COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

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

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

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

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

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

Examples of sources of data available to develop a CHNA include, 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) the Maryland Chartbook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings & Roadmaps (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx);
(12) 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;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(16) CRISP Reporting Services.

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

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

With respect to each significant health need identified through the CHNA, either—
(i) Describes how the hospital facility plans to address the health need; or
(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

   a. Bed Designation – The total number of licensed beds
   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
   c. Primary Service Area (PSA) zip codes;
   d. Listing of all other Maryland hospitals sharing your PSA;

e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
227 (total licensed beds); 188 Med/Surge, 17 Obstetric, 4 Pediatric and 18 Acute Psychiatric. Source: FY2017 Licensed Bed Designation letter from DHMH dated 06/28/2016	17,569 total admissions; 15,794 excluding nursery, 1,775 births	21711 21713 21719 21722 21733 21740 21742 21750 21758 21756 21767 21769 21779 21780 21782 21783	N/A	4.1%	28.4%	32.1%

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

(i) A list of the zip codes included in the organization's CBSA, and

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

(iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Statistics may be accessed from:

The Maryland State Health Improvement Process (http://dhmh.maryland.gov/ship/);

The Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/Pages/home.aspx);

The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf);

The Maryland Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf);

The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	More than 78% of Meritus Medical Center discharges reside in a zip code within Washington County, Maryland. The organization provides services to people living throughout a 60-mile radius of the quad-state region. The geographic boundaries of Washington County are designated as the Primary Service Area (PSA). Washington County residents served by the health system make up a representative cross section of the county's population including those considered ''medically underserved,'' as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers. The majority of patients served by the health system live in Washington County, Md., which includes the following zip codes: 21711 – Big Pool 21713 - Boonsboro 21719 – Cascade 21722 – Clear Spring 21733 – Fairplay 21740 – Hagerstown 21742 – Hagerstown 21750 – Hancock 21756 – Keedysville 21758 –Knoxville 21767 – Maugansville 21769 – Middletown 21779 – Rohrersville 21780 – Sabillasville 21782 – Sharpsburg 21783 -Smithsburg	Healthy Washington County FY2016 Community Health Needs Assessment
Median Household Income within the CBSA	$56,228	U.S. Census Bureau, 2016 American Community Survey Estimate
Percentage of households in the CBSA with household income below the federal poverty guidelines	12% of people in Washington County live below the poverty line	Source: 2015 Small Area Income and Poverty Estimates (SAIPE)
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	8.4% is the percentage of population under age 65 without health insurance residing in Washington County zip codes	County Health Rankings, org. 2017.

Percentage of Medicaid recipients by County within the CBSA.	25.9% (38,922 persons enrolled / 150,292 total population) Washington County, MD Total Medicaid Enrollment by County as of December 31, 2014	Maryland DHMH Overview of Maryland Medicaid Data Shannon McMahon Deputy Secretary, Health Care Financing April 1, 2015
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	77.4 (All) 75.7 (Black) 80.3 (White)	Maryland SHIP data, 2013-2015
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	1015.5 (All races) 1164.7 (White Non-Hispanic) 432.6 (Black Non-Hispanic) 400.8 (Asian Non-Hispanic) 74.9 (Hispanic, includes all persons of Hispanic origin of any race) *Per 100,000 population Infant mortality 7.1 (All races) 6.2 (White Non-Hispanic) 20.4 (Black Non-Hispanic) *Per 1,000 live births by race of mother	Maryland Vital Statistics Annual Report, 2015, Table 39A, pg. 147 Maryland Vital Statistics Annual Report, 2015, Table 33, pg. 121
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.o	Food security 12/24 Limited access to health y foods 6/24 Density of farmer's markets 0.03 Toxic Chemicals 352,091 lbs. Air pollution: 9.5 (particulate matter per cubic meter) Severe housing problems 32.2% (state 36.3%) Low birthweight: 9.5% (state 8.6%) Children in poverty 27% Child maltreatment rate 11.9 (per 100,000) Teen birth rate 24.7 per 1,000 Alcohol-impaired driving deaths 41% Workers using public transportation 0.95 Homicides 3 per 100,00	Maryland SHIP data, 2013-2015

rg/ph/county-indicators.aspx	Suicides 11.8 per 100,000	
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	Total population est. 150, 292 White alone 83.5% Black or African American alone 11.4% American Indian and Alaska Native alone 0.3% Asian alone 1.9% Native Hawaiian or Pacific Islander 0.1% Two or more races 2.8% Hispanic or Latino 4.7% White alone, not Hispanic or Latino 79.8% Language other than English used at home 7% Other languages include Spanish, other Indo-European languages, Asian and Pacific Island languages, and "other"	U.S. Census Bureau, Quick Facts July 1, 2016 as accessed 11/28/17.
Other	High School graduate or higher 86.7% Adults age 25+ with Bachelor's Degree 16.9% Social Determinants Data Summary • 18.63% of children in Washington County live below 100% Federal Poverty Level (FPL) compared to the state at 12.89% • 13.7% of Washington Co. population live below 100% FPL compared to state at 9.4% • 76.7% of adults in Washington Co. have inadequate fruit/vegetable consumption compared to the state at 72.4% • Low income population with low food access in Washington Co. is 7.61% compared to state at 3.24% • Population of Washington Co. living with low food access (food desert) is 34% compared to state at 22.55% • Population currently smoking	U.S. Census Bureau, Quick Facts July 1, 2016 as accessed 11/28/17. Compiled from Community Commons data 10/19/2015

	cigarettes in Washington Co. at 21.2% compared to state at 15.4% • Former or current smokers in Washington Co. at 47.42% compared to state at 40.7% • Population who has attempted to quit smoking in Washington Co. at 52.2% compared to state at 58.31	

At the time of the most recent CHNA (FY2016), the population of Washington County was estimated to be 149,573. The overall population of Washington County is growing at a slower rate than the population of Maryland overall. The growth rate has remained positive, expanding by 1% since the prior CHNA (FY13).

Washington County has less population density (322.1 persons per square mile) compared to the state. The county's residents are older and have a smaller proportion of the population under age 18 as compared with the state. Over one fifth (20.6%) of the population is over age 60. The median age of persons in Washington County is 40. Washington County is much less diverse than the state of Maryland. The vast majority of the population of Washington County is white (83.5%), representing a much higher percentage of the population compared with the state of Maryland, although there is a growing Hispanic or Latino population (4.7%), particularly in the Hagerstown zip code area of 21740.

The education level of Washington County residents continues to increase, but a slightly smaller percentage of the population are high school or college graduates (85.8%) compared with the state average (88.7%). The average travel time to work (at 28.1 minutes) is comparable with the rest of the state. Households in Washington County are slightly smaller compared with the state (2.51 persons per household), and the median household income of $56,228 is much less than the state average. A higher percentage of persons live in poverty in Washington County (13.2%) than the state.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__X__Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 05/26 /16 (mm/dd/yy). The Community Needs Health Assessment was conducted during FY 2016. Data collection occurred between June 10, 2015 – August 3, 2015 (FY2016).

____No

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

http://www.meritushealth.com/documents/FY2016-CHNA-Report-FINAL.pdf

The Community Health Needs Assessment action plan was reviewed and approved by the Meritus Medical Center Board of Directors on May 26, 2016.

(Please see "Board Approval of Action Plan" on pages 116 - 117 of the FY2016 Meritus CHNA after downloading the document)

A copy of the original CHNA Action Plan approved by the Board is included (see Appendix VI).

The prioritized community health needs from FY2016 Meritus CHNA includes:

1. Reducing obesity and increasing physical activity.
2. Improving mental health education, access to care and reducing ED visits.
3. Improving the management of diabetes illness with better access to care and education.
4. Promoting healthy lifestyles and wellness through balanced diet and exercise.
5. Improving timely access to substance abuse treatment and reducing overdose deaths.
6. Reducing heart disease and managing hypertension.

During Meritus Medical Center's annual strategic planning process, findings from the FY2016 Community Health Needs Assessment and Action Plan were used to align the organization's strategic goal for Population Health, "To improve the health of the region." A key objective of the Strategic Plan is to "implement the CHNA Action Plan" from FY2016. Section V of this narrative includes the highlights of the most recent Community Benefit initiatives, programs and outcomes that have been implemented based on the FY2016 CHNA prioritized health needs. The CHNA Action Plan continues to be updated annually to document the strategic initiatives that help meet identified needs and demonstrate the outcomes that have been achieved.

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

_X__Yes Enter date approved by governing body/authorized body thereof here: 05/26/16 (mm/dd/yy)

___No

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

http://www.meritushealth.com/documents/FY2016-CHNA-Report-FINAL.pdf
(see **Planning and Implementation Strategies** pages 112 – 117)

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

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

_X_Yes
___No

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

As a community hospital, Meritus Medical Center purposefully incorporates our commitment to community service into our internal management and governance structures as well as strategic and operational plans. Meritus conducts a community health needs assessment every three years to identify and prioritize community health needs and service gaps. An action plan of initiatives and goals are developed to address the prioritized health needs. The action plan is reviewed by the Meritus Board Strategic Planning committee and approved by the Meritus Board of Directors.

The identified community health needs and updated CHNA action plan are reviewed annually by Leadership during the environmental assessment step of the strategic planning process. Being informed by the CHNA and other inputs, Meritus aligns the Population Heath goal component of the strategic plan with measurable objectives designed to improve the health of the region. One of the specific goals is to implement the Community Health Needs Action Plan. The organization's strategic plan is approved by the Meritus Board of Directors with annual assessment of progress and goal achievement.

b. What stakeholders within the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. _X__CFO
3. _X__Other (please specify) Chief Compliance Officer

Describe the role of Senior Leadership.

Senior Leadership provides support and guidance necessary to develop the strategic framework underlying the Community Benefits activities. Senior leaders take an active role in annual organizational strategic planning that incorporates and aligns goals and initiatives, including those based on community health needs and the prior year's outcomes. The final Community Benefit report is reviewed and approved by Senior Leadership. In addition, a final audit of the CB report findings is conducted by the Finance department and approved by the CFO.

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse

3. _X__Social Worker
4. _X__Other (please specify) Dietitian, Educator

Describe the role of Clinical Leadership

In coordination with Administration, Clinical Leadership designs, plans and implements the initiatives to address community health needs. They provide the direct, front-line clinical and educational service, screenings and programs to targeted populations in our community. They document efforts and help measure and analyze outcomes monthly. Clinical Leadership makes recommendations for improvement, changes and alternative initiatives based on effectiveness using the Lean KATA and PDSA models.

iii. Population Health Leadership and Staff

1. __X__ Population health VP or equivalent (please list)
2. ____ Other population health staff (please list staff)

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

The Executive for Care Management participates in organizational strategic planning and goal setting to ensure that the population health services planned and provided effectively meet the needs of persons served. The Exec has helped research, develop and operationalize the Regional Health Transformation Plan. She is also a member of the LHIC. The Care Management staff work as part of the integrated treatment team to help meet patient health needs by coordinating treatment services, the plan of care and linkage to community resources that help lessen the burden of underlying social determinants of health. The outcomes related to the prioritized community health needs are included in the Community Benefit report.

iv. Community Benefit Operations

1. ___the Title of Individual(s) (please specify FTE)
2. _X__Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Community Benefit Committee

Executive Director, Behavioral & Community Health Services (BCHS) Leads the tri-annual Community Health Needs Assessment (CHNA) process, facilitates a quarterly review of CHNA Action Plan with Clinical and Operations leadership to assess progress with meeting goals and initiatives and oversees the organizational reporting of Community Benefit activities, co-chairs the Washington County Local Health Improvement Coalition (LHIC) known as Healthy Washington County https://healthywashingtoncounty.com/, to coordinate health initiatives with community partners. Leads the initiatives around meeting Mental Health, Substance Abuse, Obesity and Wellness needs. Contributes to writing the CB report narrative and summarizes the outcomes of the initiatives.

Department Assistant, Behavioral & Community Health Services (BCHS) Assists and supports the Director of BCHS in completion of CB activities, collects, updates and revises the CHNA Action Plan, prompts and collects Community Benefits reports for the Meritus organization, updates CBISA software program detailing CB activity monthly, and compiles, types and submits the final CB report.

Executive Director, Finance Provides assistance with financial and salary information, regulatory guidance and overall review of the Community Benefit Report to ensure that data is submitted accurately and in the correct categorization and provides description of the Financial Assistance policy.

Community Relations Coordinator, Corporate Communications Describes the general hospital demographics and characteristics of the primary service area. Researches and updates the significant socio-demographic characteristics of the population living in the CB service area, coordinates Healthy Washington County website, maintains publically posted links to our Community Health Needs Assessments and Appendixes, and publicizes the Meritus Health CB results annually.

Executive Director, Strategic Planning Provides support and guidance necessary to develop the strategic framework underlying the Community Benefits activities, leads senior leadership in annual strategic planning that incorporates and aligns organizational goals and initiatives, including those based on community health needs and the prior year's outcomes, monitors progress on goals and outcome measurement and provides updates to the Board of Directors.

Physician Recruiter Provides a written description of the availability of physicians, specialist providers, including outpatient specialty care, and gaps with regard to the service region.

Vice President, Business Integrity Provides support and guidance in carrying out the organization's Community Benefits activities, helps ensure compliance with the collection of data and completion of all reporting requirements, participates in proofing the narrative and assesses general alignment with the organization's strategy, reviews and approves the final Community Benefit report.

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

Spreadsheet __X___yes _____no

Narrative __X___yes _____no

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

An internal audit of the Community Benefit report is completed by our Finance personnel. The audit includes a review of the data, criteria used and the calculations. The audit is signed-off by our CFO prior to submission to the HSCRC. In addition, the report is audited as part of the HSCRC Special Audit on an annual basis.

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

Spreadsheet ___X__yes _____no

Narrative ___X__yes _____no

If no, please explain why.

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

___X___Yes _____No

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

Meritus Health's stated mission is to "improve the health status of our region by providing comprehensive health services to patients and families." A key step toward achieving this mission is the development of a robust population health improvement model that is designed to improve health status of persons living in Washington County, Maryland. To this end, Meritus Health has adopted the comprehensive Population Health Strategy that directly addresses the needs of Washington County with emphasis on underserved populations. The following key areas define the focus of new strategies that will require significant investment over the next three years:

— Care Management program expansion;
— Establish a "Hot Spot" clinic in the downtown;
— Establish an endocrine clinic;
— Ensure adequate Medication Assisted Treatment for opioid use disorder;
— Expand the Weight Loss Center program;
— Develop telehealth services to increase access to Behavioral Health care;
— Establish delivery of basic medical services at the homeless shelter;
— Establish a "sobering center" to manage patients with acute intoxication;
— Improve Geriatric Specialized Services that include a fall prevention program.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X___Other hospital organizations

__X___Local Health Department

__X___Local health improvement coalitions (LHICs)

__X___ Schools

__X___Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

__X___Post-acute care facilities

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Meritus Medical Center	Allen Twigg	Director Behavioral & Community Health Services	Co-chair of Washington Co. LHIC and facilitated CHNA steering committee
Washington County Health Department	Rod MacRae	Director Adult Services	Co-chair of Washington Co. LHIC and facilitated CHNA steering committee
Healthy Eating and Active Lifestyles (H.E.A.L.)	Jenny Fleming	Executive Director	CHNA steering committee member
Washington County Public Schools	Janice Howells	School Health Coordinator	CHNA steering committee member
Meritus Medical Center	Jason McPherson	Executive Director of Strategic Planning	CHNA demographics and steering committee member
Meritus Medical Center	Barbara Miller	Meritus Board of Directors and Community Member	CHNA steering committee member
Brook Lane Health System	Curtis Miller	Director of Public Relations	CHNA steering committee member, liaison with Brook Lane Board, and community survey development
Johns Hopkins University School of Public Health, Comstock Center	Melissa Minotti	Director of Operations	CHNA steering committee member and community survey development
Family Healthcare of Hagerstown (FQHC)	Kim Murdaugh	Executive Director	CHNA steering committee member
United Way of Washington County	Melissa Reabold	Executive Director	CHNA steering committee member
Meritus Medical Center	Mary Rizk	Executive Director Corporate Communications	CHNA steering committee member and publicist

(continued)			
Community Free Clinic	Adam Robinson	Clinical Director	CHNA steering committee member
Mental Health Authority (DHMH)	Rick Rock	President	CHNA steering committee member
Community Foundation of Washington County	Brad Sell	Executive Director	CHNA steering committee member
Tristate Health Partners (ACO)	Mohammad Sohail, M.D.	Executive Director	CHNA steering committee member
Washington County Health Department	Earl Stoner	County Health Officer	CHNA steering committee member
Meritus Health	Brian Stratta, M.D.	Medical Director	CHNA steering committee member
Tri-State Community Health Center (FQHC)	Susan Walter	CEO	CHNA steering committee member

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

__X___yes _____no

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

Allen Twigg, Executive Behavioral and Community Health Services at Meritus Medical Center co-chairs the LHIC for Washington County.

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

__X___yes _____no

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

Yes, additional Meritus Medical Center LHIC members include:
Cindy Earle, Manager Meritus Community Health, Wellness and Education; Washington County,
Wendy Zimmerman, Manager Meritus Parish Nursing; Washington County.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10-point type). Please be sure these initiatives occurred in the FY in which you are reporting.

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

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

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

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

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

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

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

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

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

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

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

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

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

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

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

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

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

The top health initiatives for Meritus Medical Center include:

1. Reducing obesity and increasing physical activity.
2. Improving mental health education, access to care and reducing ED visits.
3. Improving the management of diabetes illness with better access to care and education.
4. Promoting healthy lifestyles and wellness through balanced diet and exercise.
5. Improving timely access to substance abuse treatment and reducing overdose deaths.
6. Reducing heart disease and managing hypertension.

Please refer to the following tables for specific details for each initiative.

Table III – Initiative #1 Obesity

A. 1. Identified Need: A. 2. How was the need identified:	**Obesity** Reduce obesity and increase physical activity Through the FY16 CHNA process it determined that only 27.9% of the adult population of the county maintains a healthy weight (2015 MD SHIP). The Washington County obesity rate (BMI > 30) is estimated to be between 32.22% – 36.48% of the adult population. The rate of obesity for Washington County children has trended slightly higher than the state average for the past three-year surveillance period, 2010 – 2013. Washington County adults ranked next to last for adult physical inactivity when compared with 33 "like communities" (2014 CDC) As part of the FY16 CHNA the Community Survey revealed that the health issues people in our community desire more information about include: #1 diet and nutrition 45.9% #2 exercise and physical activity 36.1% The community also identified obesity and the need for weight loss as the #1 unmet health need for Washington Co.
B: Name of hospital initiative	1. Implement CATCH (Coordinated Approach to Child Health) programming in after school centers for early prevention and intervention. CATCH is a standardized, evidenced-based program that has demonstrated a reduction in the rate of obesity among children. Earlier intervention and prevention efforts will help improve the "adults at a healthy weight" standard over a longer period of time. 2. Sponsor and promote five community events centered on promotion of physical activity and health: - Mud Volleyball Tournament, August 2016 (+600 persons) - HEAL Color Splash, September 2016 (750 persons) - American Heart Walk, September 2016 (205 persons) - Team Cycle, February 2017 (238 persons) - Run for Your Luck St Patrick's Day Run 5k / 1 mile walk, March 2017 (714 persons) 3. Provide a bi-weekly community weight loss support group. 4. Offer BMI screening and health information to more than 500 people in our community.
C: Total number of people within target population	72.1% adults in Washington County overweight or obese = 85,078 persons (+/- 3.5%) 11.8% children and adolescents in Washington County obese = 3,376 persons (+/- 3%)

D: Total number of people reached by the initiative	1. 2,887 children and parents participated in the CATCH program during FY2017. 2. 2,507 persons registered for an officially sponsored healthy activity event. Additional, uncounted persons received health information at each of these events. 3. 306 participants over 12 months (0.003% of target adult population). 4. Two health fairs were held with a focus on diet, nutrition and exercise during FY2017; Hagerstown Family Healthcare 137 persons, and the Hispanic Festival 383 persons. Obesity screening was completed with a total of 520 persons.
E: Primary objective of initiative:	1. CATCH is an evidenced-based program to prevent childhood obesity and launch kids and toward healthier lifestyles by impacting a child's nutrition, level of physical activity, classroom environment and community. Longitudinal objective is to improve the number of adults at a healthy weight in Washington County in the future. 2. Opportunity to get people involved in a physical activity that does not require training. 3. Provide support and information on lifestyle changes to persons with morbid obesity. 4. To provide people with the necessary information, to understand risks associated with being overweight or obsess, their personal risk, and the resources needed to make healthier choices regarding nutrition and to increase the daily amount of physical activity.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	1. Meritus Community Health, Rehoboth Learning Center, Healthy Eating & Active Lifestyles, Inc. (H.E.A.L.), Healthy Washington County, Washington County Board of Education. 2. Meritus Medical Center: Nutrition Services staff, Community Health & Wellness staff, Corporate Communications team, Nursing dept. volunteers, Weight Loss Center team, The Community Free Clinic, H.E.A.L. of Washington Co., 3. Meritus Weight Loss Center, Meritus Community Health, Meritus Behavioral Health Services. 4. Meritus Community Health, Hagerstown Family Healthcare, The Washington Co. Hispanic Society.

H: Impact of hospital initiative:	1. 2,887 persons actively participated in the CATCH program during the course of the 36 week school year: During the 4,806 learner hours children participated in healthy activities and resource information on nutrition was provided to families and schools. CATCH is proven to prevent childhood obesity and is supported by 25 years and 120 academic papers indicating as much as 11% decrease in overweight and obesity. 2. Meritus helped to co-sponsor five key events designed to get people actively moving, even without any prior training or conditioning; over 2,500 local people registered and participated in a sponsored event focused on physical activity. 3. The 306 participants received printed educational info on diet and exercise and learned ways to make behavioral changes around diet and exercise. They also identified community resources and a support system network to call upon when needed. 100% of our support group participants had a documented reduction in BMI over time. 4. Over 500 people received a Body Mass Index score, nutrition information and a list a community supports for weight loss programs.
I: Evaluation of outcome	Indicators from the MD SHIP and CDC BRFSS indicate a continued overall trend of increasing BMI and obesity in our community population for both children and adults. 1. CATCH is evidence-based program that prevents childhood obesity. We desire to expand the program with current discussions to have the CATCH philosophy and parts of the curriculum be implemented in Washington Co. public schools with expertise and guidance from H.E.A.L. 2. Highly effective at engaging with people who are not routinely exercising with targeted marketing to "first-timers", "no experience necessary" 3. This support groups has been sustained and continues to grow. The informal network of persons desiring to lose weight has developed their own social media outlet to support one another. 4. The screening event helps raise awareness of risks associated with obesity and being overweight. Efforts lead to pre-contemplation and follow up by recipients of the educational information. For persons engaged in our programs and services, real lifestyle changes are being made on an individual basis with promising outcomes.

J: Continuation of initiative	Yes, there has been little change in the rate of obesity and physical inactivity among adults in Washington County to date. As obesity has been related to other chronic diseases and remains our number one community health need, Meritus Medical Center in collaboration with the Washington County Health Improvement Coalition will continue to make coordinated clinical efforts to provide education, screening and treatment to prevent and reduce this disease burden. New initiatives with community partners are being introduced for FY18.	
K: Expense:	a. Total Cost of Initiatives 1. $8,814 2. $12,000 3. $1,834 4. $9,839 Total Cost $32,487	b. Direct Offsetting Revenue or Grants 1. $0 2. $0 3. $0 4. $0 Total Offsetting Revenue $0

Table III – Initiative #2 Mental Health

A. 1. Identified Need: A. 2. How was the need identified:	**Mental Health** Improving mental health education, access to care and reducing ED visits. The FY1616 CHNA indicated that ED utilization for mental health visits was 40% higher than the MD state average (5,785 Wash. Co. vs. 3,442 MD). Some of the highest rates of recidivism and readmissions occur with people who suffer from a chronic mental illness. A depression screen included in the community survey was positive for 22% of respondents. Since 2008, the suicide rate in Washington County has increased annually and has been higher than both the state of Maryland average and the MD2017 goal. About 6% of FY16 CHNA survey respondents indicated an inability to receive mental health care when needed. Mental health needs were ranked the #2 priority for Washington County during the FY16 CHNA.
B: Name of hospital initiative	1. Provide targeted mental health education and support groups to community. 2. Integrate behavioral health professionals into primary care practices. 3. Implement a community case management program for high ED utilizers. 4. Educate and support the implementation of standardized depression screening in primary care practices. 5. Provide increased access to psychiatry evaluation and care when indicated.
C: Total number of people within target population	~21% of Washington County adults have a diagnosable mental health condition = 24,780 adults in Washington County.
D: Total number of people reached by the initiative	1. 2,560 persons attended 154 community education and support groups. 2. 1,869 persons were evaluated for mental health issues at PCP offices. An additional 816 referrals were made by the PCP for resource assistance. 3. 275 total persons were successfully referred to Potomac case Management Services for community linkage. 196 persons have primary mental health diagnosis and 71 were primary substance use disorder (see Initiative #5 Substance abuse and overdose fatalities) or were dually diagnosed.

	4. 10,077 people were screened for depression in a PCP office. 5. 171 patients in crisis seen by Accelerated Care Program.
E: Primary objective of initiative:	1. To decrease stigma, increase awareness of behavioral health issues and provide practical mental health education and support. 2. Provide mental health evaluation, support and linkage in the outpatient medical practices setting. 3. Collaborate with existing community partners to provide case management services for the patient population that is identified as at-risk for re-visit to the Emergency Department. 4. Identify people at risk for depression and complete evaluation by a behavioral health professional in the PCP office. 5. Improve timely access to psychiatric evaluation and crisis stabilization in a time of psychiatry shortages.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Meritus Medical Center: Behavioral Health Services, Meritus Care Management, MMG Physician Practices, ACO. Potomac Case Management Services, WayStation Inc., The Washington County Mental Health Authority (CSA), The Mental Health Center, QCI, Catoctin Counseling, Washington County Health Department and Healthy Washington County (LHIC)
H: Impact of hospital initiative:	1. Increased education, awareness and support provided to 2,560 persons. 2. Only 35 of the 1,869 persons seen by the Behavioral Health Professional at PCP office had an ED visit within 30 days (0.02%). 3. Contractual collaboration with Potomac Case Management Services, a community partner, was established to provide case management, regardless of diagnosis or payer (both identified barriers). 51.3% of patients referred were deemed "successful" and discharged from this transitional service. The rate of readmission within 30 days of discharge for patients served by Potomac CMS was 11.1% compared to overall readmission rate of 16.3%. 4. Depression screening process established for all adults in 100% of Meritus PCP offices. The CHNA Action Plan set a goal of 75% of adults would be screened for depression annually through PCP. During the first year we only achieved 10.1%

	5. Potentially avoided ED visits for 171 persons in crisis. In addition another 8 patients were diverted directly to IOP services in the outpatient ambulatory setting instead of being sent to the ED.
I: Evaluation of outcome	Indicator from the MD SHIP data demonstrates a downward trend in the rate of Mental Health ED utilization through 2014 with total visits decreasing by 19.3%. However, ED utilization remains significantly higher than the MD baseline data. 1. The public education and support groups are well attended with excellent feedback regarding the quality and usefulness of content. 2. Clinical integration of behavioral health with primary care increases immediate access to care in an office without stigma and resource expertise to primary care providers. 3. The partnership with Potomac Case Management is helping to provide an effective community case management program used to connect patients with behavioral health issues to local treatment, support and resources. It is performing with measurable outcomes that are better than seen in the general population. 4. Providing a standardized depression screen in the familiarity of the primary care office helps decrease stigma and normalizes depression as a health issue. Positive screens help providers identify depressive symptoms earlier to allow a review of needs, referral for treatment and stabilization 5. The Accelerated Care Program allows more timely access to psychiatry evaluation and medication when indicated, helping to de-escalate a patient and divert potential ED visits.
J: Continuation of initiative:	Yes. We are continuing all initiatives to include expansion of clinical integration of behavioral health services in PCP offices, depression screening, and case management with community partners. We are exploring telehealth solutions to accessing care and expanding service to more rural areas and mobile crisis services and crisis beds as alternatives to acute hospitalization.

K: Expense:	a. Total Cost of Initiative 1. $5,351 2. $159,364 (3 FTEs) 3. $190,469 (2.7 FTEs) 4. $0 5. $15,649 (91 hrs MD, 138 hrs RN) Total Cost $370,833	b. Direct Offsetting Revenue or Restricted Grants 1. $ 0 2. $0 3. $0 4. $0 5. $0 Total Offsetting Revenue $0

Table III – Initiative #3 Diabetes

A. 1. Identified Need:	**Diabetes** Improving the management of diabetes illness with better access to care and education.
A. 2. How was the need identified:	During the FY2016 CHNA, the state BRFSS data indicated that Washington County ranks 4th in the state for the rate of diabetes among the adult population (14.83%). The rate of diabetes mortality is 34.3 per 100,000 persons, the second highest mortality rate in the state of Maryland, followed only by Baltimore City. Diabetes was ranked the #3 health priority for Washington County.
B: Name of hospital initiative	1. Process improvement campaign to educate community PCP offices of diabetic risk, programs for prevention, education and support. 2. Provide 1:1 targeted diabetes education and support to 10 community primary care practices. 3. Provide Living Well education and support programs in our community at no cost. 4. Provide training and referral process for the national Diabetes Prevention Program. 5. a. Provide Diabetes Self-Management Education Program. b. Provide timely access to endocrinology services.
C: Total number of people within target population	Estimated as 17,146 adults The most recent BRFSS data available identifies the rate of diabetes among adults in Washington County as 14.83% (+/- 3%)
D: Total number of people reached by the initiative	1. 26 physician offices were provided nutrition, diabetes prevention, education and support information. 13 physician offices accepted in-person education and training meetings. 2. Two full time certified diabetes educators were integrated in 10 primary care practices as a resource to physicians and patients; they have provided 1:1 diabetes education to 547 patients for 2,499 encounters. 3. Living Well with Diabetes and Chronic Disease groups were provided in four (4) community locations with a total of 50 people having completed 1,635 hours. 4. 3 persons were trained and certified to provide the national Diabetes Prevention Program. 87 persons completed DPP. 5. a. 2,089 encounters for diabetes education. b. 6,218 encounters for endocrinology care.

E: Primary objective of initiative:	1. To assist primary care providers understand the resources available to help better manage their patients at risk or diagnosed with diabetes, a comprehensive community patient resource guide was created and distributed. 2. Improve diabetes self-management through 1:1 education to decrease likelihood of ED crisis and lower long term mortality rates. 3. Improve access to quality diabetes education information and supportive relationships at no charge. 4. Develop infrastructure to prevent persons at risk from developing Type II diabetes. 5. a. Provide diabetes education for disease management, lifestyle changes, risk reduction and decrease longer term mortality rates. b. Recruit two new endocrinology treatment providers to reduce wait time for new patient appointments.
F: Single or multi-year plan:	This continues as a multi-year initiative.
G: Key collaborators in delivery:	Meritus Medical Center: Community Health & Wellness, Meritus Endocrinology, Meritus Diabetes Education, Meritus Care Management Washington County Health Department and the Local Health Improvement Coalition Community physicians
H: Impact of hospital initiative:	Overall, indicators from the MD SHIP show a reduction in ED utilization for diabetes crisis from 208.9 in 2012 to 187.9 in 2014. 1. Approximately 7% of the possible population or 1,190 new patients were referred by physician practices to diabetes prevention, education or support groups; 778 Diabetes Education, 320 Medical Nutrition Therapy, 50 Living Well, 42 Diabetes Prevention Program. 2. The 1:1 CDE intervention in PCP offices indicate an average HbA1c reduction estimated as 1.8% for FY2017 3. As support and education become more widely available, the new FY16 CHNA survey indicates that 25.7% of persons with diabetes have received diabetes education, a 22% increase from FY13. 4. 4 new persons were trained and certified to provide the national Diabetes Prevention Program, expanding new program capacity to 240 additional persons (30 persons per class). 5. a. 969 persons receiving DSME education demonstrated an average reduction of 1.6% in HbA1c for FY2017. 21% of total patients experienced > 2% reduction in HbA1c values after 90 days of starting the program.

	b. Added 2 FTE board-certified endocrinologists to expand access to care which reduced new patient wait time from >12 weeks to < 3 weeks providing much more timely access to care.	
I: Evaluation of outcome	1. Demonstrates an impactful partnership between patients, physicians and support resources leading to improved management of diabetes, lifestyle changes and improved outcomes. 2. The CDE intervention in PCP offices demonstrates a significant reduction in patient's HbA1c values indicating improved management of diabetes and lowering mortality risk factors. Diabetes education is very effective when provided 1:1 with individualized education and care planning. 3. As support and education become more readily available, our CHNA FY16 survey indicates that 25.7% of persons with diabetes have received diabetes education, a 22% increase from CHNA FY13. 4. The national Diabetes Prevention Program outcomes have helped demonstrate a decrease in diabetes prevalence and a leveling of mortality. The DPP has been effective for those who have participated, but we reached a relatively small number. More people must be made aware of their risk and take advantage of this service. A barrier identified by participants is the commitment to multiple sessions over a long period of time. 5. a. The DSME intervention demonstrates a significant reduction in patient's HbA1c values indicating improved management of diabetes and lowering mortality risk factors. Diabetes self-management education is very effective when provided in a group setting with the opportunity for individualized education and care planning. b. Adding endocrinology providers is helping to meet longstanding patient treatment and care needs within our community.	
J: Continuation of initiative:	Yes. We are continuing all initiatives by offering certified diabetes educators in the primary care practices, continuing to address the rising risk population to prevent Type II diabetes through DPP, offering Living Well and support groups in community neighborhoods deemed to be at-risk or underserved at no cost, and offering DSME and endocrinology services when indicated.	
K: Expense:	a. Total Cost of Initiative 1. $2,415 2. $131,622 3. $7,284 4. $6,400 5. a. $405,008 Diabetes Education 5. b. $1,230,596 Endocrinology Total Cost $1,783,325	b. Direct Offsetting Revenue 1. $0 2. $0 3. $0 4. $0 5. a. $149,809 b. $540,717 Total Offsetting Revenue $690,526

Table III – Initiative #4 Healthy Lifestyles and Wellness

A. 1. Identified Need: A. 2. How was the need identified:	**Healthy lifestyles and wellness** Promoting healthy lifestyles and wellness through balanced diet and exercise. The FY16CHNA community survey identified behaviors associated with an increased risk to health and wellness. The 1,482 respondents to the Community Survey identified the #1 service most needed to improve the health of the family are "wellness services." Other identified needs included: • free health screenings • wellness checkups • information on healthy eating / nutrition • how to exercise • how to lose weight • how to manage stress
B: Name of hospital initiative	1. Provide alternative health and wellness interventions; yoga, massage, meditation. 2. Provide health screenings; diet, nutrition, general health, wellness checks. 3. Provide opportunities for wellness education. 4. Provide health related support groups.
C: Total number of people within target population	Potential for the entire primary services area, ~118,500 adults
D: Total number of people reached by the initiative	1. a. Yoga 106 people, 12 hours b. Meditation 37 people, 8 hours c. Massage 45 people, 12 hours 2. 173 people 3. 8,879 people 4. 1,020 people
E: Primary objective of initiative:	1. Offer non-traditional, alternative health interventions that have demonstrated positive health benefits. Pilot period to gauge interest. 2. Provide wellness checks and general health screenings to give feedback to participants regarding their health status. Increased awareness leads to contemplation for making changes. 3. Wellness education provides practical, applicable information to current health topics, exercise, and trends.

	Information is factual, researched and evidenced-based. 4. Opportunity for people who have shared similar health events provide one another support and offer informal advice of how to cope with individual situations. We provide support groups that cover a wide range of health related issues including cancer, Parkinson's, stroke, stress and grief. (Support groups for diabetes, weight loss and family members of addicts are not included here – see the respective health need initiative).
F: Single or multi-year plan ;	These initiatives are multi-year plans.
G: Key collaborators in delivery:	Meritus Community Health, Wellness and Education department, Massage Envy, Michelle Grimes Yoga.
H: Impact of hospital initiative:	1. Relatively modest participation from members of the community. However the feedback received from these wellness activities was very positive with participants reporting great benefit. Impact on health undetermined at this time. 2. Provided opportunities for people to interact with health professionals for general wellness checks, to ask questions and be screened for diet and nutrition. 3. These health and wellness education groups are the core of the Community Health, Wellness and Education department's mission; to provide the information, resources and support necessary to help people improve their personal health status. 4. 100% positive feedback from group members who have participated in these support groups. These groups provide means for coping with health–related concerns that have filled a gap in the community. None of these support groups are being replicated by any other organizations in Washington Co.
I: Evaluation of outcome	1.Well received by participants. Interest in these newer types of health options is driving increased demand. 2.Effective in engaging people, increasing knowledge and self-awareness. In many cases people expressed the need to learn how to make lifestyle changes to improve overall health. Allowed individualized recommendations for general health and information on resources. 3.Groups are well attended and information well received. One of the most effective means of engaging community members, by taking information, education and programs to the communities where people live. 4.Support group attendees are engaged with high rate of return visits.

J: Continuation of initiative:	1. Meritus Community Health plans to continue offering information and access to alternative health interventions such as yoga, massage, meditation. 2. We will continue conducting general health screenings and offer the opportunity to interact with health professionals in informal community settings (outside of the office). New initiatives for FY18 are being explored, including "walk with a doc". 3. Wellness and education activities help sustain efforts to improve the health status of persons living in our region. The majority of these programs will be continued while new programming, content and education opportunities will be identified based on community needs. 4. We will continue to offer specific support groups at no cost for specific health conditions in our community based on strong participation and feedback from members.	
K: Expense:	a. Total Cost of Initiatives 1. $920 2. $1,554 3. $79,700 4. $32,835 Total cost $115,009	b. Direct Offsetting Revenue or Grants 1. $0 2. $0 3. $0 4. $2,706 Total Offsetting Revenue $2,706

Table III – Initiative #5 Substance abuse and overdose fatalities

A. 1. Identified Need:	**Substance abuse and overdoses** Improving timely access to substance abuse treatment and reducing overdose deaths.
A. 2. How was the need identified:	The rate of alcohol and illicit drug disorders are very similar between Washington County and the state of Maryland. However Meritus Medical Center has experienced a sharp increase in ED visits for emergent addictions treatment between 2010 and 2015. A key driver has been a steady increase in opioid related overdose and fatalities since 2010, which in prior years had remained lower than the state of Maryland average. Heroin overdose information indicates Jan. 2017 – June 2017 include160 ODs with 16 fatal, compared to the same time period in 2016 of 168 ODs and 21 fatal. Heroin OD has remained steady with a monthly average of 23, until June 2017 which saw an increase to 50 for the month. This number records the 2nd highest level since February 2016. The trend is concerning as for recent positive test of Carfentanil in drug samples from overdose cases, this could negatively affect the overdose death rate. Local trends that have been identified by Meritus Health and the Washington County Overdose Task Force include: 1. Existing health conditions prior to/in conjunction with substance abuse. 2. Prior visits to emergency department. 3. History of traumatic event(s), e.g., abuse, death in family, etc. 4. Lack of system communication. 5. When last observed, decedents were snoring/gurgling/nodding off, which could have been indicators of overdose. 6. Utilization of outlying areas, e.g., Baltimore, West Virginia, to obtain drugs. 7. Multi-treatment attempts/did not complete treatment plans. 8. Prior criminal history/repeat offenders. 9. Department of Social Services' involvement; received assistance, especially food stamps and medical assistance.

B: Name of hospital initiative	1. Create task force to conduct a gap analysis of treatment services and develop plan to bridge services. 2. Implement a community case management program for ED patients with substance use disorder. 3. a) Offer short term hospitalization for crisis stabilization to persons with an opioid overdose in the ED who required resuscitation. b) Transfer inpatients to drug rehab when possible 4. Participation in a state wide Neonatal Abstinence Syndrome Collaborative and partner with community providers. 5. Provide support group and education to family members of persons with addiction.
C: Total number of people within target population	Alcohol ~9,875 adults in Washington County One in every 12 adults, suffer from alcohol abuse or dependence along with several million more who engage in risky, binge drinking patterns that could lead to alcohol problems. -NCADD Other drugs – Unknown ; estimated as ~5,925 We do not know with specificity the target population. Our best estimates are based on rates of people seeking treatment, arrests and emergency dept. utilization for drug related treatment
D: Total number of people reached by the initiative	1. 0 2. 193 patients with primary or co-occurring substance dependence 3. a)18 patients offered stabilization, only 3 accepted, b) 68 pt consults with 32 transferred to drug rehab 4. 72 during monthly support sessions, 29 women and babies 5. 851 persons served during FY17
E: Primary objective of initiative:	1. Identify existing community resources, analyze gaps and develop an action plan to meet patient substance disorders needs. 2. Partner with Potomac Case Management Services to help patients with substance use disorders enter community treatment and link with support system. 3. Prevent fatal overdose by providing medical detoxification and management with transfer to appropriate ASAM level of care. 4. Connect with addicted pregnant families prior to coming to the hospital. Establish a relationship with treatment providers in the community to improve the mother's health and minimize/manage newborn withdrawal symptoms.

	5. To help family and friends understand how to help a loved one with the disease of addiction.
F: Single or multi-year plan:	These are all multi-year plan initiatives with the exception of 1. The task force.
G: Key collaborators in delivery:	1. Meritus Health, Brooke's House, Trivergent Health Alliance, MD Emergency Physicians, WCHD, community members 2. Meritus Behavioral Health and Potomac Case Management Services 3. Meritus Medical Center, Meritus Behavioral Health Service Line, Washington County Health Department, regional tx facilities. 4. Meritus Women's and Children Service Line, Maryland Neonatal Abstinence Syndrome Collaborative, Phoenix Treatment Center. 5. Meritus Behavioral Health Services, Community treatment providers; WCHD, ADAC, Serenity, 12 step programs
H: Impact of hospital initiative:	1. Identified recommendations for treatment in the community. Improved communication and identified opportunities for collaboration between Meritus Health and community organization. Joint applications for grants and planning coordination of future services. 2. Contractual collaboration with Potomac Case Management Services, a community partner, was established to provide case management, regardless of diagnosis or payer (both identified barriers). 51.3% of patients referred were deemed "successful" and discharged from this transitional service. The rate of readmission within 30 days of discharge for patients served by Potomac CMS was 11.1% compared to overall readmission rate of 16.3%. 3. a) 3 patients were successfully transferred to a partial hospital level of care. b) 36 pts transferred to drug rehab 4. Currently we are working with the collaborative to standardize our approach to managing addicted babies. Therapeutic alliance has been formed with the Phoenix Treatment Center. Improved relationships and lines of communication between the hospital and addicted, pregnant women. 5. The long-standing free support group is recognized by the community as the primary resource to refer family and friends to for support and help. The group is opened and has expanded significantly over the past 2 years.

I: Evaluation of outcome	1. Completed all recommendations on time and disbanded as intended. Plans and recommendations several members were incorporated into the county's Senior Opioid Senior Policy workgroup which is in process with a comprehensive community plan that includes EMS, providers, Meritus, consumers, and support programs. 2. The partnership with Potomac Case Management is helping to provide an effective community case management program used to connect patients with addictions issues to local treatment, support and resources. It is performing with measurable outcomes that are better than seen in the general population. 3. a)This help made a difference in the lives of the three persons stabilized. Considered an emergency stop-gap service that will be phased out as additional services such as ambulatory detox and MAT become available on demand. b) 53% success rate accessing direct transfer to an inpatient drug rehabilitation level of care. 4. Positive, improved lines of communication and coordination between a community methadone clinic, it's patients and Meritus. Initial stages of assessing improved management of NAS. A future goal will be shorter length of stay for these babies. 5. Feedback from group members is that there would be nowhere to turn without this resource.
J: Continuation of initiative:	1. The task force concluded. Its recommendations will be continued with plans to expand Medication Assisted Treatment (MAT) in hot spot neighborhood downtown and exploration of a stabilization center. 2. Continues at end of FY17. Services for community navigation and linkage to community treatment planned to transition from PCMS to new grant-funded Peer Recovery supports to be located in the Meritus ED. PCMS resources will be shifted to mental health focus. 3. Intervention be continued until alternative treatment is readily available. 4. Yes, we will plan to continue this work in FY18 5. Yes, the Concerned Persons Group is the only recognized support group for family and concerned loved ones of persons with an addicted illness.

K: Expense:	a. Total Cost of Initiative	b. Direct Offsetting Revenue or Restricted Grants
	1. $1,020 2. $66,922 0.9 FTE 3. $4,554 4. $1,170 5. $1,630 Total cost $75,296	1. $0 2. $0 3. $0 4. $0 5. $0 Total offsetting revenue $0

Table III – Initiative # 6 Heart disease and hypertension

A. 1. Identified Need: A. 2. How was the need identified:	**Heart disease and hypertension** Reduce heart disease and manage hypertension. From the FY2016 CHNA heart disease remains the leading cause of death in the state of Maryland. At the rate of 196.1 per 100,000 lives, Washington County ranks as the 10th highest county for heart disease death in Maryland . The Washington County rate of Emergency Department visits for hypertension is 182.4 per 100,000, an increase of 12.1 from the 2012 SHIP data (170.3 per 100,000). While the prevalence of hypertension is observed to be decreasing, ED visits for unmanaged hypertension have trended upward. In 2015, the 22.9% ED presentation for hypertension among Blacks was proportionally 2.1 times greater per capita. There is a need to better understand the underlying causes of this disparity including access to primary care, medications, screening, and the underlying social determinants of health. Seniors are also at higher risk with nearly 50% of the population that is age 55+ have been told they have high blood pressure. Heart disease and hypertension were ranked as the #6 health priority for Washington County through the FY16 CHNA process.
B: Name of hospital initiative	1. Conduct blood pressure screenings in community neighborhoods to identify persons with hypertension, provide education and refer to medical management. 2. Continue the community wide blood pressure awareness that conducts a minimum of 25,000 adult screenings annually; > 20% of community population. 3. Provide monthly B/P screening clinics and education at senior residential centers. 4. Sponsor heart healthy activities and events that promote heart health. 5. Provide education events focused on heart and blood pressure wellness. 6. Provide telehealth support and monitoring to persons with Congestive Heart Failure to improve overall management.
C: Total number of people within target population	31% of Washington County adults in FY16CHNA survey had been told they have hypertension = ~36,735 adults in Washington County have hypertension and are at risk for heart disease (+/- 3%).

D: Total number of people reached by the initiative	1. Community blood pressure screenings and heart health information was provided to 3,001 people through faith community interventions. 226 people at a Meritus sponsored Farmer's Market. 2. 26,209 blood pressure screenings at sponsored kiosks occurred over the past year with 2,873 unique page views of the Healthy Washington Co. website (7/1/15 – 6/30/16). 3. 507 blood pressure screenings were conducted at senior living centers. Two cardiac education events were conducted at the senior living towers, 25 people. 4. An American Heart Association walk was held on the Meritus campus in Sept. 2016 with 114 participants. 5. 2,483 people received written education material on lifestyles changes leading to improved blood pressure and management through the faith community nursing program. 5,000 community guides on heart disease were printed and distributed. Additional educational events included: • Living Well with Hypertension, 17 people, • Tobacco Free for Life, 21 people, • Just for the Heart of It, 12 people, • Heart Healthy Lifestyle, 17 people. Total 2,550+ 6. Total: 156 patients. 113 patients received remote telehealth monitoring and counseling through Meritus Home Health and 43 through Meritus Cardiac Rehabilitation.
E: Primary objective of initiative:	1. Screen for hypertension and provide heart health information. 2. Provide infrastructure and information to increase awareness that is necessary to change the community culture to focus on personal health status. 3. Screen for untreated or poorly managed hypertension and improve cardio health in senior population. 4. Increase healthy cardiovascular awareness and support. 5. Provide heart health support and education to the community. 6. Improve outpatient monitoring of CHF patients at home to promote health management and stabilization.
F: Single or multi-year plan:	Multi Year
G: Key collaborators in delivery:	Meritus Medical Center: Cardiac Rehab, Community Health & Wellness, Parish Nursing, Care Management, Corporate Communication, Meritus Home Health. Washington County Health Department and Local Health Improvement Coalition, Chamber of Commerce, Herald-Mail

	newspaper.
H: Impact of hospital initiative:	In 2012, the overall rate of heart disease mortality was measured at 208.4 per 100,000. The current rate of 196.1 per 100,000 demonstrates a significant decline of 12.3 in the mortality rate.. CHNA FY16 survey responses for people who had been told that they have hypertension decreased from 34.4% in 2012 to 31% in 2015, a positive change of 3.4%. 1. Identified 476 persons with elevated B/P (14.8%) and obtained PCP follow up and increased education and awareness to lower risk factors with persons in normal range. 2. Maintained 3 blood pressure kiosks at strategic community locations and populated interactive website with links to heart health education and resources. www.healthywashingtoncounty.com The kiosks have registered 26,209 bp screens over the past year reaching ~22% of adult population. The website has received 2,873 unique page views during FY2017. 3. 11.6% screened with elevated blood pressure. Provided 59 persons with positive screen help to obtain and coordinate PCP follow up appt. 4. 114 persons participated in physical heart health activity and received educational information on how to continue with a daily physical exercise routine, walking.. 5. It is not know how many people have followed through with making personal lifestyle changes as a result of the information received through these heart health education events. 19/21 persons stopped smoking following completion of classes. 6. The majority of CHF patients remained stable during the tele-monitoring program. Meritus home health nurses made intervened with CHF patients based on results triggered by monitoring program. It is estimated that 14 hospitalizations were averted through timely intervention. Seven patients were triggered to be seen from the Cardiac Rehab monitoring program.
I: Evaluation of outcome	Indicators from the MD SHIP demonstrate a downward trend in the rate of heart disease mortality for Washington Co. from 2011 – 2015. However, ED utilization for hypertension has increased from 152.7 in 2010 to 182.4 in 2014. Overall the Washington County rates are well below the MD state average and the MD 2017 goal of 234).
J: Continuation of initiative:	Yes. We are continuing B/P screening, education and referrals and are following up the success of the knowledge gained from motivating persons to make lifestyle changes in the published work. New outreach initiative includes partnering with a local African American church to be the hub for health resources in their neighborhood. Additional activities that help to connect and communicate with people in high health-risk areas of Washington Co. are in progress.

K: Expense:	a. Total Cost of Initiative	b. Direct Offsetting Revenue from Restricted Grants
	1. $276 2. $0 3. $1,492 4. $169 5. $1,798 6. $45,643 tele-monitoring Total Cost $49,378	1. $0 2. $0 3. $0 4. $0 5. $0 6. $0 Total Offsetting Revenue $ 0

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

   At the conclusion of the CHNA data assessment it was recognized that many more needs were identified and exist than can be successfully met by the hospitals alone due to limited, finite resources. The prioritization criterion and assigned weights assisted the Coalition to narrow the focus and directly address the issues that would have the greatest impact for improving the health of people in our community. When other community organizations have a mission aligned to meet the CHNA needs that were identified, the need was scored as a lower priority for Meritus Medical Center, avoiding the duplication of existing community services and providing an opportunity to coordinate the linkage of patients to alternative services whenever appropriate.

   Meritus Medical Center focused our primary Community Benefit activities on the top six health priorities. Some of the health needs not made a priority for the health systems to directly address at this time include access to affordable health care, cancer treatment, access to dental care, teen pregnancy, and senior care. Because these needs were not ranked among the "highest priorities" does not mean that resources will not be allocated and directed to meeting needs. Our community providers are using the results of the CHNA to help target these unmet needs based on strengths, expertise and resources of individual organizations, and where interests are shared, new collaborative relationships between organizations will be formed.

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

   Cancer continues to be a leading cause of death for Washington County residents. Meritus Medical Center has made a significant investment in the expansion of cancer services over the past two years and continues a strategic plan to further develop services. New programs include:

   - Establishing the Center for Breast Health; adding 3 surgeons and 1 nurse practitioner, an RN clinical breast navigator to support patients from biopsy through surgery. The program received National Accreditation Program for Breast Centers (NAPBC) in the Fall of 2015,
   - Developed lung CT low dose screening program with a lung navigator to identify lung cancer at an earlier stage,
   - Provides lung nodule surveillance for non-cancer patients,
   - Developed a High Risk Assessment Program and Genetic testing program for patients at risk,
   - Added nutritional consultation for moderate and high risk assessed cancer patients.

   To help reduce teen pregnancy The Community Free Clinic provides "services for Today's Teens", a program operated by the Clinic for Washington County teens ages 13-19. Teens may present to the Clinic without appointment to receive strictly free and confidential services including contraception, STI testing, HIV testing, pregnancy testing, counseling, educational information and appropriate referrals to other community resources. The program offers honest conversation around lifestyles, behavioral concerns and seeks to answer questions. Substance abuse, assault, violence and general safety are also addressed at each visit.

   Hagerstown Family Healthcare FQHC (formerly Walnut Street Clinic) has expanded access to dental care to persons in Washington County since relocating to a new facility on Cleveland Avenue. The Family Healthcare Dental Practice provides comprehensive dental care to children and adults. They provide a pediatric dentist who specializes in the dental needs of children of all ages, as well as special needs patients. The Healthy Smiles in Motion mobile dental program provides dental care to students of Washington County Public Schools on-site at

their home schools. Findings from the FY2016 CHNA will be used to support grant procurement for future dental care funding.

Other identified CHNA health needs are being addressed by the Strategic Community Impact Council (SCIP), a collaboration of diverse community providers, leaders and volunteers who are targeting needs through targeted work committees:

- Education – reduce learning loss rates over three years
- Jobs and Economic Development - increase number of new jobs, reducing unemployment
- Health and Well-Being - decrease obesity rates, increase access to substance abuse treatment
- Family Safety – reduce child abuse and maltreatment, reduce domestic violence
- Seniors – increase use of advanced directives, increase % living at home
- Transportation – expand service point data collection system and improve based on database
- Public Safety – decrease number of incarcerations for drug and alcohol possession by 5%
- Disabilities – increase number of disabled workers in the workforce
- Self Sufficiency – increase financial literacy, initiate a Housing First program

Meritus Medical Center routinely meets to assess how the organization is making progress on the goals and meeting CHNA needs. The Action Plan includes collaborative efforts between Meritus Medical Center and community partners as coordinated through the local LHIC, Healthy Washington County. The Action Plan helps document the county wide community health initiatives that are designed to meet prioritized health needs and improve the overall health of people living in the region. The plan is being reviewed periodically to measure progress towards goal achievement and modify action steps as needed. As resources become available and can be allocated, the action plan will incorporate additional needs and goals.

Community needs identified in the FY 2016 CHNA but not directly addressed by Meritus Medical Center in the Action Plan:

Additional Prioritized Community Needs CHNA FY2016	**How need is being alternatively addressed**
Health care affordability	Healthy Washington County (LHIC) is addressing access to affordable healthcare issues and a lack of health insurance by providing locations for the MD Health Exchange Navigators to reach uninsured persons. Meritus Medical Center and Brook Lane Health System provide a financial assistance policy for persons deemed unable to afford the cost of care. The county is fortunate to have two Federally Qualified Health Centers located in Hancock and Hagerstown, MD, both of which are committed to providing quality healthcare services on a sliding-scale basis. The Community Free Clinic located in Hagerstown provides quality, comprehensive outpatient health care services, free of cost, to all Washington County residents who are uninsured.
Cancer	Cancer continues to be a leading cause of death for Washington County residents. Meritus Medical Center has made a significant investment in the expansion of cancer services over the past two years and continues a strategic plan to further develop services. New programs include: • Establishing the Center for Breast Health; adding 3 surgeons and 1 nurse practitioner, an RN clinical breast navigator to support patients from biopsy through surgery, • Developed lung CT low dose screening program with a lung

	navigator to identify lung cancer at an earlier stage, • Provides lung nodule surveillance for non-cancer patients, • Developed a High Risk Assessment Program and Genetic testing program for patients at risk, • Added nutritional consultation for moderate and high risk assessed cancer patients.
Teen pregnancy	To help reduce teen pregnancy The Community Free Clinic provides "services for Today's Teens", a program operated by the Clinic for Washington County teens ages 13-19. Teens may present to the Clinic without appointment to receive strictly free and confidential services including contraception, STI testing, HIV testing, pregnancy testing, counseling, educational information and appropriate referrals to other community resources. The program offers honest conversation around lifestyles, behavioral concerns and seeks to answer questions. Substance abuse, assault, violence and general safety are also addressed at each visit. Family planning services are made available at the WCHD and The Community Free Clinic. Care for pregnant teens is extended through Meritus Women's & Children's practice and Capitol Women's Care.
Dental care costs	Hagerstown Family Healthcare FQHC (formerly Walnut Street Clinic) has expanded access to dental care to persons in Washington County since relocating to a new facility on Cleveland Avenue. The Family Healthcare Dental Practice provides comprehensive dental care to children and adults. They provide a pediatric dentist who specializes in the dental needs of children of all ages, as well as special needs patients. The Healthy Smiles in Motion mobile dental program provides dental care to students of Washington County Public Schools on-site at their home schools. Findings from the FY2016 CHNA will be used to support grant procurement for future dental care funding.
Availability of specialists	*See PHYSICIANS section, pages 46-49*
Other	Other identified CHNA health needs are being addressed by the Strategic Community Impact Council (SCIP), a collaboration of diverse community providers, leaders and volunteers who are targeting needs through eleven different work committees: Education, Arts, Culture and Tourism, Jobs and Economic Development, Health and Well-Being, Family Safety, Older Adults, Transportation, Public Safety, Disability, Self Sufficiency and Civic Engagement.

Outcome measurement of improvement being realized and the assessment of changing needs and services gaps are ongoing. With the advent of the next CHNA in FY2019 we will explore trends, outcomes and conduct a new community survey to more fully reassess and prioritize the health needs of people living in our community.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

Meritus developed its mission, vision, and current strategic plan in 2017 in response to the changes in healthcare delivery both in Maryland and nationally. Meritus Health envisions a health care system in which multi-disciplinary teams work in collaboration to manage and meet patient health needs to improve outcomes, lower costs, and enhance patient experience. The new strategy heightened the organization's focus on providing high quality, cost effective care, meeting and exceeding our patients' expectations.

Meritus Health has aligned strategic planning with both the CHNA and SHIP processes, to allocate and deploy resources in coordination with community partners such as the WCHIC (LHIC) to target the priority health needs. Planning and assessment are completed annually between Meritus Health and the LHIC. The effectiveness of interventions and outcomes are measured quarterly. Longer term trends and improvement is reviewed by monitoring the SHIP BRFSS trends and goals.

The proposed Regional Transformation Plan with Trivergent Health Alliance is an extension of Meritus' population health strategy for success in the evolving value-based healthcare environment and will play a significant part in further achieving our vision for improving the health of people living in our community.

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) http://dhmh.maryland.gov/ship/SitePages/Home.aspx
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

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.

   Washington County has very limited HPSA status for Primary Care and Mental Health. These designations are specifically assigned to the two FQHC facilities, one in downtown Hagerstown and the other in Hancock. The entire county is designated as a HPSA for Medical Assistance patients requiring dental care.

   Specific benchmarking was completed by an outside vendor in the form of a Physician/Community Needs Assessment. This documented physician demand, physician assets and defined the gaps in this community. The document was prepared to support physician recruitment needs and complies with Stark III. The most recent Assessment was completed May 2016, and forms the basis of the three-year recruiting plan encompassing FY 2017-2019.

   For purposes of determining physician needs for this HSCRC Community Benefit Report, we considered the defined Total Service Area which includes 23 zip codes in Maryland, 8 zip codes in Pennsylvania and 6 zip codes in West Virginia.

The largest identified Primary and Medical gaps by the 2016 Assessment are:

	Current FTEs			Percent
Specialty	Supply	Demand	Surplus / (Deficit)	Unmet Need
Primary Care				
Family Medicine	*112.5*	*117.8*	*(5.3)*	*(4%)*
Internal Medicine	*64.6*	*76.4*	*(11.8)*	*(15%)*
General Primary Care	177.1	194.2	(17.1)	(9%)
Obstetrics & Gynecology	38.0	28.0	10.0	35%
Pediatrics	39.1	40.2	(1.2)	(3%)
Total Primary Care	**254.1**	**262.5**	**(8.3)**	**(3%)**
Medical Sub-Specialties				
Allergy & Immunology	1.2	5.9	(4.7)	(80%)
Cardiology - Medical	*24.5*	*13.6*	*11.0*	*81%*
Cardiology - Electrophysiology	*-*	*2.0*	*(2.0)*	*(100%)*
Cardiology - Interventional	*2.0*	*6.3*	*(4.3)*	*(68%)*
Cardiology - Total	26.5	21.8	4.7	21%
Dermatology	7.5	12.0	(4.5)	(37%)
Endocrinology	5.0	4.9	0.1	2%
Gastroenterology	8.0	16.1	(8.1)	(50%)
Hematology/Oncology	11.3	11.4	(0.1)	(1%)
Infectious Disease	2.0	3.7	(1.7)	(46%)
Nephrology	4.5	7.8	(3.3)	(43%)
Neurology	7.9	13.1	(5.2)	(40%)
Pain Management	4.5	4.5	(0.0)	(0%)
Physical Medicine & Rehab	5.6	8.7	(3.1)	(36%)
Psychiatry	17.0	13.0	4.0	31%
Pulmonary	4.8	9.4	(4.7)	(49%)
Reproductive Endocrinology	-	0.4	(0.4)	(100%)
Rheumatology	3.6	4.4	(0.8)	(18%)
Sleep Medicine	1.8	1.0	0.7	70%
Sports Medicine	-	2.3	(2.3)	(100%)
Total Medical Specialties	**111.1**	**140.6**	**(29.5)**	**(21%)**

In FY 2017, the following new primary care providers were added as employees of Meritus Health:

Internal Medicine: 1 FTE

Family Medicine: 6 FTE

In FY 2017, providers in the following specialty providers were added:

Behavioral Health: 2FTE

Oncology: 1FTE

General Surgery: 3FTE

Pain Management: 1FTE

Gastroenterology: 1FTE

Endocrinology: 3FTE

Nursing Home: 3FTE

Specialty	Current FTEs			Percent Unmet Need
	Supply	Demand	Surplus / (Deficit)	
Surgical Sub-Specialties				
Cardiac Surgery	*-*	*2.9*	*(2.9)*	*(100%)*
Thoracic Surgery	*1.0*	*2.9*	*(1.9)*	*(65%)*
Cardio/Thoracic Surgery	1.0	5.8	(4.8)	(83%)
Gynecology Oncology	0.3	1.0	(0.7)	(69%)
Maternal Fetal Medicine	-	3.1	(3.1)	(100%)
Neurosurgery - Cranial	*0.4*	*1.2*	*(0.8)*	*(66%)*
Neurosurgery - Spine	*0.9*	*2.4*	*(1.4)*	*(61%)*
Neurosurgery - Total	1.3	3.6	(2.2)	(63%)
Ophthalmology	13.0	18.5	(5.5)	(30%)
Orthopedic Surgery - General	*19.9*	*22.1*	*(2.2)*	*(10%)*
Orthopedic Surgery - Hand	*-*	*0.9*	*(0.9)*	*(100%)*
Orthopedic Surgery - Spine	*0.4*	*1.6*	*(1.2)*	*(75%)*
Orthopedic Surgery - Total	20.3	24.6	(4.3)	(18%)
Otolaryngology	10.3	12.3	(1.9)	(16%)
Plastic Surgery	3.0	2.2	0.8	35%
Podiatry	17.5	10.5	7.0	66%
Urology	9.3	11.0	(1.7)	(16%)
Bariatric Surgery	*1.0*	*1.6*	*(0.6)*	*(39%)*
Breast Surgery	*0.6*	*2.1*	*(1.5)*	*(71%)*
Colon & Rectal Surgery	*-*	*2.3*	*(2.3)*	*(100%)*
General Surgery	*12.5*	*13.3*	*(0.8)*	*(6%)*
Oncology Surgery	*-*	*1.3*	*(1.3)*	*(100%)*
Transplant Surgery	*-*	*0.2*	*(0.2)*	*(100%)*
Vascular Surgery	*3.0*	*6.8*	*(3.8)*	*(56%)*
General Surgery - Total	17.1	27.7	(10.6)	(38%)
Total Surgical Sub-Specialties	**93.2**	**120.3**	**(27.1)**	**(23%)**
Total All Specialties	**458.5**	**523.4**	**(64.9)**	**(12%)**

According to the County Health Ratings published by Robert Wood Johnson Foundation, Washington County, MD, scores below national benchmarks on 27 out of 30 categories. The ratio for Primary Care Physicians to patients is 1:1,658, 64% worse than the National Benchmark of 1:1,067. The surrounding counties in Pennsylvania and West Virginia, which are part of the Total Service Area, are similarly ranked, but the ratio of physician/patient is significantly worse than in this county.

Referral staff reported no difficulties in obtaining appointments for uninsured or Medicaid patients who are seeking care in a Meritus Health owned specialty practice such as Gastroenterology, Endocrinology or OB/GYN. Psychiatry services are also available through both the Meritus Health outpatient practice and through local mental health resources. One private cardiology practice accepts uninsured/Medicaid patients with minimal down payment and a payment plan.

The most difficult specialty for patient access is orthopedics where high down payments are required. Other specialty services with limited access, reported by the local FQHC are Dermatology, Allergy/Asthma, Neurology, Neuro-surgery, Urology, Pulmonology and Otolaryngology.

As a sole community provider, Meritus Medical Center must provide around the clock care in the Emergency Department. It has become increasingly difficult to insure 24/7 specialist coverage for the ED in the current environment of decreased physician reimbursement and increasing volume. Therefore, Meritus Medical Center pays on-call fees for Emergency Specialist Call to insure adequate physician coverage in the Emergency Department. The specialties contracted to provide Emergency Specialist Call include: Cardiology, Critical Care, ENT, Eye, GI, General Surgery, Interventional Cardiologist, Neurology, Neurosurgery, Ortho, Pediatrics, Plastics, and Urology.

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

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

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	Meritus Medical Center subsidizes the Hospitalist program in response to a community need for this service. An increasing number of area physicians have elected to no longer admit their patients to the hospital so that they can focus their time and resources to their office practices. This along with an increase in the uninsured/underinsured

	population necessitated the need for a Hospitalist program subsidized by the Hospital.
Coverage of Emergency Department Call	Meritus Medical Center subsidizes Emergency Dept. call coverage in response to a community need for these services. Without subsidy these services could not be adequately covered. Those specialties contracted with to provide Emergency Specialist Call include: Cardiology, Critical Care, ENT, Eye, GI, General Surgery, Interventional Cardiologist, Neurology, Neurosurgery, Ortho, Pediatrics, Plastics, and Urology.
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	N/A
Other – (provide detail of any subsidy not listed above – add more rows if needed)	N/A

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

   a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

      For ***example***, state whether the hospital:

      - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
      - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
      - Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
      - Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
      - Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
      - Besides English, in what language(s) is the Patient Information sheet available;
      - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

   b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

   c. Include a copy of your hospital's FAP (label appendix III).

   d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix V).

Attachment A

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

- Increase life expectancy
- Reduce infant mortality
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

APPENDIXES

Appendix I Financial Assistance Policy Description

Meritus Medical Center (MMC) is committed to providing quality health care for all patients regardless of their inability to meet the associated financial obligation and without discrimination on the grounds of race, color, national origin or creed. Financial assistance can be offered during or after services are rendered. The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State, and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their own ability to pay.

MMC informs patients and/or their families of the hospital's financial assistance policy by providing a summary of the policy and contact information as part of the intake process. It is also included on the back of the patient billing statement. This information is available in both English and Spanish languages. Notice of availability of financial assistance and contact information is posted in the admitting area, emergency room, and other areas throughout the facility where eligible patients are likely to present. When applicable, a representative of the hospital discusses the availability of financial assistance as well as Medicaid and other governmental benefits with patients or their families. The hospital makes every effort to inform patients of this policy throughout their visit.

Appendix II Description of How Hospital's FAP has changed since ACA

The Accountable Care Act (ACA) enhanced access to health care insurance for a population of patients either uninsured or under-insured. This coupled with the Medicaid Expansion activities of the past few years has resulted in Meritus seeing a reduction in our uninsured population. In FY 2016 we saw a 1% decrease in our self-pay patients, with a 3% increase uninsured patients charges as compared to FY 2015. This resulted in an increase in overall uncompensated care of 15.5%, charity care and a decrease of 1.0% bad debts. We do continue to see Financial Assistance needs within this population of patients due to gaps in coverage provided in the ACA. Meritus as part of its mission will continue to support the care and provide necessary assistance to these patients.

Appendix III Financial Assistance Policy

MERITUS MEDICAL CENTER

DEPARTMENT:	Patient Financial Services
POLICY NAME:	Billing & Collections
POLICY NUMBER:	0444
ORIGINATOR:	Patient Financial Services
EFFECTIVE DATE:	8/14
REVISION DATE(s):	11/14; 12/15
REVIEWED DATE:	

SCOPE

This policy applies to hospital patient accounts identified as self-pay or with a remaining patient responsibility after insurance and/or financial assistance.

This policy applies to any Meritus Health (Meritus) employee who performs collection activity in the Patient Financial Services Department (PFS). These standards are intended as a guideline to assist in the management of hospital services, they are not intended to replace professional judgment in administrative matters.

PURPOSE

The purpose of this policy is to establish a policy and procedure for initiating collection actions and the write off of accounts receivable as well as the subsequent placement of the receivables with outside agencies or attorneys for collection. This policy documents a consistent practice for collecting amounts due from patients, regardless of insurance coverage, and the procedures necessary to record write-offs taken.

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

POLICY

A. OVERVIEW

1. Meritus expects patient payment at the time service is provided or within thirty (30) days of the first billing to patient for services not covered by insurance or financial assistance.
2. Meritus must take effective action to maintain timely accounts receivable turnover and ensure that the value of accounts receivable is accurately stated. To do this, patient accounts will be aged and written off as bad debts or charity and may be outsourced to collection agencies for further follow-up.
3. Emergency services will be provided to all patients regardless of ability to pay. Scheduled services will be provided after appropriate financial arrangements are confirmed by Meritus. Deposits may be required prior to scheduling services. Failure to pay required deposits may result in the rescheduling of the service.
4. Financial Assistance is potentially available for patients based on financial need as

defined in the Meritus' Financial Assistance Policy.

a. It is the patient's responsibility to provide accurate information regarding address, employment and health insurance in order to determine eligibility for services, amounts due from the patient and/or eligibility for Financial Assistance.

5. Meritus complies with all state and federal law and third party regulations to perform credit and collection functions in a dignified and respectful manner.
6. Meritus does not discriminate on the basis of age, race, creed, sex or ability to pay.
7. Meritus will not sell the bad debt receivables or charge a prejudgment interest rate for self-pay or balances after insurance.
8. Meritus may use external collection agencies for extended business office, legal and/or collection activity to assist with collecting on patient accounts. These agencies do not sell the receivable and act as an extended business office on behalf of Meritus.
9. Prior to initiating any extraordinary collection activities (ECAs), Meritus shall notify the patient at 30 days prior to taking such actions. Meritus may take the following actions in order to collect on patient accounts:

a. Reporting adverse information to a consumer credit reporting agency or credit bureau;

b. Garnishment of wages;

c. Placing a lien on primary home values above $150,000

B. CASH COLLECTIONS

1. Payment for identified co-payments and deductibles will be requested prior to or at the time of service.

a. Meritus accepts cash, checks and credit cards to settle outstanding accounts.

b. Medically necessary care will not be deferred or denied due to an outstanding balance for previously provided care.

2. Payment arrangements may be made for patients who have difficulty paying in full.

a. Where appropriate, arrangements should be set up to resolve open balances within a reasonable timeframe.

b. Payment arrangements that remain current will not be forwarded to bad debt collections.

3. Patient statements will be sent to the responsible party approximately every thirty (30) days.

a. Payment in full is expected for services rendered and not covered by insurance or another third party within thirty (30) days of the receipt of the first statement.

b. Meritus' contact information and a notice of availability of financial assistance are provided on all statements sent to the guarantor/patient.

4. There may be scenarios that occur during the collection process outlined above that result in placing an administrative hold on the account until additional information is provided. All accounts on administrative hold will be compiled into a report for review by management on a monthly basis.

C. WRITE-OFF REVIEW

1. The patient accounting management system will be driven by the generation of patient statements, letters or data mailers on a 30-day cycle. If a patient account reaches a pre-determined aging *with no account payment activity*, the account will be assessed for possible small balance, bad debt or charity write off as follows:

    a. **Small balance write-offs**: An automated process will be used to identify accounts with a debit balance. The accounts are processed with adjustment transactions and do not pass to bad debt but rather to established "small balance write-off" codes for balances outlined in the Responsibility section of this policy.

    b. **Bad Debt write-offs**: A periodic report will be generated to "pre-list" self-pay and self-pay after insurance accounts that may meet bad debt criteria outlined in the Responsibility section. Those accounts will be subject to review by management based upon dollar balance prior to submitting into bad debt status.

        i. Where controllable by our patient accounting system, only certain specific employees in the patient financial services area will be given access to the bad debt functions in the patient accounting system.

        ii. Unless an administrative hold is placed on an account that has qualified for the bad debt pre-list, all accounts will automatically be moved into a bad debt status during the overnight batch processing within the patient accounting system.

        iii. For those self-pay accounts with no patient payment activity, the account may be written off to bad debt if the account has aged >90 days, so long as no ECAs are initiated until at least 120 days from date of first patient statement or 30 days after patient has been notified of pending ECAs, whichever is later.

        iv. For those accounts with third-party insurance coverage, the account may be written off to bad debt immediately upon insurance payment if the account has aged >90 days from date of first patient statement and has received no patient payment activity.

        v. Accounts written off to bad debt may be referred to an external collection agency for assistance on collecting past due amounts.

            A. External collection agencies are prohibited from charging interest on amounts due for self-pay patients unless a court judgement has been obtained in Meritus' favor.

            B. External collection agencies are prohibited from reporting adverse information to a consumer credit reporting agency or credit bureaus until the account has aged >180 days and the patient has received notice of pending actions at least thirty (30) days in advance.

vi. Accounts with a third-party insurance balance that have not received any payment from the insurer for sixty (60) days may have that balance deemed to be self-pay. At that time, the patient may begin to receive statements in the same manner as a self-pay patient.

vii. Wherever appropriate, write-offs shall be identified as charity care in accordance with Meritus' Financial Assistance Policy. Any write-offs so identified will not be referred to any outside collection agencies.

viii. Patient may request, or may be requested by Meritus, to apply for Medical Assistance prior to being awarded Financial Assistance. This request may be made prior to service, at time of service or during the billing and collection cycle. The account in question will not be forwarded to a collection agency during the Medical Assistance application process.

D. DEBT COLLECTIONS

1. Where appropriate, Meritus may use a bad debt collection agency to continue to try to collect on severely aged accounts. Patient accounts that have been referred to a collection agency must resolve unpaid balances, make payment arrangements, dispute amounts owed or request financial assistance.
2. Patient accounts that have been referred to a bad debt collection agency may have adverse information reported to a consumer credit reporting agency or credit bureau.
    a. Meritus shall ensure that no adverse information is reported until 180 days after the first post-discharge billing statement.
    b. Prior to reporting any adverse information, Meritus shall ensure patients, or responsible parties, receive written notice at least thirty (30) days prior to the report being made. Such written notice shall:
        i. Inform the patient of availability of financial assistance;
        ii. Identify the actions that Meritus plans to initiate to obtain payment;
        iii. State a deadline after which such collection actions may be initiated that is no earlier than 30 days after the date that the written notice is provided.
        iv. Include a plain language summary of Meritus' financial assistance policy;
        v. Meritus shall make a reasonable effort to orally notify the individual about Meritus' financial assistance policy and the process for applying.
3. Balances that remain open due to insurance denials will not be placed with a collection agency. However, a collection agency may perform payer collections on insurance denials acting as an extension of the business office.
4. Collection agency personnel may be given viewership access to the patient accounting system via remote access or while onsite so as to initiate their collections efforts.
5. A payment list is presented to the agency daily in order to allow them to update their system(s) with accurate payment information.
6. The collection agency will invoice Meritus for appropriate amounts due, which will be reviewed by patient financial services management. If the invoiced amounts are correct,

invoices are approved and submitted for payment through the Accounts Payable Department.

7. Bad debt collection agencies will have a reasonable number of days to resolve the outstanding balances due and must close and return those accounts at that time.
    a. Accounts may be placed with a second bad debt agency for an appropriate period of time from the initial bad debt collection agency.
    b. Accounts not resolved after an appropriate period of time may be returned to Meritus and closed.
8. With approval from Meritus, legal action may be taken on accounts that have not been disputed or are not on a payment arrangement.
    a. Meritus shall refrain from taking any legal actions until at least 120 after the first post-discharge billing statement.
    b. Prior to initiating any legal action, Meritus shall provide written notice in accordance with section D.2. above.
    c. Garnishments may be applied to these patients if Meritus is awarded judgment.
    d. A lien may be placed on primary home values above $150,000. Meritus will not pursue foreclosure of a primary residence but may maintain its position as a secured creditor if a property is otherwise foreclosed upon.
9. Patients may file a grievance with Meritus regarding treatment or undesirable activities performed by contracted outsource agencies by contacting the Patient Financial Services department.

E. FINANCIAL ASSISTANCE

1. Prior to initiating any actions under this policy, Meritus shall determine whether or not a patient is eligible for Meritus' Financial Assistance Program. For patients who have not submitted a Financial Assistance Application, Meritus shall send the patient information on the Financial Assistance Program.
2. The Patient Access Department will be responsible for reviewing the application, reviewing the appropriate documentation, and determining eligibility based on Meritus' policy guidelines.

RESPONSIBILITY

Bad debt pre-list criteria:

	Criteria	Other Criteria
MMC	>$10	>90 days from first post-discharge statement. Action must be reviewed by management prior to sending
MEI, Trauma & Wound	>$5	>90 days from first post-discharge statement. Action must be reviewed by management prior to sending

Bad debt approval process criteria:

	Approval Criteria	Approval Level
MMC	<$1,000	Supervisor, Hospital PFS
	<$20,000	Manager, Hospital PFS
	<$50,000	Regional Director, Hospital PFS
	>$50,000	Meritus Designated Representative
MEI, Trauma & Wound	<$250	Supervisor, Physician PFS
	<$500	Manager, Physician PFS
	<$1,000	Regional Director, Physician PFS
	>$1,000	Meritus Designated Representative

Small Balance criteria:

	Criteria
MMC	9.99
MEI, Trauma & Wound	4.99

REFERENCES

I.R.C. § 501(r) (2015).
26 C.F.R. § 1.501(r)-6 (2015).

RELATED POLICIES

1. Financial Assistance Policy and Procedure Number ADM0436
2. Collector Bad Debt Policy and Procedure Number PA 002-CA
3. MH Bad Debt Agencies Policy and Procedure Number PA 005-CA

Appendix III Financial Assistance Policy - continued

MERITUS MEDICAL CENTER

Appendix 1

Sliding Scale

		% of Federal Poverty Level Income					
		200%	250%	300%	350%	400%	500%
Size of Family Unit	FPL Income	Approved % of Financial Assistance					
		100%	80%	60%	40%	20%	0%
1	$11,670	$23,340	$29,175	$35,010	$40,845	$46,680	(3) $58,350
2	$15,730	$31,460	$39,325	(2) $47,190	$55,055	$62,920	$78,650
3	$19,790	$39,580	$49,475	$59,370	$69,265	$79,160	$98,950
4	$23,850	(1) $47,160	$58,950	$70,740	$82,530	$94,320	$117,900
5	$27,910	$55,820	$69,775	$83,730	$97,685	$111,640	$139,550
6	$31,970	$63,940	$79,925	$95,910	$111,895	$127,880	$159,850
7	$36,030	$72,060	$90,075	$108,090	$126,105	$144,120	$180,150
8	$40,909	$81,818	$102,273	$122,727	$143,182	$163,636	$204,545

Example # 1	Example # 2	Example # 3
1. Patient earns $57,000 per year 2.There are 4 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 80% (they earn more than $47160 but less than $58,950)	1 .Patient earns $50,000 per year. 2. There are 2 people in the patient's family. 3. The % of potential Financial Assistance coverage would equal 40% (they earn more than $47190 but less than $55,055	1 .Patient earns $59,000 per year. 2. There is 1 people in the patient's family. 3. The balance owed is $20,000. 4. The patient qualifies for Hardship coverage, owes $14,750 (25% of 59,000).

Appendix IV a. Patient Information Sheet (English)

Hospital Financial Assistance Policy

Meritus Health is committed to providing all patients with medically necessary care regardless of their ability to pay. If you are unable to pay for medical care, you may qualify for free or reduced cost medically necessary care if you have a low income, have no health insurance or no other insurance options or sources of payment.

Meritus Medical Center

Patients' Rights

Meritus Health will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

Patients' Obligations

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

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

How to Apply:

Applications can be download from the following link: www.meritushealth.com/financialassistance. Paper copies of the application can be obtained at the following locations in Meritus Medical Center:

- Registration- main lobby
- Same Day Services
- Emergency Room
- The Imaging Center

To have an application mailed to you, please call 301-790-8928.

Contacts:

Call 240-313-9500 with questions concerning:

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

Call 301-790-8928 with questions concerning:

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

For information about Maryland Medical Assistance contact your local department of Social Services

1-800-332-6347 TTY 1-800-925-4434 Or visit: www.dhr.state.md.us

Physician Charges

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

Appendix IV b. Patient Information Sheet (Spanish)

Política de Asistencia financiera de Meritus Medical Center

Meritus Medical Center está comprometido a brindar a todos los pacientes la asistencia médica necesaria sin importar su capacidad de pago. Si no pudiera pagar la atención médica, puede que califique para recibir atención médica necesaria gratuita o de costo reducido si tiene ingresos bajos, si no tiene seguro de salud ni ninguna otra opción de seguro o fuente de pago.

Derechos de los pacientes

Meritus Medical Center trabajará con sus pacientes sin seguro para adquirir un entendimiento de los recursos financieros del paciente.

- Aquellos pacientes que reúnan los criterios de la política de asistencia financiera de Meritus Medical Center podrán recibir asistencia para el pago de su factura de parte de Meritus Medical Center.
- Meritus Medical Center proporcionará asistencia con la inscripción en Medicaid u otras posibilidades de financiación que pudieran estar disponibles de parte de otras organizaciones benéficas.
- Si no califica para Asistencia médica o para asistencia financiara, tal vez sea elegible para un plan de pago extendido de sus facturas médicas hospitalarias.
- Si cree que lo transfirieron equivocadamente a una agencia de cobranzas, tiene derecho a comunicarse con el hospital para pedir ayuda. (Consulte la información de contacto a continuación.)

Obligaciones de los pacientes

Meritus Medical Center cree que sus pacientes tienen responsabilidades personales relacionadas con los aspectos financieros de sus necesidades de atención médica. Se espera que nuestros pacientes hagan lo siguiente:

- Paguen la factura del hospital en tiempo y forma, si tuvieran capacidad de pago.
- Se comuniquen inmediatamente con el hospital si no tuvieran medios para pagar la factura en su totalidad y procuren obtener ayuda para resolver el tema de su saldo adeudado.
- Proporcionen información de seguro y financiera completa y precisa.
- Proporcionen los datos solicitados para completar las solicitudes de Medicaid en tiempo y forma.
- Mantengan el cumplimiento de las condiciones del plan de pagos dispuesto.
- Nos informen de inmediato, al número que aparece a continuación, sobre cualquier cambio en sus circunstancias.

Cómo solicitar

Las solicitudes se pueden descargar del siguiente enlace: www.meritushealth.com/financialassistance. Se pueden obtener copias impresas de la solicitud en los siguientes locales de Meritus Medical Center:

- Ingresos - Vestíbulo principal
- Servicios en el mismo día
- Sala de emergencias
- Centro de imaginología

Para que le envíen una solicitud por correo, llame al 301-790-8928.

Contactos

Si tiene preguntas acerca de alguno de los siguientes puntos, llame al 240-313-9500.

- Su factura del hospital
- YSus derechos y obligaciones respecto a su factura del hospital

Si tiene preguntas acerca de alguno de los siguientes puntos, llame al 301-790-8928.

- Cómo solicitar Medicaid de Maryland
- Cómo solicitar atención gratuita o de costos reducidos

Meritus Medical Center

11116 Medical Campus Road
Hagerstown, MD 21742

Para obtener información acerca de Maryland Medical Assistance comuníquese con su departamento local de Servicios Sociales.

1-800-332-6347 TTY 1-800-925-4434 Or visit: www.dhr.state.md.us

Costos de los médicos

Los costos de los médicos no están incluidos en las facturas del hospital sino que el mismo médico los factura por separado.

Appendix V a. Mission, Vision and Value Statement

Mission

Meritus Medical Center in collaboration with Meritus Health exists to improve the health status of our region by providing comprehensive services to patients and families.

This mission emphasizes three core activities:

Providing patient and family centered care

Bringing the patient and family perspectives into the planning, delivery and evaluation of care to improve quality and safety

Improving the health status of our region

Responding to national healthcare reform and total patient revenue economic structures that incentivize value, by expanding the focus to include improving the health status of our region

Functioning as a regional health system

Meeting the healthcare needs of the communities beyond the Meritus Health's traditional service area of Washington County

Vision

Relentlessly pursue excellence in quality, service, and performance. This vision embodies the imperative expressed by our community that emphasized becoming an organization that continually strives for excellence.

Values

Our culture is driven by the values of respect, integrity, service, and excellence delivered to patients and families through teamwork. It is through these values that Meritus Health will fulfill our mission and achieve our vision.

Meritus has established a strategic plan to achieve its vision by focusing on improvements in the areas of quality, service, performance, and culture:

Quality

- Successfully manage the quality of care, the cost of care, and the volume (utilization) of care in response to the national healthcare delivery and reimbursement trends.

Service

- Provide an exceptional patient experience by utilizing patient and family centered care principles across the organization.

Performance

- Improve financial performance in response to changes in healthcare reimbursement and to ensure we have the resources to pursue the fulfillment of our mission and vision.

- Develop information technology capabilities to support the achievement of the organizational vision and strategies.

Culture

- Empower employees and providers to put patients and families at the center of everything we do while attracting, retaining, developing, and rewarding our workforce.

- Strengthen physician and provider alignment with Meritus Health by developing an innovative, high-performing medical staff.

Appendix V b. Mission, Vision and Value Statement (publically posted)

Meritus Health
Who We Are

Meritus Medical Center is perhaps our most easily recognized facility, but Meritus Health offers much, much more. For generations, Meritus Health has been responding to the specific needs of the region with the foresight of a true community partner by developing and sustaining a total healthcare system. Branches of care including primary care physician practices, specialists in disciplines from obstetrics to cardiology and satellite services from diagnostics to home medical equipment complement the hospital's efforts to provide quality care. Meritus Health is not just a hospital. That said, Meritus Medical Center does offer cutting-edge technology and services for inpatients and outpatients in a facility without a cold, clinical feel. Care is provided by a multi-generational workforce from around our region–your friends and neighbors. Access to advanced diagnostics, treatments and services is right here, delivered by competent and caring, familiar faces.

The quality services offered include a regional trauma center, a cardiac catheterization lab, a stroke center, a bariatric surgery center, a wound center and a nationally-recognized joint replacement program. Patients seldom have a reason to go "down the road" to receive excellent medical care. Meritus Health is the largest healthcare provider in the region and serves as a leader in the continued evolution of a comprehensive approach to wellness in the tri-state area and beyond.

Meritus Health

MeritusHealth.com

MISSION

Meritus Health exists to improve the health status of our region by providing comprehensive health services to patients and families.

VISION

Meritus Health will relentlessly pursue excellence in quality, service and performance.

OUR VALUES

Respect, Integrity, Service and Excellence

Appendix VI FY2016 CHNA Action Plan

Community Health Needs Assessment
Action Plan 2016
Strategic Plan Goal: Improve Population Health

HEALTH NEED	OBJECTIVE	GOAL	2015 Baseline	2016 ACTIONS	AGENCIES	OUTCOME	DATE MET
Obesity #1	Reduce obesity and increase physical activity	Increase the percentage of adults at a healthy weight by 3% over 3 years	27.9 DHMH 2015	Offer 3 new opportunities, activities or community events designed to increase physical activity during 2016; WC Walking Plan, TEAM Cycle event	HWC		
		Decrease the rate of childhood obesity by 2% over 3 years	11.8 DHMH 2015	Provide Coordinated Approach To Child Health (CATCH) to at least 8 after-school programs	MMC, WCPS		
		Decrease the percentage of obese adults by 2% over 3 years	30.8 CDC 2015	Complete BMI screening and offer health care referrals to 250 persons	HWC		
		Decrease percentage of adults who are physically inactive by 2% over 3 years	26.6 CDC 2015				
Mental Health #2	Improve mental health access and reduce ED visits Improve mental health awareness and education	Decrease ED visits related to mental health conditions by 5%	5785 visits DHMH 2014	Provide mobile crisis service to support law enforcement	MHA, WAY		
				Implement a community case management program for frequent ED patients	MMC		
		Decrease behavioral health hospital readmissions within 30 days by 3% over 3 years	Avg. 7% MMC FY13-15	Improve coordination of discharge planning with community providers	MMC		
				Provide onsite social workers in PCP offices to improve clinical integration and treatment coordination	MMC		
		Screen 75% of adults for depression in primary care practices annually	No reliable data	Implement standardized depression screening in PCP offices	HFHC, MMC, MMG, TCHC		
		Screen 500 persons in community for depression by June 30, 2017		Conduct community depression screening events and provide resource information	BLHS, MMC		
		Hold eight (8) Mental Health First Aid trainings by June 30, 2017	4 events 2015	Provide quarterly Mental Health First trainings (adult and youth) to decrease stigma and increase awareness	BLHS		
Diabetes #3	Improve management of diabetes and reduce mortality	Decrease the rate of new diabetes diagnosis by 3% over 3 years	10.7 per 100 adults MD Vital Stats 2015	Implement a diabetes prevention program that reaches 250 persons	MMC, WCHD		
		Decrease the diabetes mortality rate by 2% over three years	35.6 per 100,000 MD Vital Stats 2015	Increase availability of diabetes education and support to primary care practices	MMC		
		Reduce # of ED visits for diabetes by 5% over 3 years	272 avg. visits Meritus FY13-15	Expand availability Living Well support program to reach 300 persons	COA, MMC, WCHD		
				Provide outreach and free screenings to targeted neighborhoods with demonstrated diabetic health disparities	MOTA, MMC, WCHD		

HEALTH NEED	OBJECTIVE	GOAL	2015 Baseline	2016 ACTIONS	AGENCIES	OUTCOME	DATE MET
Healthy Lifestyle #4	Improve diet & exercise	Increase the percentage of adults at a healthy weight by 3% over three years	27.9 DHMH 2015	Implement healthy eating initiatives with at least 5 employers	HWC		
				Provide nutritional & dietary counseling to 500 persons	MMC, WCHD		
		Implement employee wellness programs with 5 Washington County employers who do not offer programs currently	2015	Help at least 3 employers develop workplace wellness programs	HWC		
				Expand wellness programs to all Washington County schools	HEAL, WCPS MMC		
Substance Abuse #5	Improve addictions treatment access and reduce overdose deaths	Decrease number of overdose fatalities in Washington County by 10%	37 deaths 2014 MD Vital Stats	Implement use of SBIRT in evaluative settings	MMC, WCHD		
				Offer Naloxone training to community	WCHD		
		Decrease ED visits for addictions related conditions by 5% over 3 years	1746 visits DHMH 2013	Create task force to conduct a gap analysis of treatment servcies and develop plan to bridge services	MMC, WCHD		
				Implement a community case management program for frequent ED patients	MMC		
				Provide substance abuse education to help facilitate linkage to SA services	WCHD		
				Conduct media campaign to address educating the public about prevention and treatment	MMC, WCHD		
Heart Disease #6	Reduce heart disease mortality and manage hypertension	Decrease age-adjusted mortality rate from heart disease by 1% within 3 years	196 per 100,000 MD Vital Stats 2015	Provide community and employer health education events to increase heart health awareness	HWC		
		Decrease the # of ED visits for hypertension by 5% over 3 years	272 avg. visits Meritus FY13-15	Provide community and employer blood pressure screening and education	HWC		
				Provide outreach and free screenings to targeted neighborhoods with demonstrated cardiac health disparities	MOTA, MMC, WCHD		
				Provide smoking cessation programs and support	MMC		
				Offer Vascular Screenings	MMC		

ACO - Meritus/THP Accountable Care Organization, BLHS - Brook Lane Health Services, COA - Commission on Aging, HFHC - Hagerstown Family Healthcare, HWC - Healthy Washington County, MHA - Mental Health Authority, MMC - Meritus Medical Center, MOTA - Minority Outreach & Technical Assistance, TCHC - TriState Community Health Center, WCPS - Washington County Public Schools, WCHD - Washington County Health Department, WAY - Waystation

2/24/2016