health Status Indicators

Injuries

The Healthy People 2020 goal for injury-related emergency department visits is 7533.4 per 100,000 population and Allegany County has 14,361 injury-related emergency department visits per 100,000. The target for injury-related hospital discharges is 555.8 per 100,000 and Allegany County has 1,866 per 100,000.



	ED visits per 100,000	Discharges per 100,000
Target	7533.4	555.8
US	8370.4	617.6
Allegany	14361	1866

DHMH Injuries 2005-2008

Behavioral Health

In Allegany County, there is a 6% prevalence of mental disorders in adults and 13% prevalence among children ages 13-18. During the first three quarters of fiscal year 2011, mental disorders have grown to be the fourth largest category of hospital admissions at Western Maryland Health System, accounting for 8.01% of admissions. From 2001- 2005, there were 903 hospital discharges per 100,000 for substance abuse. In the past year, severe depression was the

sixth most prevalent reason for hospital admission. High rates of depression are found among adults 65 and older. In the U.S. in 2006, 18% of women 65 and older and 10% of men 65 and older reported depressive symptoms. People who report depressive symptoms often experience higher rates of physical illness and higher health care resource utilization.

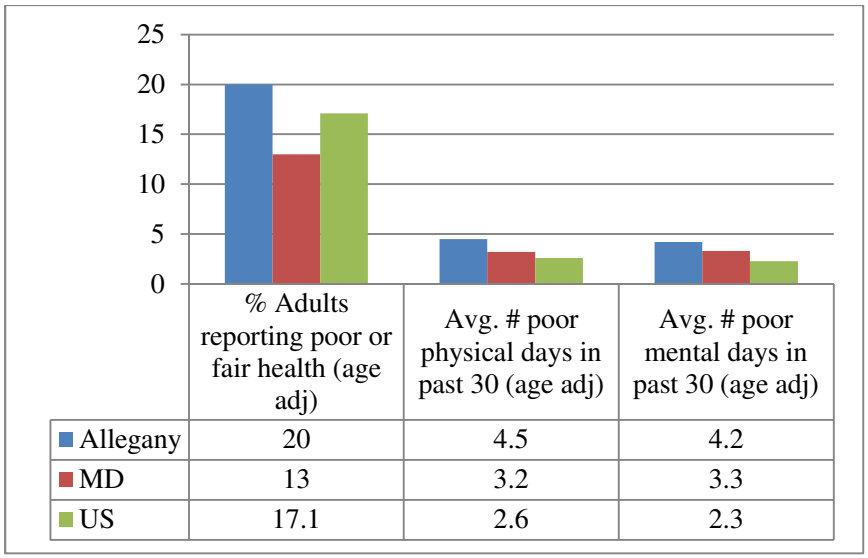
Dental Health

In Allegany County, 15.8% of residents report that they have not had a dental visit in the past five years. 12.4% of Allegany County adults have lost all of their permanent teeth compared to 3.4% of Maryland adults. It was only within the past ten years that most of the Allegany County public water systems were fluoridated, which has contributed to poor oral health in the County.

Tooth loss is associated with age and income. In the U.S., 42% of adults ages 65 and older with incomes below the poverty line reported no natural teeth. Low-income adults without dental coverage are most likely to seek care in the WMHS emergency department for dental pain.

Self-Reported Health Status

20% of Allegany County adults report that they are in poor or fair health compared to 13% of Maryland adults and 17.1% of U.S. adults. When asked about their health in the past 30 days, Allegany County adults report a higher of number of poor physical health days (4.5) and poor mental health days (4.2) than the U.S. benchmarks (2.6 physical, 2.3 mental).

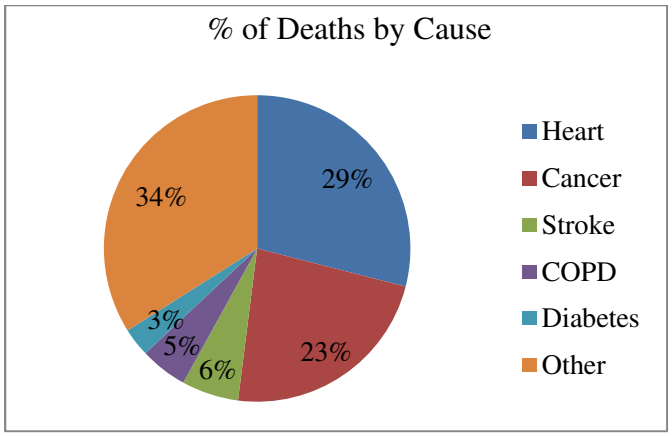


	% Adults reporting poor or fair health (age adj)	Avg. # poor physical days in past 30 (age adj)	Avg. # poor mental days in past 30 (age adj)
Allegany	20	4.5	4.2
MD	13	3.2	3.3
US	17.1	2.6	2.3

County Health Ranking 2011 (University of Wisconsin)

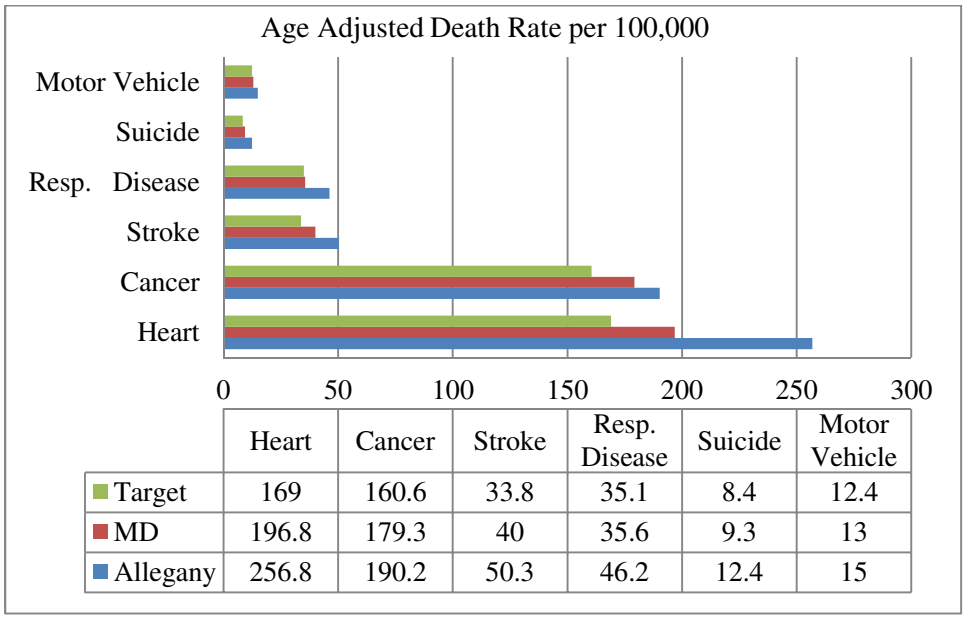
Death Rates

In Allegany County, heart disease, cancer, stroke, and chronic respiratory disease are the leading causes of death accounting for 63% of deaths.



Maryland Vital Statistics & BRFSS 2009

Age-adjusted death rates (rate per 100,000) for heart disease, cancer, stroke, chronic respiratory disease, suicide, and motor vehicle crashes are higher in Allegany County than in Maryland.



	Heart	Cancer	Stroke	Resp. Disease	Suicide	Motor Vehicle
Target	169	160.6	33.8	35.1	8.4	12.4
MD	196.8	179.3	40	35.6	9.3	13
Allegany	256.8	190.2	50.3	46.2	12.4	15

Maryland Vital Statistics 2007-2009

Because the racial minority population is so small in Allegany County, death rates and leading causes of death cannot be calculated by racial and ethnic groups. Deaths among minority populations reflect what is seen in the overall County population.

The incidence rate for all types of cancer in Allegany County is 470.6 per 100,000 population compared to 464.5 per 100,000 in the U.S. Allegany County death rates for lung and bronchus cancer (females) and non-Hodgkin lymphoma (males) are rising and are similar to U.S. rates. Lung and bronchus cancer deaths among males are above the U.S rate and are remaining stable. Deaths due to non-Hodgkin lymphoma in females and prostate cancer in males are similar to U.S. rates and are stable. Allegany county deaths due to breast cancer and colorectal cancer are decreasing along with U.S. rates.

Emergency Department Visits

In 2010, the top ten emergency department diagnoses at the Western Maryland Health System (WMHS) were:

1. Chest Pain
2. Abdominal Pain
3. Urinary Tract Infections
4. Acute Bronchitis
5. Sprain of Ankle
6. Noninfectious Gastroenteritis
7. Head Injury
8. Otitis Media (Ear Infection)
9. Sprain of Neck
10. Headache

Hospital Admissions

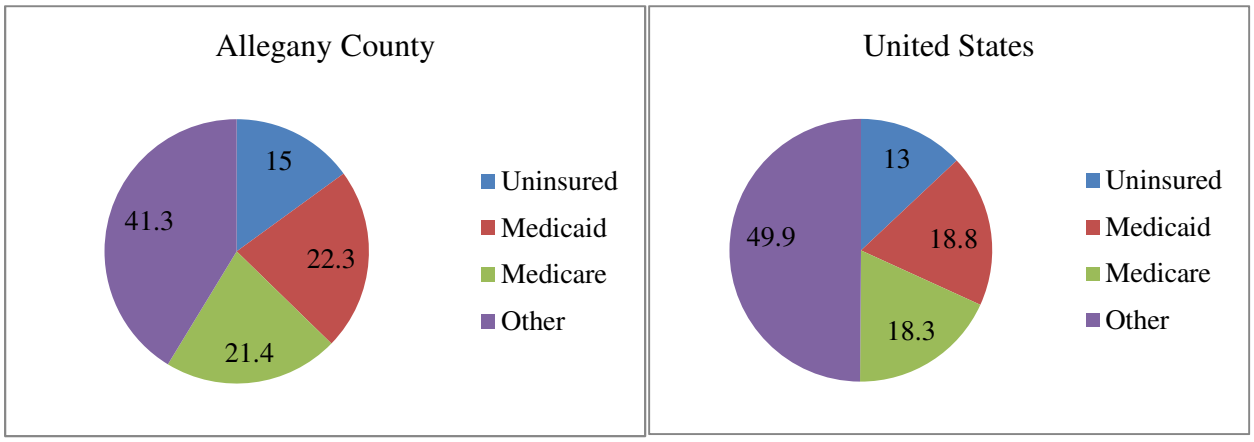
From July 2010 to April 2011, the most prevalent diagnoses for admission to WMHS were:

1. Natural Birth
2. Coronary Atherosclerosis
3. Pneumonia
4. Rehabilitation Process
5. Obstructive Chronic Bronchitis
6. Recurring Depressive Disorder
7. Osteoarthritis
8. Cesarean Birth
9. Chest Pain
10. Atrial Fibrillation
11. Acute Chronic Systolic Failure
12. Septicemia

Access to Care

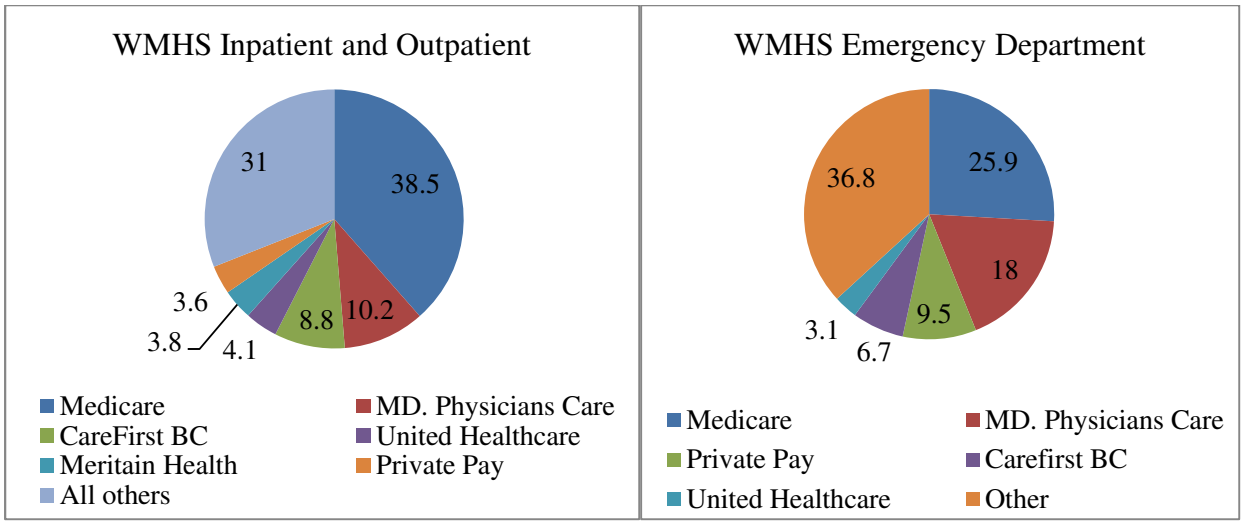
Payor Mix

Allegany County has a larger percent of uninsured residents (15%) than the U.S. benchmark (13%). The county also has more people with Medical Assistance (22.3% v. 18.8%) and Medicare (21.4% v. 18.3%).



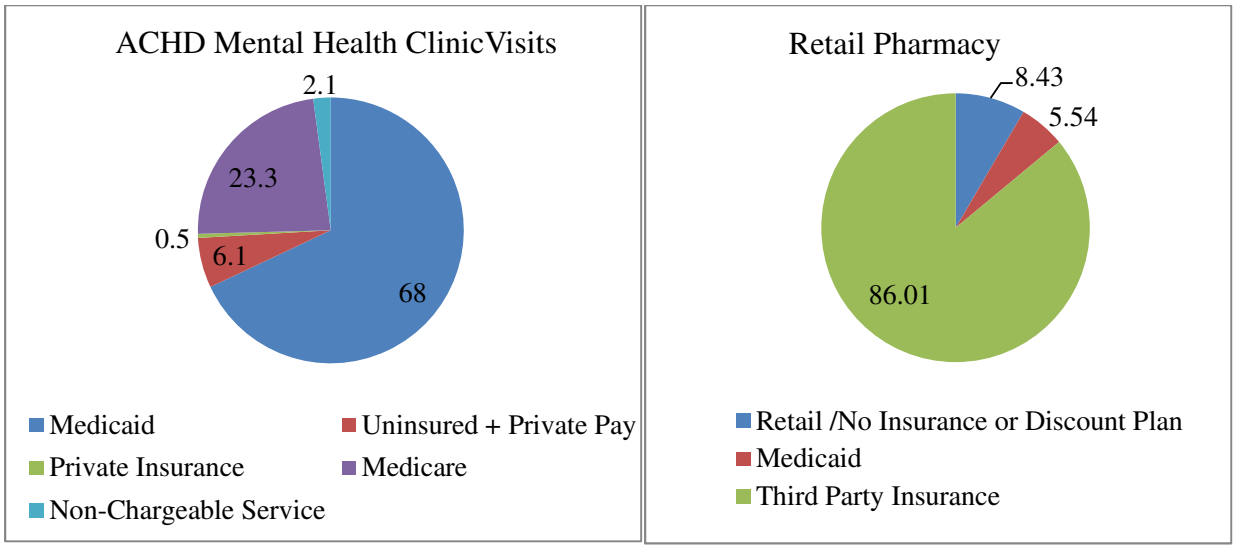
2011 County Health Ranking & Community Health Status Indicators

At Western Maryland Health System in 2010, 38.5% of patients receiving inpatient or outpatient treatment and 25.9% of emergency department patients had Medicare. 10.2% of patients receiving inpatient and outpatient treatment and 18% of emergency department patients were covered by Maryland Physicians Care, a Medical Assistance Managed Care Organization.



Western Maryland Health System

The majority of visits to the Allegany County Health Department mental health clinic are covered by Medicaid (68%) and Medicare (23.3%). 86% of retail pharmacy costs are covered by third party insurance.



Allegany County Health Department Mental Health Clinic Report 2010 and PharmaCare Network 2010

Providers

Allegany County is a designated health professional shortage area (HPSA) for primary care for low-income populations, mental health care for Medical Assistance populations, and dental care for low-income populations.

The top provider needs in Allegany County are primary care and psychiatry. According to the County Health Rankings, the U.S. benchmark is to have one primary care provider for every 631 people and Allegany County has one primary care provider for every 1,023 people. In Maryland, there is one mental health provider for every 1,617 people, but in Allegany County there is one mental health provider for every 2,271 people.

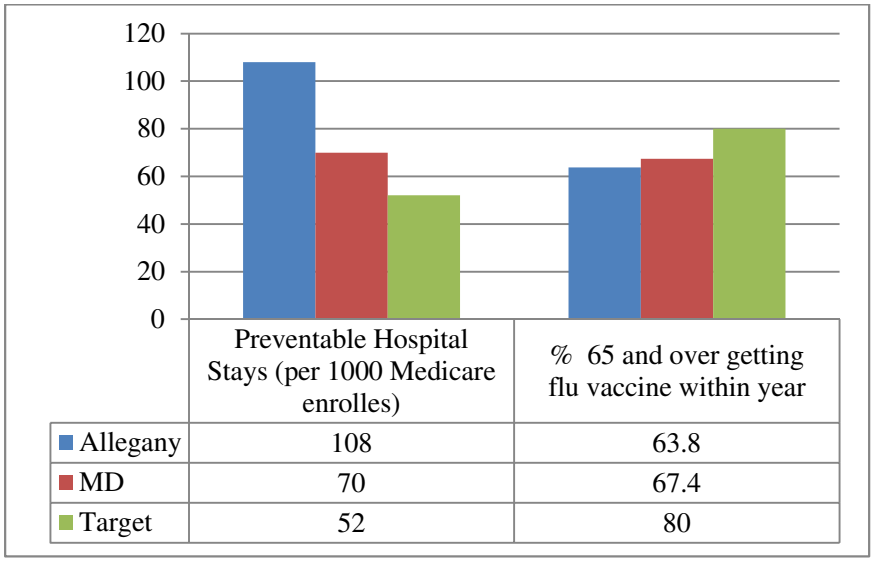
Allegany County also needs specialty providers including medical oncology, gastroenterology, vascular surgery, and urology, as well as dentists willing to provide care for adults with no insurance or Medical Assistance.

Utilization and Barriers to Care

Preventable Hospital Stays and Preventive Services

Preventable hospital stays among Medicare enrollees (hospital utilization rates for ambulatory care sensitive conditions) are 108 per 1,000 in Allegany County, more than double the U.S. benchmark of 52 per 1,000.

For preventive services, the U.S. benchmark is for 74% of female Medicare enrollees to receive a mammogram screening and Allegany County is at 74%. The Healthy People 2020 target is for 93% of females ages 18 and over to have a pap smear but currently Allegany County is at 81% of females. The U.S. benchmark is for 89% of diabetic Medicare enrollees to receive HbA1c screening and Allegany County is at 85%. The target is to have 80% of adults ages 65 and over vaccinated for the flu within the past 12 months and Allegany County has a 63.8% vaccination rate among this population.



	Preventable Hospital Stays (per 1000 Medicare enrolles)	% 65 and over getting flu vaccine within year
Allegany	108	63.8
MD	70	67.4
Target	52	80

County Health Rankings 2011

Barriers to Care and Factors that Contribute to Poor Health

High rates of poverty are a major contributor to poor health status in Allegany County. According to the Centers for Disease Control and Prevention, there is a direct correlation between lower income and higher rates of premature mortality in the U.S. In a 2008 study for the Appalachian Regional Commission, it was found that poverty and percentage of people without health insurance consistently defined localized areas that suffered the highest rates of premature mortality. The median household income in Allegany County is well below the U.S. median and 14.2% of residents and 19% of children are living below the poverty line.

Social determinants associated with poverty including limited transportation, unstable/unsafe housing, and limited access to healthy foods affect health outcomes in Allegany

County. Healthy People 2020, the evidence-based 10-year agenda for improving the nation's health, recognizes that addressing social determinants is vital to improving health. To improve health outcomes, Healthy People 2020 indicates that we must address socioeconomic conditions, transportation options, and resources to meet daily needs (e.g., safe housing, local food markets).

In Allegany County, 11% of households are without vehicles and transportation represents a barrier to care. 25% of respondents to a 2011 community survey reported missing health and human service appointments due to lack of transportation. Some transportation services are available including fixed routes and demand response services from Allegany County Transit. Half fares are available for those with Medicare, disabled, or senior citizen cards. Demand Response is an ADA service. ADA service is limited to individuals with disabilities who are unable to ride accessible, fixed route bus service because of disability. Seniors ages 65 and older are provided with curb to curb transportation within the service area. To be eligible for ADA service, one must live less than .75 miles from a bus route.

Allegany County has an Appalachian culture that is characterized by valuing self-reliance and distrusting outsiders and formalized medical systems. The Appalachian culture can represent a barrier to care, especially for preventive health services.

Health literacy is another significant barrier in Allegany County. According to the National Action Plan to Improve Health Literacy, nearly 9 out of 10 adults have difficulty using the everyday health information that is routinely available in health care facilities and in the community. According to research from the U.S. Department of Education only 12% of English speaking adults in the U.S. have proficient health literacy skills, and poor health literacy disproportionately impacts lower socioeconomic groups.

Strengths and Resources

Strong partnerships exist in Allegany County that assist in addressing community health needs. Organizations are working together to implement a variety of strategies. Western Maryland Health System provides community health and wellness, clinical prevention, care coordination, home care, and provider recruitment. As a Total Patient Revenue hospital it has a vested interest in population health and prevention. The Allegany County Health Department provides screening and prevention programs, family planning, WIC, inpatient and outpatient behavioral health services, mental health care management, dental services, and food and water protection. Many workgroups bring a variety of partners together to address specific needs in the community. Examples include: Making Healthy Choices Easy (obesity and healthy living), Community Wellness Coalition (integrated wellness), Workgroup on Access to Care and Community Access Program (uninsured and underinsured), Mountain Health Alliance (adult dental care), and Garrett Allegany Health Workforce Development Network (provider recruitment and development).

In addition to existing partnerships and a culture of collaboration, Allegany has other resources that assist in promoting community health. Allegany County has excellent air quality, a large number of recreational facilities, and a hospital that is larger and provides more services than in many other rural areas. Allegany College of Maryland and Frostburg State University

train local health care providers in nursing, psychology, dental hygiene, radiologic technology, respiratory therapy, and other areas and support continuing education for health care professionals. The Western Maryland Area Health Education Center (AHEC) facilitates continuing education and training for health professionals, conducts health workforce development activities, and promotes interdisciplinary health practice. Allegany County also has a county government that recognizes the area's health needs and supports public health.

Community Input

Through extensive data collection and analysis, 13 health priorities were selected based on magnitude, severity compared to target, and level of need for vulnerable populations. The 13 priorities were: tobacco cessation (especially during pregnancy); emotional and mental health (suicide rate and self-diagnosed depression); prenatal care – healthy start; access to care and providers; health literacy; screening and prevention (diabetes, hypertension, cancer); substance abuse (alcohol and drugs); obesity; immunization (flu); heart disease and stroke; cancer; chronic respiratory disease; dental.

From June 2011 to October 2011, WMHS and the Allegany County Health Department met with more than 20 organizations and community groups to present community health data and gather input on community health needs. The groups included:

- WMHS Board of Directors and Community Advisory Board
- Workgroup on Access to Care
- Local Drug and Alcohol Abuse Council
- Local Management Board
- Community Wellness Coalition
- Western Maryland Area Health Education Center (AHEC) Board
- School Health Council
- Mental Health Advisory Board
- Board of Health
- Cumberland Ministerial Association
- County United Way
- Cumberland Housing Rental Advisory Board
- Neighborhood Advisory Commission
- Community Trust Foundation
- Faculty and Allied Health Students at Allegany College of Maryland
- Community Forum (open to the public)

Many of these groups include a number of organizations. For example, the Local Drug and Alcohol Abuse Council involves representatives from Department of Social Services, Department of Juvenile Services, Regional Parole and Probation, State's Attorney, District Public Defender, County Sheriff, Administrative Judge of Circuit Court, substance abuse provider, consumer of addictions treatment, Allegany County Health Department, Maryland State Police, Board of Education, Frostburg State University, Allegany College of Maryland,

Allegany Radio Corporation, Salvation Army, Chessie Federal Credit Union, Community Unity in Action, Affected Newborn Program, and a youth representative.

Participants in the community group meetings and public forum were asked to provide input on the 13 health priorities. The option to identify additional needs was made available, but none were suggested. Participants were asked to select the top 5 priorities in rank order, taking into consideration: community capacity to act on the issue (funding, politics, culture), feasibility of having a measurable impact on the issue, community resources already focused on the issue, and whether or not the issue is a root cause of other problems. A nominal group ranking process was used to combine the various rankings from the groups into a final list of priorities.

Community Health Priorities

The following community health priorities were chosen (ranked from most to least important) and will serve as the basis for the Local Health Improvement Plan:

1. Tobacco Cessation (especially during pregnancy)
2. Obesity
3. Access to Care and Providers
4. Emotional and Mental Health (suicide rate and self-diagnosed depression)
5. Substance Abuse (alcohol and drugs)
6. Screening and Prevention (diabetes, hypertension, cancer)
7. Heart Disease and Stroke
8. Health Literacy
9. Healthy Start (prenatal care)
10. Dental
11. Cancer
12. Immunizations (flu)
13. Chronic Respiratory Disease

Building on a long history of collaboration and strong partnerships, Allegany County organizations will work together to develop the Local Health Improvement Plan and ensure successful implementation to improve the health of our community.

Appendix

A. Demographics – Community Characteristics

Measure	US	MD	Target	Allegany MD	Source #
Social Characteristics					
Average Household Size	2.6	2.63		2.25	1
Number of Households/% family households	112.6m (67)	21m (67)		29,000 (61)	1
Single Parent Household	20 (bench)	32		33	3
Number Grandparents living with own grandchildren under18 yrs and % responsible	6.2m (33.4)	122,482 (36.7)		1084 (54.2)	1
Population 25 years and over	197m	3.7m		48,681	1
% High school graduate or higher	84.6	87.5		85.2	1
% of 9th grade cohort graduating in 4 years	92 (bench)	80		85	3
% Dropout (age 25+ not graduated/in high school	15	12	0	15	1
% Bachelor's degree or higher	27.5	35.2		15.2	1
% Civilian Veterans (civilian 18 yrs and over)	10.1	10.9		13.5	1
% Foreign Born	12.4	12.3		1.3	1
% Speak a Language Other than English at home	19.6	14.9		3.6	1
% Languages spoken other than English	Spanish 62 Other 38	Spanish 39 Other 61		Spanish 44 Other 55	1
% Population 16 and over Illiterate		11.2		11.3	3
% Population not proficient in English		6		1	3
Economic Characteristics					
% In Labor Force (16 yrs and over)	65	69.4		54.5	1
Unemployment (16 yrs and over seeking work)		6.6(Labor April 11)		8.5 8.9	3
Median household income (2009 inflation adj S)	51,425	69,475		36,810	1
%Families below poverty level	9.9	5.5		9.5	1
% Individuals below poverty level	13.5	8.2		14.2	1
% Children enrolled in public schools eligible for free lunch	19.4m (USDA)	33		36	3,5
% Children below poverty level	11 (bench)	10		19	3
Employment					
% Leading Industries	22 ED,Health, SocA. 12 Retail	22 ED,Health, SocA. 14 Prof,Sci		25 ED,Health, SocA. 12 Retail	1
% Private wage and salary worker	79	73		75	1
% Government worker	15	22		20	1
% Self employed	7	5		5	1
Travel to Work					
Mean travel time to work in minutes	25.2	31.1		21.4	1
% Drive alone	76	73		81	1
% Carpool	11	11		10	1
% Public Transportation	5	9		1	1
% Other	5	4		6	1
% Work at Home	4	4		2	1
Other income sources					
% Households receiving retirement income other than social security	17	20		25	1
% Households receiving Social Security	27	24		38	1

Housing Characteristics					
% Owner Occupied Housing Units	66.9	69.6		70.5	1
% Renter Occupied Housing Units	33.1	30.4		29.5	1
% Vacant Housing Units	11.8	9.5		12.7	1
% Single Unit Structures	67	73		76	1
% Multi Unit Structures	26	25		20	1
% Mobile Home	7	2		4	1
% Built since 1990	26	24		11	1
% Houses without Telephones	4	3.2		5	1
Houses without access to Vehicles	9	9.1		11	1
% Total occupants paying high housing costs (<30% income)/renters only	30/50	37/49		27/43	3/1
% Houses lacking complete plumbing facilities	0.5	0.3		0.3	1
% Houses without complete kitchen facilities	0.7	0.4		0.9	1
Demographic Estimates					
Total Population				72,598	1
% Male	49.3	48.4		50.3	1
% Female	50.7	51.6		49.7	1
Median Age	36.5	37.3		40.5	1
% Under 5 years	6.9	6.7		4.6	1
% 18 years and over	75.4	75.8		81.3	1
% 65 years and over	12.6	11.8		18.1	1
% White	74.5	60.9		91.4	1
% Black or African American	12.4	28.8		6.2	1
% American Indian & Alaska Native	0.8	0.3		0.2	1
% Asian	4.4	4.9		0.6	1
% Pacific Islander	0.1	0.1		0	1
% Other	5.6	3		0.5	1
% Two or more races	2.2	2		1.1	1
% Hispanic or Latino (of any race)	15.1	6.6		1.1	1
Population Density (people per sq. mile)	44			170	2
% Population living in rural area		14		26	3
Gini coefficient household income inequality 2005-07		43.8	0	43.4	36

m = million
bench = U.S. benchmark

B. Health Needs and Disease Status

Measure	US	MD	Target	Allegany MD	Source #
Average Life Expectancy median	76.5 77.9(CDC 07)			76.3 (77.4)	9
Deaths per 100,000 population all causes median	1136.9	768.4 (VS07-09)		890.8 853.6	2
% Poor or Fair Reported Health Status Adults – Age Adjusted	17.1	13		20	3
Poor physical health days-Avg # reported past 30 days age adjusted	2.6(bench)	3.2		4.5	3
Poor mental health days -Avg # reported past 30 days age adjusted	2.3(bench)	3.3		4.2	3
Adults report BMI>30 %	25(bench)	27		29	3
% Adults 20 years and over diagnosed with diabetes age adjusted	8.3	8.6 9-'09	8.5	12.3	21

% Adults with high blood pressure	28.7	30	26.9	32.9	2
% Tooth loss-all permanent teeth				12.4	10
Birth Measures					
% Low Birth Wt (<2500 g)	8.2	9.2	7.8	7.2	5
% Very Low Birth Wt (<1500 g)	1.5	1.8	1.4	1.9	2
% Premature Births (<37 weeks)	12.7			12.1	2,22
Teen Birth Rate per 1000	22 (bench)	34		35	5
% Births to Women age 40-54	2.7			1.7	2
% Births to Unmarried Women	36.9			42.7	2
% No Care in First Trimester	16.1	19.8	<12	19	5
# Prenatal Risks Asst. Received for Medicaid eligible pregnant women		15938		414	26
-% Using illicit drugs within past 6 months		5.7	0 (HP)	8.7	26
-% Current or history of Mental health issues		8.9		18.1	26
-% Tobacco use during pregnancy		19.7	<9	41.3	26
Infant Mortality (deaths per 1000 live births)					
Infant Mortality	6.9	7.2	6	8.4	5,9
White/ Non Hispanic Infant Mortality	5.8			9	2
Black/Non Hispanic Infant Mortality	13.6			Nrf=<500 births + 5 events	2
Hispanic Infant Mortality	5.6			Nrf	2
Neonatal Infant Mortality-<28 days	4.5		4.1 (HP)	6	2
Post Neonatal Infant Mortality	2.3		2 (HP)	3.4	2
Mortality (premature death years of potential life lost before age 75, per 100,000population age adjusted)	5564	7535		8073	3
Death Measures (age adjusted per 100,000)					
Heart Disease	126.0	201.3 196.8	169	258.9 256.8	9
Cancer	178.4	182.6 179.3	160.6	186.8 190.2	9
Stroke	42.2	41.3 40	33.8 (HP)	52.7 50.3	9
Chronic Respiratory Disease	40.8	34.9 35.6	35.1	52.4 46.2	9
Accidents		25.8 25.3		29.4 35.5	9
Diabetes		22.4 21.8		<20 deaths	9
Flu & Pneumonia		18.7 17.8		<20 deaths	9
Septicemia		17.3 17.4		20.3 20.7	9
Alzheimers		17.1 16.9		<20 deaths 17	9
Nephritis		13.5		<20 deaths	9
Substance Abuse	12.6		11.3 (HP)	16.5	23
Suicide	10.9	9.3	8.4 (SHIP)	12.4	2
Motor Vehicle Crash Deaths per 100,000 population	12 (bench)	13	12.4 (HP)	15	3
Injuries (MD 63)not age adjusted				69	24
Unintentional Injury Mortality (No MVA) per 100,000 pop. Age adj. 1996-2005	40		36	12.70	36
Cancer Rates					

Incidence Rate, all cancer-cases per 100,000 population per year)	464.5	460.9		470.6	8
Incidence Rate all cancers, ages<20 cases per 100,000 population per year	16.9	14.4		Less than 16 cases	8
Mental Health Prevalence					
Children				709/5456	11
Adults				3558/59297	11
Infectious Diseases-National Notifiable (# cases reported)					
E-coli				1	2
Salmonella				52	2
Shigella				2	2
Screened positive for HIV per 100,000 population				194	3
Haemophilus Influenzae B (<5yrsold)	0.3		.27 (HP)	7	2
Hepatitis A				2	2
Hepatitis B	.06		0 (HP)	5	2
Measles	115		30 (HP)	0	2
Pertussis	2777		2500 (HP)	13	2
Congential Rubella Syndrome	0		0 (HP)	0	2
Syphilis				2	
STI- Chlamydia rate per 100,000 population	83 (bench)	439	365	241	3

HP = Healthy People 2020
SHIP = Maryland State Health Improvement Process

C. Access to Care – Payors and Providers

Measure	US	MD	Target	Allegany MD	Source #
Uninsured individuals under age 65	13(bench)	17	0	15	3
% Uninsured children				6.7	5
Medicare beneficiaries –elderly				12815	2
Medicare beneficiaries – disabled				2511	2
% Medicare	18.3			21.4	
Medicaid beneficiaries	18.8			16180	2
% Receiving Medical Assistance 2008				22.3	32
Population to Primary Care Provider ratio	631:1 (bench)	713:1		1023:1	3
Mental Health Providers ratio of population to mental health providers		1617:1		2271:1	3
% Residents without dental visit in past 5 years				15.8	10
% Medical Asst. Patients served by Public Mental Health system		14.1		18.8	28
Health Professional Shortage Area* – Primary Care				LI,P	45
Dental HPSA				LI, P (MA pending)	45
Mental Health HPSA				P, MA	45
Providers per 100,000 population					
Primary Care	54.6			71.6	44
General Surgeon	4.9			9.6	44
Psychiatrists	0			12.4	44
Specialists	31.7			168.1	44
Total Physicans	87.6			239.7	44
Dentists	33			59.2	44

LI = low income, P = correctional institutions, HC = health ctr/FQHC, C = county, MA = Medical Assistance

D. Lifestyle Choices and Environment

Measure	US	MD	Target	Allegany MD	Source #
Health Behaviors					
% Adults report smoking (100 +cigarettes)	15(bench)	18	12 (HP)	26	3
Excessive Drinking (Binge & Heavy)	8 (bench)	15		16	3
% Adults report Binge Drinking past 30 days		13		15	3
% Adults aged 20 and over reporting no leisure time physical activity	49	24		30	3
Socio-economic factors					
% Adults without Social/emotional Support	14(bench)	21	12	20	3
Violent Crime Rate per 100,000 population	100(bench)	649		360	3
Juvenile Arrest Relative Index rate				3.8	5
Juvenile Drug Arrest # (%-Marijuana)				68 (73.5)	25
Adult Drug Arrest # (%-Marijuana)				610(63.4)	25
Physical Environment					
Air Pollution- annual number of unhealthy air quality days due to fine particulate matter or ozone		4/16		0/0	3
Access to healthy foods	92 (bench)	62		46	3
% Adults report eating fewer than 5 fruits & vegetables per day 2007	76.6	73.4		76.3	36
Access to recreational facilities rate facilities per 100,000 population	17 (bench)	12		19	3
Liquor store density –number per 100,000 population		20		18	3
Toxic chemicals released annually pounds				2466905	2
New Wells: Number Fecal Contamination				65:0	20
Number people treated with post exposure prophylaxis Rabies				67	20
Food Bourne Disease –Number Outbreaks				1	20
Water Bourne Disease –Number Outbreaks	7		2	0	20
% Children 0-72 months tested Blood Lead Level			0.9 (HP)	27.4	20
% Children with Elevated Blood Level				1.1	20
Alcohol Related crashes % of total (fatal)				13.1 (0)	25
Domestic Violence 2009 #offenses (deaths)				306 (0)	35
Well Being Index (Rank of 436 Congressional districts)					
Overall Rank				99	33
Life Evaluation				132	33
Emotional Health				264	33
Physical Health				206	33
Healthy Behavior				200	33
Work Environment				42	33
Basic Access				93	33

E. Continuum of Care and Utilization

Measure	US	MD	Target	Allegany MD	Source #
Adult Preventive Services					
% Pap Smears age 18 and over	84.5		93 (HP)	81.6	2
% Female Medicare enrollees receive Mammogram screening	74	64		74	3
Sigmoidoscopy 50+	42.3			44.6	2

% Pneumonia vaccine 65+ 2003-09				62	36
% Flu vaccine 65+ in past 12 months 2003-09	90	67.4	80	63.8	36
% Diabetic Medicare enrollees that receive HbA1c screening	89	81		85	3
Preventable Hospital Stays - hospitalization rate for ambulatory care sensitive conditions per 1000 Medicare enrollees	52	70		108	3
Alcohol and Drug Abuse					
Visits Methadone				20300	23
Admissions for Alcohol & Drug Abuse				1463	23
Hospital Discharges substance abuse rate per 100,000				903	23
Injuries					
ED visits per 100,000	8370.4		7533.4 (H)	14361	24
ED visits age 0-14				1951	24
ED Visits age 65+				1318	24
Hospital discharges per 100,000	617.6		555.8 (H)	1866	24
Mental Health Clinic					
Medicaid Visits				15601	11
Grey Area PP				1413	11
Non-Grey PP				109	11
Medicare/Private Ins.				5335	11
Non chargeable Svs				473	11
WMHS Patients					
Inpatient #				11814	12
Outpatient #				190351	12
% of Total IP &OP				72.51	12

F. Sources

Code	Source	Timeframe
1.	American Community Survey/ Census 2010 Data	2005-2009 5 year estimates
2.	Community Health Status Indicators (DHHS)	2009 Report –using data sources 2001-2009
3.	County Health Rankings (University of Wisconsin)	2011 Report- Data elements have varied timeframes
4.	Data Resource Center for Child and Adolescent Health	2007 National Survey of Children's Health-State level only
5.	KIDS COUNT (Annie E Casey Foundation) County Profiles	Most recent 5 years varies 2005-2011
6.	Community Need Index (Catholic Healthcare West) Standardized index -severity of health disparity by zip code based on income,language/culture,education, insurance & housing.	2011- support data elements proprietary to Thomson Reuters
7.	AgingStats.Gov Trends in Population, Economics, Health Status & Risks, Health Care-US Older Americans	2010 Report using various data & trend periods
8.	NCI-State Cancer Profiles (Incidence Rate by State & County, Death Rate)	Rate Period 2003-2007, as reported to CDC Cancer Registry (NCPR-CSS) Nov. 2009-Jan. 2010
9.	MD Vital Statistics	2006-08 (2009 report unavailable) Birth data 2009
10.	MD Behavioral Risk Factor Surveillance Survey (Dental Care-Allegany County)	2006 & 2008
11.	ACHD Program & Clinic Report-Mental Health Clinic Utilization *NIMH & NCHS-Mental Health prevalence	2008-2010 *2009
12.	Demographics from WMHS Strategic Plan (Finance)	2010

13.	Physician Needs Assessment-WMHS Foundation	2011
14.	On Call Coverage Utilization	2010 anecdotal
15.	Most Prevalent Diagnoses in ED (WMHS IT)	CY2010
16.	Payor Mix (Payor Mix for WMHS and ED only-by Ins Group IP,OP & combined and the same by just payor mix)	CY2010
17.	Workforce Development Network Baseline Assessment (Western Maryland AHEC)	2011
18.	Patient Satisfaction (HCAHPS, OP Survey, HomeCare CAHPS, Patient Satisfaction Team Plan)	FY10 (July 1, 2009-June 30, 2010)
19.	Patient Feedback (Dept Comparison Report, Volume Complaint Type)	CY2010 (Jan-Dec)
20.	ACHC Environmental Health Report-Rabies, New Wells MDE-Lead Poisoning Annual Report, DHMH Water & Food Bourne Illnesses	CY2007-10 Allegany County CY2006,2008, 2009 CY2008-10
21.	CDC-County/State Data & Trends Diabetes Diagnosed, Physical Inactivity, Obesity	2008
22.	Diversitydata.org	US Census Bureau 2000 & 2010, MSA-Cumberland, MD
23.	ACHD Clinic Records and Report- Alcohol & Substance Abuse (utilization, ED visits, arrests, etc)	2008-10 Allegany County 2001-05 Need for Substance Abuse Treatment-Maryland Final Report
24.	DHMH Injuries (ED visits, discharges & death rates)	2005-08 Allegany County
25.	CESAR-Uniform Crime Report MSP (drug arrests and alcohol related crashes)	2001-05 (2009 crashes) Allegany County
26.	ACHD Perinatal Substance Abuse Intervention Program DHMH Division of Outreach & Care Admin. MD Prenatal Risk Asst.	FY10 and FY11 Mid-Year Reports FY08-10 Allegany County
27.	DHMH Tobacco Use Prevention & Cessation Program-prevalence	2000, 2002, 2006, 2008
28.	ACHD Mental Health Systems Office FY12-14 Plan	FY08-10 Allegany County
29.	Allegany County Transit –Fares, Routes, Benefits	2010
30.	Local Findings-Community Strategies & Measurements to Prevent Obesity in US (various data sources)	Report 2010
31.	Cumberland CDBG Consolidated Plan (2005-09)	2005
32.	WMHS Community Benefit Report -Narrative	FY 10
33.	Gallup- Healthways Well Being Index Congressional Districts	CY 2010
34.	WMHS Inpatient Admissions (# patients, costs, % , by code groups)	FY10 & 11 thru 4-15
35.	Maryland Network Against Domestic Violence Crime Report	FY10 MD only
36.	Health Indicator Warehouse via HealthyPeople.gov	Dates vary with source
37.	Inpatient Characteristics & Payor	FY10 & Fy11 YTD
38.	Nursing Vacancy Rate-Board Dashboard Human Resources	FY10
39.	Outmigration of Patients by Service Line	CY2008
40.	National Plan to Improve Health Literacy	2011 Report
41.	Birth Data WMHS	CY10
42.	PharmaCare Network Top Rx and Payers	CY10
43.	Burden of Chronic Disease (MD Vital Statistics & BRFSS)	2009 Allegany County
44.	HRSA Area Resource File (Provider data from AMA 2007)	2008
45.	HRSA Shortage Designation	2011
46.	ED use for Dental Reasons (WMHS)	FY10
47.	Transportation Survey (ACHD, WMHS-ED & TSCHC)	July 2011