Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile it into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. Detailed reporting instructions have been distributed to your hospital's community benefit contacts, and additional copies can be requested at the email below.

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

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

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

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

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

Q4. Please select the community health statistics that your hospital uses in its community benefit efforts.

- ☑ Median household income
- ☑ Percentage below federal poverty level (FPL)
- ☑ Percent uninsured
- ☑ Percent with public health insurance
- ☑ Percent with Medicaid
- ☑ Mean travel time to work
- ☑ Percent speaking language other than English at home
- ☑ Race: percent White
- ☑ Race: percent Black
- ☑ Ethnicity: percent Hispanic or Latino
- ☑ Life expectancy
- ☐ Crude death rate
- ☑ Other

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

In addition to the community health statistics for Washington County linked above, we use: Demographic and socioeconomic data obtained from Nielsen/Claritas (www.claritas.com) and the US Census Bureau (www.census.gov) Disease and Mental Hygiene incidence and prevalence data obtained from the Maryland Department of Health and Maryland Vital Statistics Administration (http://dhmh.maryland.gov) The Centers for Disease Control and Prevention (http://www.cdc.gov) Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Some health-related indicators included in this report include BRFSS data collected by the CDC http://www.cdc.gov/brfss/ CDC Chronic Disease Calculator, available at http://cdc.gov/chronicdisease/resources/calculator/index.htm The health-related indicators included in this report for Maryland are BRFSS data and benchmarks coordinated by the Maryland Department of Health and Mental Hygiene as part of the State's Health Improvement Plan (SHIP)http://dhmh.maryland.gov/ship/SitePages/Home.aspx last updated May 8, 2020 Selected utilization data based on hospital claims data, HSCRC American Community Survey Social Determinants Data Meritus Health Cancer Registry Cases Maryland Chronic Disease Burden County Health Rankings, A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, www.countyhealthrankings.org focus Washington County, Maryland 2021 United Way ALICE Report, 2021 Conduent Healthy Communities Institute Data Scoring, Washington Co. 2021 MD Dept. of Health Crisis Services Expansion Data Analysis, 2021 Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Q6. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Youth Risk Behavior WASH CO 2018.pdf
169.2KB
application/pdf

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

Q8. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

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

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

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

- [x] Other. Please describe.

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

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

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

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

At the time that this Community Health Needs Assessment process was conducted, more than 76% of Meritus Health discharges resided in a zip code within Washington County, Maryland. While services are provided to people living throughout a 60 mile radius of the quad-state region, the geographic boundaries of Washington County were designated as the Primary Service Area (PSA) for the purposes of the CHNA. Both the CHNA and GBR agreement definitions of the PSA are the same; Washington County, Maryland approximately 155,000 persons. The PSA makes up a representative cross section of the county's population including those considered 'medically underserved,' as well as populations at risk of not receiving adequate medical care as a result of being uninsured or underinsured, or other access issues and disparities. Meritus Medical Center serves over 200,000 persons when SSA's of Pennsylvania and West Virginia are included.

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

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

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

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

05/04/2022

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

https://www2.meritushealth.com/files/fy2022-bookletpdf.pdf

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

Appendix FY22 CHNA.zip
16.4MB
application/zip

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

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

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Executive Director, Behavioral & Community Health
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Chief Health Officer, Chief Strategy Officer
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Board of Directors member and Full Board reviewed CHNA ap action
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	"Community Health" team members
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Nurse(s)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Social Workers	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

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

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

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

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

Refer to the FY 2023 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2023.

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

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

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

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

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

- (●) Yes
- ( ) No

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

February 24, 2022

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

https://www.meritushealth.com/about/CHNA

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

R. Meritus CHIP FY2023 - 2025 FINAL.xlsx
21.2KB

application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

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

The Community Health Improvement Plan tracks implementation and documents the impact of strategies to address priority health needs. Tracking metrics for each prioritized health need measures progress towards achieving goals on a monthly basis. The outcome metrics are displayed on a dashboard that is reviewed by both Meritus Health and Healthy Washington County. The FY2023 CHIP with final outcomes are attached below. Strategies and goals are modified for FY24 based on goal achievement, progress, obstacles and re-assessment of needs.

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

Healthy Wash Co Dashboard FY23.xlsx
16.1KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q57. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q58. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q59.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

- ☐ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☐ Health Conditions - Blood Disorders
- ☐ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☐ Health Conditions - Foodborne Illness
- ☐ Health Conditions - Health Care-Associated Infections
- ☐ Health Conditions - Heart Disease and Stroke
- ☐ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☐ Health Conditions - Osteoporosis
- ☐ Health Conditions - Overweight and Obesity
- ☐ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☐ Health Conditions - Sensory or Communication Disorders
- ☐ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☐ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Vaccination
- ☐ Health Behaviors - Violence Prevention
- ☐ Populations - Adolescents
- ☐ Populations - Children
- ☐ Populations - Infants
- ☐ Populations – LGBT
- ☐ Populations - Men
- ☐ Populations - Older Adults
- ☐ Populations - Parents or Caregivers
- ☐ Populations - People with Disabilities
- ☐ Populations - Women
- ☐ Populations - Workforce
- ☐ Settings and Systems - Community
- ☐ Settings and Systems - Environmental Health
- ☐ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☐ Settings and Systems - Health Insurance
- ☐ Settings and Systems - Health IT
- ☐ Settings and Systems - Health Policy
- ☐ Settings and Systems - Hospital and Emergency Services
- ☑ Settings and Systems - Housing and Homes
- ☐ Settings and Systems - Public Health Infrastructure
- ☐ Settings and Systems - Schools
- ☐ Settings and Systems - Transportation
- ☐ Settings and Systems - Workplace

- [ ] Health Behaviors - Injury Prevention
- [ ] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [x] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality
- [ ] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [ ] Other Social Determinants of Health
- [x] Other (specify) dental health, teen pregnancy

Q60. Why were these needs unaddressed?

At the conclusion of the FY2022 CHNA health needs ranking it was recognized that more needs were identified and exist than the top five prioritized health needs that the community has chosen to focus on. Some of the other health needs for the community include access to dental care, teen pregnancy, and housing insecurity. Our community providers are using the results of the CHNA to help target these unmet needs based on the strengths, expertise and resources of individual organizations, and when interests are shared, new collaborative relationships between organizations can be formed. Findings from the FY2022 CHNA may be used to support grant procurement, donations and gifts to fund new program services. Hagerstown Family Healthcare (FQHC) has expanded access to dental care to persons in Washington County. The Hagerstown Family Healthcare Dental Practice provides comprehensive dental care to children and adults. They provide a pediatric dentist who specializes in the dental needs of children of all ages, as well as special needs patients. The Healthy Smiles in Motion mobile dental program provides dental care to students of Washington County Public Schools on-site at their home schools. To help prevent teen pregnancy The Community Free Clinic provides services to reduce teen pregnancy as a part of the YOLO program (Youth Overcoming Life Obstacles) serving adolescents ages 13-18 and up to age 24. Youth may present to the Clinic without appointment to receive strictly free and confidential services including family planning, 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 use, assault, violence and general safety is also addressed at each visit. The CFC has expanded to meet comprehensive health needs of uninsured youth in the community. Mental Health services were expanded 3 years ago to provide counseling, crisis intervention and emotional support for those experiencing life difficulties such as anxiety, depression, grief, trauma and more. Health care organizations and community resource agencies must work collaboratively across sectors to address Economic Stability which can encompass health, wellness, housing, transportation, food insecurity, and income. The United Way of Washington County will use this report as another tool that helps determine appropriate funding for local programs that are tackling pressing community issues. The funding process begins with funding strategies that are formulated with data, and input from multiple community members, businesses and nonprofit organizations. Data is very important and is used to set goals that help meet the mission: “The United Way of Washington County inspires collaborations to impact community improvement. To do this, we function as a rallying point for attracting and fostering leadership to advance collective action.” Cooperation with our local shelters and the Horizon Goodwill is helping to provide primary care services, meals, mental health counseling, access to health coverage, and community resource navigation possible to unhoused persons. We are fortunate to have two Federally Qualified Health Clinics in Washington County along with the Community Free Clinic which provides free health care to uninsured persons. In addition, Meritus offers Financial Aid, Medication Assistance and transportation to help offset costs associated with receiving health care.

Q61. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

We track SDOH county level updates to the CDC's Social Vulnerability Index (last updated 2020) and American Community Survey Social Determinants of Health Data by Zip Code (2016-2020), but obviously the data is significantly lagging. Meritus Health and San Mar Family and Community Services have invested with the Conduent Healthy Communities Institute to develop a community solutions hub that provides real time data to centralize fragmented Washington County data to measure quality of life for residents, monitor progress, strengths and needs, and ultimately catalyze action to achieve community well-being. Part of the data helped develop the SocioNeeds Index, a measure of socioeconomic need that is correlated with poor health outcomes in health equity, food insecurity and mental health. Using zip codes, census tracts, and health outcomes data, our communities are given an index value from 0 (low need) to 100 (high need) to help provide outreach to underserved neighborhoods and geographic locations with the greatest health disparities. It was used when conducting the FY22 CHNA and ensured representation for focus groups to obtain input from the persons living in these locations. www.communitysolutionshub.org We also make use of the Chesapeake Regional Information System for our Patients (CRISP) health information exchange to identify geographic "hotspots" for disease specific communities at higher risk. Additional patient outcome data and trends are generated from specific internal reports from our EHR system. Meritus has established a metric to complete SDOH screening in ambulatory practices as part of our strategic health aims. The patient population has SDOH screened and documented as unique patients with visits each month in the Epic EHR. At the end of FY2022 86% of the patient population seen at Meritus Medical Centered had been screened to determine "what matters most" to them. The data is being used to both link patients to resources in real time as well as develop new strategies for the health system to bridge gaps and help meet identified social needs in our community. During FY23 Meritus hospital encounters 39,591 persons were asked "In the last week, have you felt lonely?". Over 2,600 persons said yes (7%) and were offered to participate in a care caller program. 96% of persons who participate report feeling "less lonely."

Q62. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

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

Q63. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q64. Section III - CB Administration

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

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

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

- (●) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q74. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

As a community hospital, Meritus Health purposefully incorporates our commitment to community service in our internal management, governance structures, strategic and operational plans. Meritus Health conducts a community health needs assessment every three years to identify community health needs and service gaps, and develops a strategy with goals to address to health needs. A Community Health Improvement Plan (CHIP) including a description of health needs, strategic initiatives, and measurable goals are developed to address the prioritized health needs. The Community Health Needs Assessment data, prioritized health needs and recommendations are shared with the Senior Executive Team and Board of Directors. The action plan is reviewed by the Meritus Board Strategic Planning committee and approved by the Meritus Board of Directors. This information along with other hospital data and information was used to develop the health system's 10-year strategic plan, 2030 Bold Goals. Using the quintuple aim framework, the 2030 Bold Goals were created to improve the health of people in our community, improve healthcare, have joy at work, provide affordable medical care, and develop a world class medical school. The Board of Directors completes strategic planning annually with key Meritus leadership. The Chief Strategy Officer and Director of Community Health helps provide data and conclusions to better align priorities between the Meritus Strategic Plan and CHNA Implementation Strategy as a component of community benefit planning. Priority actions for 2022 – 2025 include: 1. Obesity; lose 1 million community pounds by promoting increased physical activity (DO), eating a healthy diet (EAT), and achieve emotional balance (BELIEVE), 2. Improve behavioral health by ensuring timely access to appropriate, quality mental health treatment and support, and reduce addiction and overdose fatalities to protect the health, safety and quality of life for all, 3. Improve prevention and the management of type II diabetes and reduce mortality, 4. Prevent heart disease, reduce mortality and manage hypertension, 5. Increase healthy equity by helping all people attain the highest level of health, 6. Engage and empower people to choose healthy behaviors and make changes to reduce risk.

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

N/A

Q76. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents

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

- [x] Opioid Use Disorder - Improve overdose mortality

Use of peer support in the medical center, SBIRT screening, initiation of MAT in the ED. Established crisis intervention center and six beds to disrupt the cycle of addiction. The program provides warm hand-off to residential treatment or IOP; outcomes demonstrate 70%+ confirmed follow-up with next provider of care, and < 22% recidivism to Emergency Dept. in 30 days (only 27% within 90 days).

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

Q77. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Consistent with the SIHIS, Meritus has active initiatives across most of the identified domains: 1. Improve Hospital Quality by reducing avoidable admissions - Meritus has a Readmissions Workgroup charged with reducing PAU, meeting weekly. Action plan: Improve 30 day readmission rate to an overall O/E less than1.00 by 6/30/2024 2. Care Transformation to include timely follow up after acute exacerbations of chronic conditions. Both of these domains are being addressed with a comprehensive kata (quality improvement tool) Priority #1 Real-time review of readmissions Priority #2 Disease state education Priority #3 Deliver meds to beds prior to discharge Priority #4 Collaboration with SNFs Priority #5 Home Health and Mobile Health intervention Priority #6 Follow up appointment with community provider within 7 days of discharge Priority #7 Outpatient transitional care Priority #8 Access to timely behavioral health care Domain 3 is addressed above (diabetes and opioid use disorder)

Q78. Section IV - Physician Gaps & Subsidies

Q79. (Optional) Please attach any files containing further information and data justifying physician subsidies at your hospital.

(This year, all information on physician gap subsidies is collected on the financials. However, if you have additional information on these subsidies to report, you may do so through attachments here.)

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

Q80. Section V - Financial Assistance Policy (FAP)

Q81. Upload a copy of your hospital's financial assistance policy.

FY-24-Meritus-Financial-Assistance-Policy-Final.pdf
211.6KB
application/pdf

Q82. Provide the link to your hospital's financial assistance policy.

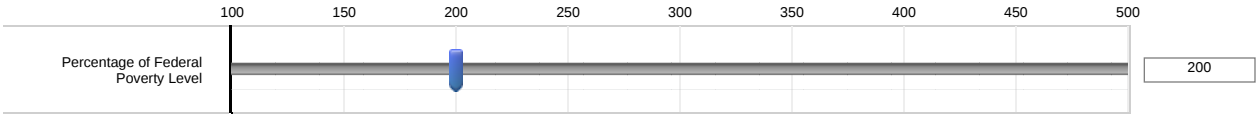
https://www.meritushealth.com/about/patients-visitors/financial-assistance

Q83. Has your FAP changed within the last year? If so, please describe the change.

- ○ No, the FAP has not changed.
- ◉ Yes, the FAP has changed. Please describe: February, 2023: Revised FA to allow Meritus to extend financial assistance to outside facilities where treatment is provided by a Meritus employed provider and a non-Meritus facility fee is incurred.

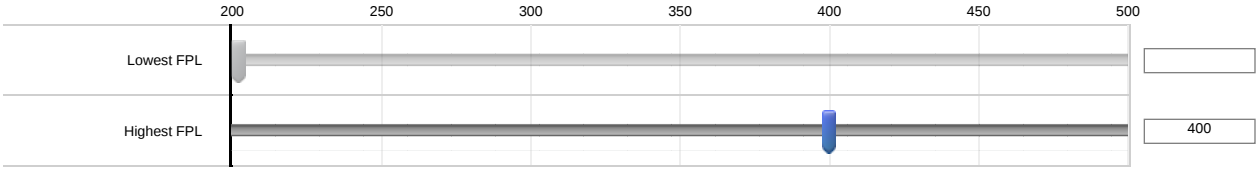
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



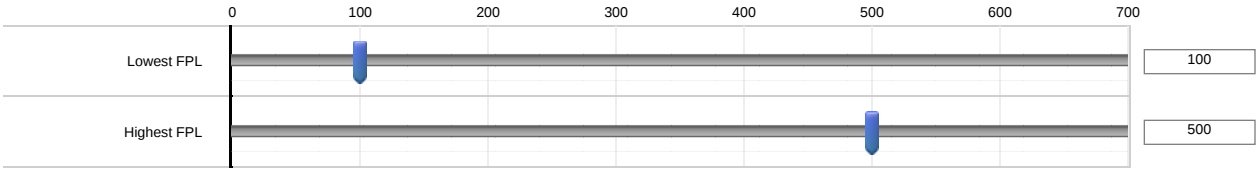
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

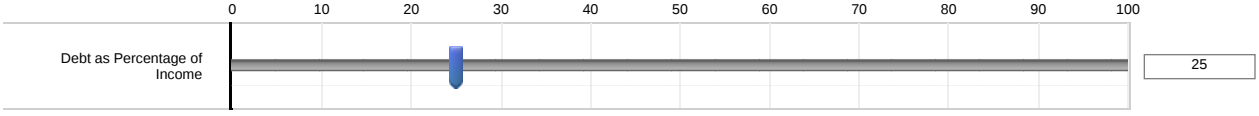


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q87. Please select the threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.



Q88. Section VI - Tax Exemptions

Q89. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- ☐ Federal corporate income tax
- ☑ State corporate income tax
- ☑ State sales tax
- ☑ Local property tax (real and personal)

☐ Other (Describe)

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (39.6343, -77.7337)

Source: GeoIP Estimation

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Unintentional Injuries/Violence

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN9: Percentage of students who rode with a driver who had been drinking alcohol (in a car or other vehicle, one or more times during the 30 days before the survey)	14.4 (12.7-16.3)	2,177	14.4 (11.0-18.7)	325			•
QN10: Percentage of students who drove a car or other vehicle when they had been drinking alcohol (one or more times during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	4.5 (2.9-6.9)	884	6.5 (2.9-13.9)	104			•
QN11: Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	30.0 (26.1-34.2)	909	28.4 (20.4-37.9)	109			•
QN13: Percentage of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	4.4 (3.5-5.5)	2,132	8.3 (5.6-12.2)	321		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Unintentional Injuries/Violence

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN14: Percentage of students who carried a gun (not counting the days when they carried a gun only for hunting or for a sport such as target shooting, on at least 1 day during the 12 months before the survey)	4.0 (3.1-5.2)	2,172	4.1 (2.2-7.4)	325			•
QN15: Percentage of students who did not go to school because they felt unsafe at school or on their way to or from school (on at least 1 day during the 30 days before the survey)	10.7 (9.2-12.4)	2,169	16.3 (12.8-20.4)	324		•	
QN16: Percentage of students who were threatened or injured with a weapon on school property (such as a gun, knife, or club, one or more times during the 12 months before the survey)	7.4 (6.1-9.0)	2,165	11.7 (8.5-16.0)	322		•	
QN18: Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	9.6 (8.3-11.1)	2,174	11.7 (8.7-15.7)	323			•
QN22: Percentage of students who experienced physical dating violence (being physically hurt on purpose by someone they were dating or going out with [counting such things as being hit, slammed into something, or injured with an object or weapon] one or more times during the 12 months before the survey, among students who dated or went out with someone during the 12 months before the survey)	9.3 (7.6-11.4)	1,256	20.4 (14.9-27.3)	192		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Unintentional Injuries/Violence

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN23: Percentage of students who were bullied on school property (ever during the 12 months before the survey)	18.8 (16.8-21.0)	2,158	35.0 (29.6-40.9)	318		•	
QN24: Percentage of students who were electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media, ever during the 12 months before the survey)	14.3 (12.6-16.1)	2,160	29.4 (24.3-35.2)	318		•	
QN25: Percentage of students who felt sad or hopeless (almost every day for >=2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	28.3 (26.1-30.5)	2,159	69.5 (63.9-74.6)	318		•	
QN26: Percentage of students who seriously considered attempting suicide (ever during the 12 months before the survey)	15.1 (13.2-17.2)	2,144	48.7 (43.1-54.4)	318		•	
QN27: Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	12.6 (11.0-14.2)	2,146	35.4 (29.8-41.4)	315		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Tobacco Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN31: Percentage of students who first tried cigarette smoking before age 13 years (even one or two puffs)	7.9 (6.4-9.7)	2,155	16.1 (12.2-21.1)	320		•	
QN32: Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	5.9 (4.5-7.7)	2,168	13.5 (9.9-18.1)	322		•	
QNFRCIG: Percentage of students who currently smoked cigarettes frequently (on 20 or more days during the 30 days before the survey)	1.9 (1.2-3.0)	2,168	3.8 (2.0-7.0)	322			•
QNDAYCIG: Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	1.4 (0.8-2.4)	2,168	2.9 (1.4-6.0)	322			•
QN34: Percentage of students who ever used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens [such as blu, NJOY, Vuse, MarkTen, Logic, Vapin Plus, eGo, and Halo])	46.5 (43.3-49.7)	2,125	52.9 (47.0-58.7)	316		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Tobacco Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN35: Percentage of students who currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens [such as blu, NJOY, Vuse, MarkTen, Logic, Vapin Plus, eGo, and Halo], on at least 1 day during the 30 days before the survey)	29.8 (26.9-33.0)	2,024	34.7 (29.1-40.7)	300			•
QNFREVP: Percentage of students who currently used electronic vapor products frequently (on 20 or more days during the 30 days before the survey)	9.2 (7.3-11.5)	2,024	8.5 (5.7-12.4)	300			•
QNDAYEVP: Percentage of students who currently used electronic vapor products daily (on all 30 days during the 30 days before the survey)	5.7 (4.2-7.6)	2,024	5.6 (3.4-9.0)	300			•
QN36: Percentage of students who usually got their own electronic vapor products by buying them in a store (such as a convenience store, supermarket, discount store, gas station, or vape store, during the 30 days before the survey, among students who currently used electronic vapor products and who were aged <18 years)	5.9 (3.8-9.0)	536	6.5 (2.9-13.8)	100			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Tobacco Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN37: Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products [such as Copenhagen, Grizzly, Skoal, or Camel Snus], not counting any electronic vapor products, on at least 1 day during the 30 days before the survey)	5.4 (4.3-6.8)	2,161	5.8 (3.4-9.8)	322			•
QN38: Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars, on at least 1 day during the 30 days before the survey)	6.1 (5.0-7.5)	2,162	10.3 (7.2-14.5)	323		•	
QNTB2: Percentage of students who currently smoked cigarettes or cigars (on at least 1 day during the 30 days before the survey)	9.1 (7.5-11.1)	2,161	17.2 (13.2-22.3)	323		•	
QNTB3: Percentage of students who currently smoked cigarettes or cigars or used smokeless tobacco (on at least 1 day during the 30 days before the survey)	11.6 (9.7-13.8)	2,158	17.9 (13.8-22.9)	321		•	
QNTB4: Percentage of students who currently smoked cigarettes or cigars or used smokeless tobacco or electronic vapor products (on at least 1 day during the 30 days before the survey)	33.1 (30.0-36.2)	2,048	40.5 (34.5-46.7)	309		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Tobacco Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QNTB5: Percentage of students who currently smoked cigarettes or used electronic vapor products (on at least 1 day during the 30 days before the survey)	31.0 (28.0-34.2)	2,037	38.6 (32.8-44.8)	308		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Alcohol/Other Drug Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN40: Percentage of students who had their first drink of alcohol before age 13 years (other than a few sips)	14.4 (12.5-16.5)	2,078	19.0 (14.7-24.2)	305			●
QN41: Percentage of students who currently drank alcohol (at least one drink of alcohol, on at least 1 day during the 30 days before the survey)	24.2 (21.8-26.9)	2,087	35.7 (29.5-42.3)	305		●	
QN42: Percentage of students who currently were binge drinking (had four or more drinks of alcohol in a row for female students or five or more drinks of alcohol in a row for male students, within a couple of hours, on at least 1 day during the 30 days before the survey)	11.7 (9.7-14.0)	2,107	20.6 (16.0-26.1)	308		●	
QN45: Percentage of students who ever used marijuana (one or more times during their life)	30.2 (27.2-33.3)	2,067	50.3 (44.4-56.3)	311		●	
QN46: Percentage of students who tried marijuana for the first time before age 13 years	6.8 (5.4-8.5)	2,098	10.0 (6.9-14.3)	316			●

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Alcohol/Other Drug Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN47: Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	17.4 (15.3-19.6)	2,105	30.1 (25.5-35.1)	315		•	
QN48: Percentage of students who ever used synthetic marijuana (one or more times during their life)	5.9 (4.7-7.4)	2,135	7.2 (4.9-10.4)	318			•
QN49: Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	10.5 (8.9-12.4)	2,144	22.2 (18.0-27.1)	319		•	
QN50: Percentage of students who ever used cocaine (any form of cocaine, including powder, crack, or freebase, one or more times during their life)	3.6 (2.7-4.8)	2,142	6.0 (3.8-9.2)	321			•
QN52: Percentage of students who ever used heroin (also called "smack," "junk," or "China White," one or more times during their life)	2.3 (1.6-3.3)	2,137	3.2 (1.8-5.7)	318			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Alcohol/Other Drug Use

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN53: Percentage of students who ever used methamphetamines (also called "speed," "crystal meth," "crank," "ice," or "meth," one or more times during their life)	2.5 (1.7-3.5)	2,141	3.8 (2.2-6.5)	319			●
QN54: Percentage of students who ever used ecstasy (also called "MDMA," one or more times during their life)	3.6 (2.6-4.9)	2,135	6.1 (4.0-9.2)	320			●
QN56: Percentage of students who ever injected any illegal drug (used a needle to inject any illegal drug into their body, one or more times during their life)	2.9 (2.2-3.9)	2,120	3.5 (1.9-6.4)	315			●
QN57: Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.8 (16.7-21.0)	2,119	22.9 (17.4-29.5)	318			●

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Sexual Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN58: Percentage of students who ever had sexual intercourse	32.2 (28.7-35.9)	1,892	43.1 (36.8-49.6)	284		•	
QN59: Percentage of students who had sexual intercourse for the first time before age 13 years	2.9 (2.2-3.8)	1,878	4.3 (2.3-8.0)	287			•
QN60: Percentage of students who had sexual intercourse with four or more persons during their life	6.7 (5.3-8.5)	1,889	11.5 (8.2-15.8)	287		•	
QN61: Percentage of students who were currently sexually active (had sexual intercourse with at least one person, during the 3 months before the survey)	23.4 (20.4-26.8)	1,886	29.8 (24.2-36.1)	288		•	
QN62: Percentage of students who drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	18.2 (14.5-22.4)	415	20.9 (13.6-30.6)	88			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Sexual Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN63: Percentage of students who did not use a condom during last sexual intercourse (among students who were currently sexually active)	43.7 (38.6-49.0)	408	64.1 (52.8-74.0)	87		•	
QN64: Percentage of students who did not use birth control pills before last sexual intercourse (to prevent pregnancy among students who were currently sexually active)	63.9 (58.5-69.0)	400	72.1 (61.3-80.8)	86			•
QNIUDIMP: Percentage of students who did not use an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	92.0 (88.5-94.5)	400	94.0 (86.8-97.4)	86			•
QNOTHHPL: Percentage of students who did not use birth control pills; an IUD or implant; or a shot, patch, or birth control ring (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	52.2 (47.0-57.3)	400	62.5 (51.8-72.2)	86			•
QNDUALBC: Percentage of students who did not use both a condom during and birth control pills; an IUD or implant; or a shot, patch, or birth control ring before last sexual intercourse (to prevent STD and pregnancy among students who were currently sexually active)	82.1 (77.3-86.0)	396	89.8 (80.5-94.9)	85			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Sexual Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QNBCNONE: Percentage of students who did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	8.9 (6.4-12.3)	400	28.6 (20.3-38.7)	86		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Dietary Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QNOBESE: Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)[¶]	14.1 (12.3-16.0)	2,004	21.8 (17.6-26.7)	281		•	
QNOWT: Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts)[¶]	16.6 (15.0-18.4)	2,004	19.0 (14.2-25.0)	281			•
QN67: Percentage of students who described themselves as slightly or very overweight	27.6 (25.7-29.6)	2,103	42.2 (36.8-47.8)	315		•	
QN69: Percentage of students who did not drink fruit juice (100% fruit juices one or more times during the 7 days before the survey)	35.0 (32.6-37.5)	2,117	38.0 (32.7-43.6)	316			•
QN70: Percentage of students who did not eat fruit (one or more times during the 7 days before the survey)	15.5 (13.6-17.5)	2,110	20.2 (15.8-25.3)	314			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.
[¶]Based on reference data from the 2000 CDC Growth Charts. In 2017, new, slightly different ranges were used to calculate biologically implausible responses to height and weight questions.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Dietary Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QNFR0: Percentage of students who did not eat fruit or drink 100% fruit juices (such as orange juice, apple juice, or grape juice, during the 7 days before the survey)	9.4 (7.9-11.2)	2,105	10.4 (7.4-14.3)	313			●
QN71: Percentage of students who did not eat green salad (one or more times during the 7 days before the survey)	46.1 (43.6-48.6)	2,109	47.9 (41.9-54.0)	314			●
QN72: Percentage of students who did not eat potatoes (one or more times during the 7 days before the survey)	37.7 (35.4-39.9)	2,112	45.2 (39.3-51.3)	315		●	
QN73: Percentage of students who did not eat carrots (one or more times during the 7 days before the survey)	54.9 (52.6-57.1)	2,105	57.5 (51.7-63.0)	314			●
QN74: Percentage of students who did not eat other vegetables (one or more times during the 7 days before the survey)	20.6 (18.2-23.1)	2,100	22.9 (18.2-28.4)	310			●

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Dietary Behaviors

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QNVEG0: Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	9.0 (7.5-10.6)	2,079	10.3 (6.9-15.1)	310			●
QNSODA1: Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (such as Coke, Pepsi, or Sprite, not counting diet soda or diet pop, during the 7 days before the survey)	14.3 (12.6-16.1)	2,097	14.0 (10.3-18.9)	313			●
QNSODA2: Percentage of students who drank a can, bottle, or glass of soda or pop two or more times per day (such as Coke, Pepsi, or Sprite, not counting diet soda or diet pop, during the 7 days before the survey)	8.6 (7.2-10.2)	2,097	11.4 (7.8-16.3)	313			●
QN77: Percentage of students who did not eat breakfast (during the 7 days before the survey)	15.2 (13.7-16.9)	2,093	18.0 (14.1-22.7)	313			●
QNBK7DAY: Percentage of students who did not eat breakfast on all 7 days (during the 7 days before the survey)	67.1 (64.8-69.3)	2,093	80.8 (75.7-85.1)	313		●	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Physical Activity

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN78: Percentage of students who were not physically active at least 60 minutes per day on 5 or more days (in any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	57.1 (54.5-59.6)	2,084	74.2 (67.4-79.9)	307		•	
QNPA0DAY: Percentage of students who did not participate in at least 60 minutes of physical activity on at least 1 day (in any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	18.6 (16.6-20.8)	2,084	29.0 (23.7-35.0)	307		•	
QNPA7DAY: Perentage of students who were not physically active at least 60 minutes per day on all 7 days (in any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	76.6 (74.5-78.5)	2,084	88.5 (84.0-91.8)	307		•	
QN79: Percentage of students who watched television 3 or more hours per day (on an average school day)	16.3 (14.6-18.2)	2,096	21.4 (16.8-26.9)	313			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Physical Activity

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN80: Percentage of students who played video or computer games or used a computer 3 or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work, on an average school day)	39.3 (36.8-42.0)	2,086	48.7 (43.2-54.2)	310		•	
QN81: Percentage of students who did not attend physical education (PE) classes on 1 or more days (in an average week when they were in school)	70.9 (67.2-74.3)	2,068	80.9 (75.0-85.7)	310		•	
QNDLYPE: Percentage of students who did not attend physical education classes on all 5 days (in an average week when they were in school)	77.7 (74.3-80.8)	2,068	88.5 (84.2-91.8)	310		•	
QN83: Percentage of students who had a concussion from playing a sport or being physically active (one or more times during the 12 months before the survey)	16.5 (14.7-18.5)	2,089	10.4 (7.3-14.7)	311	•		
QN88: Percentage of students who did not get 8 or more hours of sleep (on an average school night)	70.8 (68.3-73.1)	2,084	80.5 (75.8-84.5)	312		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Other

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN84: Percentage of students who were never tested for human immunodeficiency virus (HIV) (not including tests done when donating blood)	87.2 (85.2-88.9)	2,073	88.1 (83.6-91.5)	311			•
QN86: Percentage of students who did not see a dentist (for a check-up, exam, teeth cleaning, or other dental work, during the 12 months before the survey)	21.9 (19.6-24.3)	2,071	29.2 (24.1-34.9)	311		•	
QNNODNT: Percentage of students who never saw a dentist (for a check-up, exam, teeth cleaning, or other dental work)	1.2 (0.8-1.8)	2,071	4.2 (2.3-7.8)	311		•	
QN87: Percentage of students who had ever been told by a doctor or nurse that they had asthma	22.4 (20.4-24.5)	2,078	25.4 (20.9-30.4)	308			•
QN89: Percentage of students who described their grades in school as mostly C's, D's, or F's (during the 12 months before the survey)	21.0 (18.5-23.7)	2,076	27.1 (22.3-32.5)	306		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN90: Percentage of students who are transgender	0.7 (0.4-1.3)	2,174	8.4 (5.5-12.5)	322		•	
QN91: Percentage of students who did not usually sleep in their parent's or guardian's home (during the 30 days before the survey)	2.6 (1.9-3.5)	2,174	7.0 (4.5-10.9)	323		•	
QN92: Percentage of students who have ever slept away from their parents or guardians because they were kicked out, ran away, or were abandoned (during the 30 days before the survey)	5.8 (4.6-7.2)	2,170	8.5 (5.7-12.4)	324			•
QN93: Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	29.3 (25.4-33.4)	966	28.4 (20.7-37.6)	116			•
QN94: Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	3.6 (2.7-5.0)	2,128	8.7 (6.0-12.5)	314		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN95: Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who smoked cigarettes during the 30 days before the survey and who were aged <18 years)	12.9 (5.7-26.3)	83	-	27			
QN96: Percentage of students who were not asked to show proof of age (during the 30 days before the survey, among students who bought or tried to buy cigarettes in a store during the 30 days before the survey)	49.4 (35.1-63.9)	46	-	15			
QN97: Percentage of students who did not have someone refuse to sell them cigarettes because of their age (among students who tried to buy cigarettes during the 30 days before the survey)	83.8 (74.2-90.3)	96	71.6 (47.5-87.6)	31			•
QN98: Percentage of students who smoked tobacco in a hookah, narghile, or other type of waterpipe (on at least 1 day during the 30 days before the survey)	2.5 (1.8-3.5)	2,122	5.5 (3.3-9.0)	312		•	

[*]Confidence interval.
[†]Based on t-test analyses, $p<0.05$.
- = Fewer than 30 students in the denominator (subgroup).

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN99: Percentage of students who usually use a kind of flavoring other than tobacco flavor with an electronic vapor product (among students who have ever used an electronic vapor product)	97.4 (95.9-98.4)	791	95.7 (90.2-98.2)	144			•
QN100: Percentage of students who used electronic-vapor products mainly because a friend or family member used them	15.8 (14.2-17.6)	1,984	18.9 (14.4-24.4)	299			•
QN101: Percentage of students who have ever used an electronic vapor product to smoke marijuana, THC or hash oil, or THC wax	15.1 (12.8-17.6)	1,978	20.4 (16.1-25.5)	300		•	
QN102: Percentage of students who think they definitely or probably will smoke a cigarette, cigar, cigarillo, or little cigar in the next year	14.9 (13.0-17.1)	2,152	19.0 (14.5-24.5)	322			•
QN103: Percentage of students who used flavored tobacco products (flavored cigars, cigarillos, or little cigars, flavored smokeless tobacco products, or both, not counting menthol cigarettes, during the 30 days before the survey)	6.5 (5.1-8.1)	2,085	5.5 (3.4-8.9)	310			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN104: Percentage of students who tried or used tobacco products for the first time (during the 12 months before the survey)	6.9 (5.8-8.2)	1,983	8.8 (5.9-13.1)	284			•
QN105: Percentage of students who did not completely quit using all tobacco products (during the 12 months before the survey, among students who used tobacco products during the 12 months before the survey)	88.5 (84.5-91.7)	352	88.2 (78.0-94.0)	78			•
QN106: Percentage of students who live with someone who now smokes cigarettes or cigars	34.4 (32.0-36.9)	2,138	46.1 (39.8-52.4)	313		•	
QN107: Percentage of students who report that the rule about smoking inside their home is that there are no rules about smoking, that smoking is allowed in some places or at sometimes, or that smoking is allowed anywhere, inside their home (not counting decks, garages, or porches)	18.0 (16.2-19.9)	2,149	30.1 (24.8-35.9)	320		•	
QN108: Percentage of students who were in the same room with someone who was smoking (on at least one day during the 7 days before the survey)	28.9 (26.6-31.4)	2,150	42.6 (37.0-48.5)	322		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual†	Gay, Lesbian, or Bisexual More Likely Than Heterosexual†	No Difference†
	% 95% CI*	N	% 95% CI	N			
QN109: Percentage of students who gambled on a sports team, gambled when playing cards or a dice game, played one of their state's lottery games, gambled on the Internet, or bet on a game of personal skill such as pool or a video game (one or more times during the 12 months before the survey)	16.8 (15.1-18.6)	2,058	16.8 (12.8-21.8)	309			•
QN110: Percentage of students who were not taught or who were not sure if they were taught in any of their classes about the dangers of tobacco use (during the last school year)	47.9 (45.4-50.5)	2,072	53.9 (47.4-60.2)	309			•
QN111: Percentage of students who reported that their family was often or sometimes worried that their food money would run out before they got money to buy more (during the 12 months before the survey)	22.4 (20.2-24.8)	2,057	38.9 (33.5-44.6)	304		•	
QN112: Percentage of students who reported that often or sometimes the food their family bought did not last and they did not have money to get more (during the 12 months before the survey)	15.6 (13.7-17.7)	2,066	29.0 (24.3-34.2)	307		•	

*Confidence interval.
†Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN113: Percentage of students who have ever lived with anyone who was an alcoholic or problem drinker, used illegal street drugs, took prescription drugs to get high, or was a problem gambler	24.3 (22.3-26.3)	2,047	37.6 (32.5-43.1)	303		•	
QN114: Percentage of students who ever lived with anyone who was depressed, mentally ill, or suicidal	28.5 (26.2-31.0)	2,043	56.3 (50.0-62.3)	302		•	
QN115: Percentage of students who reported someone in their household has ever gone to jail or prison	24.2 (21.9-26.6)	2,054	33.1 (27.4-39.4)	304		•	
QN116: Percentage of students who reports a parent or other adult in their home regularly swears at them, insults them, or puts them down	20.0 (17.9-22.4)	2,034	36.5 (31.3-42.0)	299		•	
QN117: Percentage of students who say definitely yes or probably yes that young people who smoke have more friends	36.4 (34.1-38.8)	2,052	39.8 (34.3-45.6)	307			•

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Maryland High School Survey

Washington County

Risk Behaviors and Sexual Identity Report

Site-Added

Health Risk Behavior	Heterosexual		Gay, Lesbian, or Bisexual		Heterosexual More Likely Than Gay, Lesbian, or Bisexual[†]	Gay, Lesbian, or Bisexual More Likely Than Heterosexual[†]	No Difference[†]
	% 95% CI[*]	N	% 95% CI	N			
QN118: Percentage of students who say definitely yes or probably yes that smoking makes young people look cool or fit in	24.9 (22.6-27.2)	2,058	25.4 (20.7-30.8)	309			•
QN119: Percentage of students who would not feel comfortable seeking help from adults besides their parents if they had an important question affecting their life	21.5 (19.5-23.7)	2,061	30.6 (25.6-36.1)	309		•	

[*]Confidence interval.
[†]Based on t-test analyses, p<0.05.

Meritus Community Health Improvement Plan FINAL
FY2022 - 2025
Strategic Plan Goal: Improve Health

HEALTH NEED	OBJECTIVE	GOAL	ACTIONS	AGENCIES	TARGET OUTCOME	Baseline	FY2023 Outcome
Obesity	Lose 1 Million Pounds by 2030	Increase registered users actively logging pounds in the community weight tracker	Improve media promotion of campaign, implement participation incentives, share best practices among partners	Meritus, HWC	≥ 95% user activity	92.3% FY 2021	
		Community documents total pounds lost	Implement program for participation incentives	Meritus, HWC	> 100,000 pounds lost	11,200 FY 2021	
Disease Management	Prevent and improve management of diabetes and hypertension	Improve management of hbA1c in patients with diabetes	Provider education, care coordination standards, referrals to evidence-based self management	Meritus	≥ 90% of patients hbA1c value ≤ 9	78.3% CY 2019	
		Provide Diabetes Prevention Program (DPP)	Expand DPP sites, virtual, add DPP trainers, increase provider referrals	Meritus, COA, WCHD	1,909 patients referred 191 enrolled	New	
		Provide Diabetes Self-Management Program (DSMT)	Expand DSMT services, add virtual option, increase provider understanding and referrals	Meritus	1,413 patients referred 304 enrolled	New	

HEALTH NEED	OBJECTIVE	GOAL	ACTIONS	AGENCIES	TARGET OUTCOME	Baseline	FY2023 Outcome
Health Equity	Attain the highest level of health for all people	Increase racial/ethnic diversity in the workforce that looks like the community	Adopted use of the Rooney Rule for all Leadership hire process. Expand to 3 other organizations with more than 150 employees.	Meritus, HWC	24% Minority leadership	New	
		Increase access to health care and healthy food	Establish downtown health hub with access to primary care, screening, food prep	Meritus, Goodwill	10% reduction in ED visits for Black and Hispanic residents 21740	New	

Meritus Community Health Improvement Plan FINAL
FY2022 - 2025
Strategic Plan Goal: Improve Health

HEALTH NEED	OBJECTIVE	GOAL	ACTIONS	AGENCIES	TARGET OUTCOME	Baseline	FY2023 Outcome
Access to Behavioral Health	Improve access to timely behavioral health treatment and recovery	Establish regional crisis center services	Plan, fund, renovate, recruit	Meritus	Provide walk-in crisis center service 24/7 by June 30, 2023	New	
		Decrease number of overdose fatalities in Washington County	Decrease opioid prescriptions, implement buprenorphine in ED, expand MAT services, sustain Peer Support	Meritus, WCHD	Decrease annual overdose fatalities by 25%	100 CY2020	
		Reduce suicide rate	Increase timely access and crisis intervention	HWC	Decrease suicide rate by 25% (goal 10.8 per 100k)	14.4 FY2019	
Wellness &	Engage and empower people to	Increase health screening	Mobile Health, Residency, MMG practices; linkage of positive screens, earlier intervention, prevention of chronic illness	Meritus	Complete ≥ 1,095 preventative health screens	New	

X

Prevention	choose healthy behaviors and make changes to reduce risks	Reduce loneliness	Add community partners, dedicated staff, individual contacts, implement home visits	Meritus	Reduce report of loneliness by 50%	1578 FY21	

FY2022 - 2025

Healthy Washington County Dashboard FY23

Health Priority	Metric	Calculation / Measure	FY 2022 Results	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	FY 23 YTD		*FY 2023 Target*
Obesity	Lose 1 million pounds	# registered users	4000	4069	4201	4330	4491	4577	4719	5000	5071	5286	5447	5741	5949	🔴	5949	8000
	Lose 1 million pounds	# community lbs lost	42,580	44,059	46,381	49,423	53,442	59,786	62,460	68,453	73,738	82,641	88,267	88,550	89,000	🟢	89,000	80,000
Behavioral Health	Est. Crisis Center	Provide 24/7 walk-in crisis by 6/30/23	NEW	Expression of Interest	3 crisis beds	x	x	Plans approved	Relocate existing services			Construction				🟡	Open 9/13/23	Open by 6/30/23
	Reduce Suicide Rate	Provide Mental Health First Aide	8	1	1	1	0	1	0	0	0	0	1	0	1	🟡	6	12
Diabetes HTN	Diabetes Action Plan	# DPP Referrals	369	52	43	39	43	23	114	35	14	108	198	299	162	🟢	1130	500
	Early Detection	# Risk Screenings (DPP, BP etc)	873	93	175	317	380	324	42	52	192	339	197	287	216	🟢	2939	1500
Health Equity	Increase Minority Leadership	Three employers +150 staff adopt the Rooney Rule	1	1	0	0	0	0	0	0	0	0	0	0	0	🔴	1	3
	Increase Access to Care	# Mobile Health primary care	NEW	1093	888	256	298	129	113	77	45	12	49	31	50	🟢	3041	2850
Wellness	Increase Health Accountability	Community Health Events	NEW	2	6	2	3	7	3	7	10	12	17	37	42	🟢	148	14
	Increase Access to Health & Healthy Food	Horizon Goodwill Store Encounters	NEW	44	56	90	90	42	33	36	48	18	71	85	177	🔴	773	2500

Meritus Health

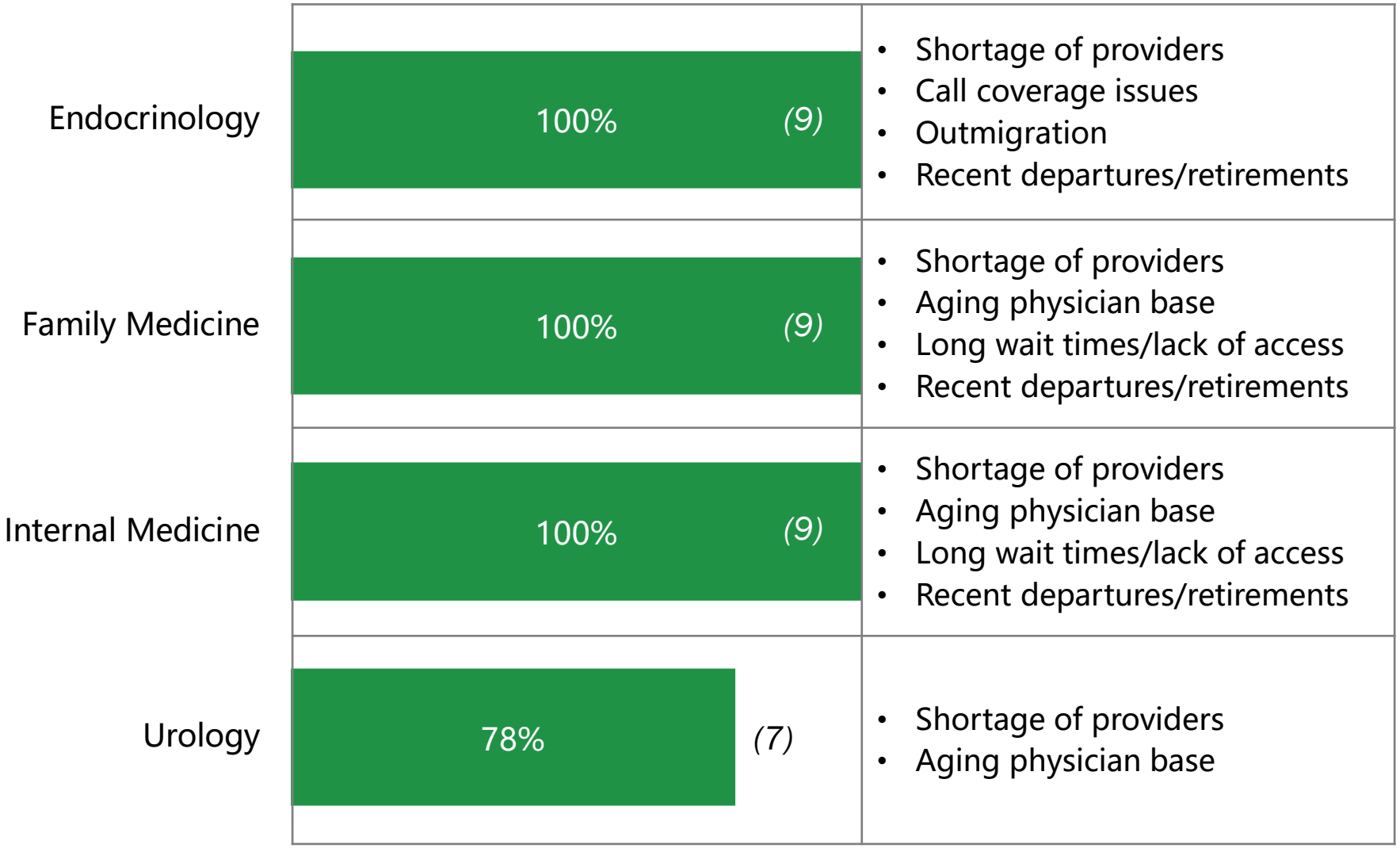
Provider Gap Analysis and Development Plan

July 1, 2019 – June 30, 2022

Local Market Reality Findings

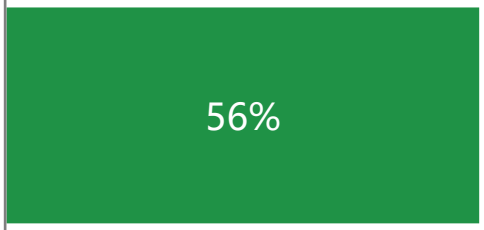
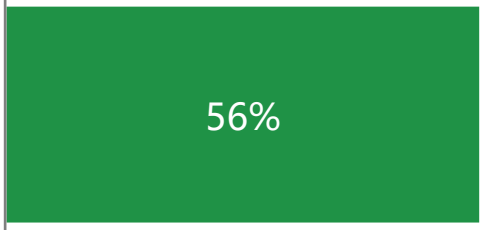
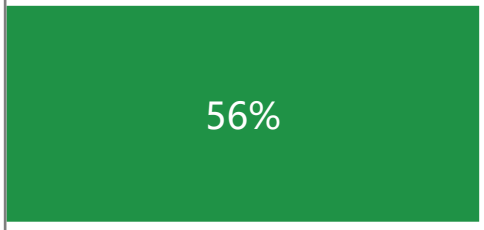
Leadership Interviews

Interviews: Top Areas of Identified Need



3d Health, Inc.

Interviews: Top Areas of Identified Need

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

Local Market Reality Findings

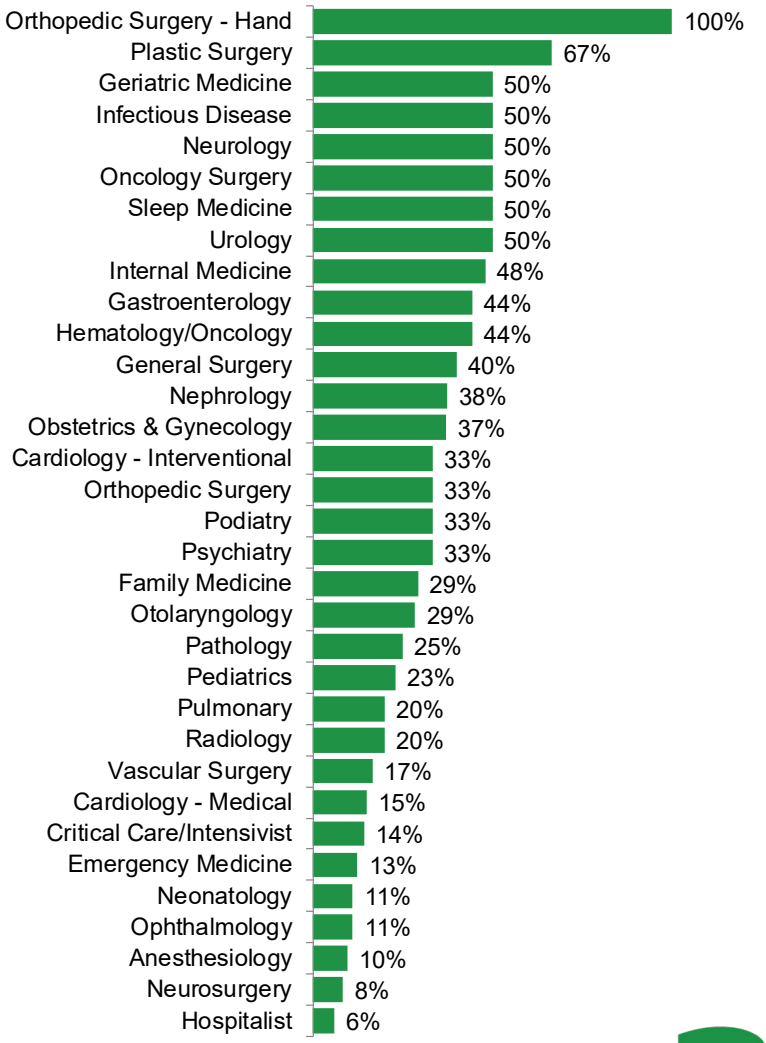
Physician Survey

123 Providers Responded to the Survey

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

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

Responses by Specialty

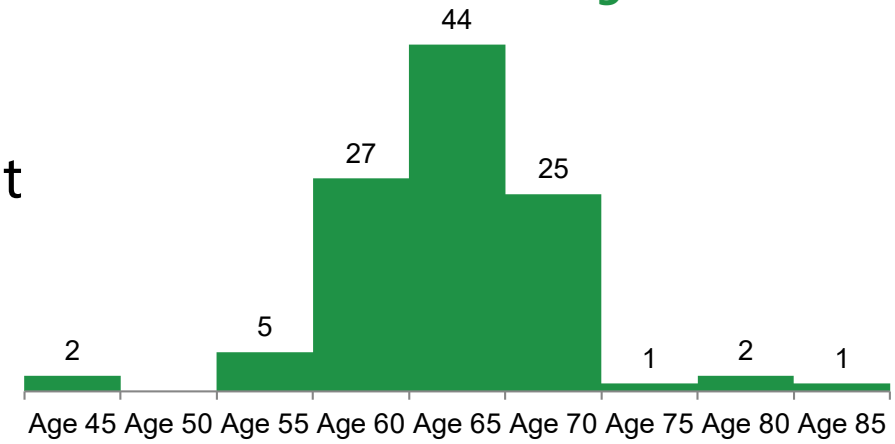


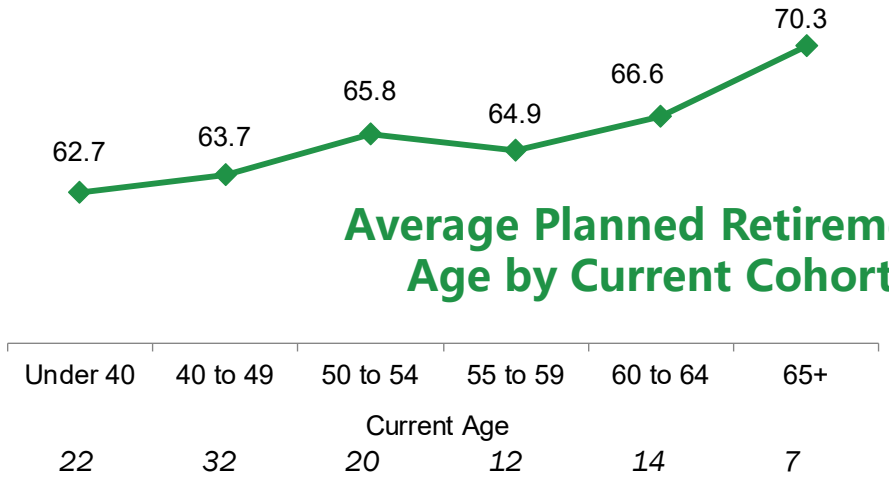
3d Health, Inc.

Average Planned Retirement Age is 64.8 Years Old

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

Frequency of Planned Retirement Age





Average Planned Retirement Age by Current Cohort

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

3d Health, Inc.

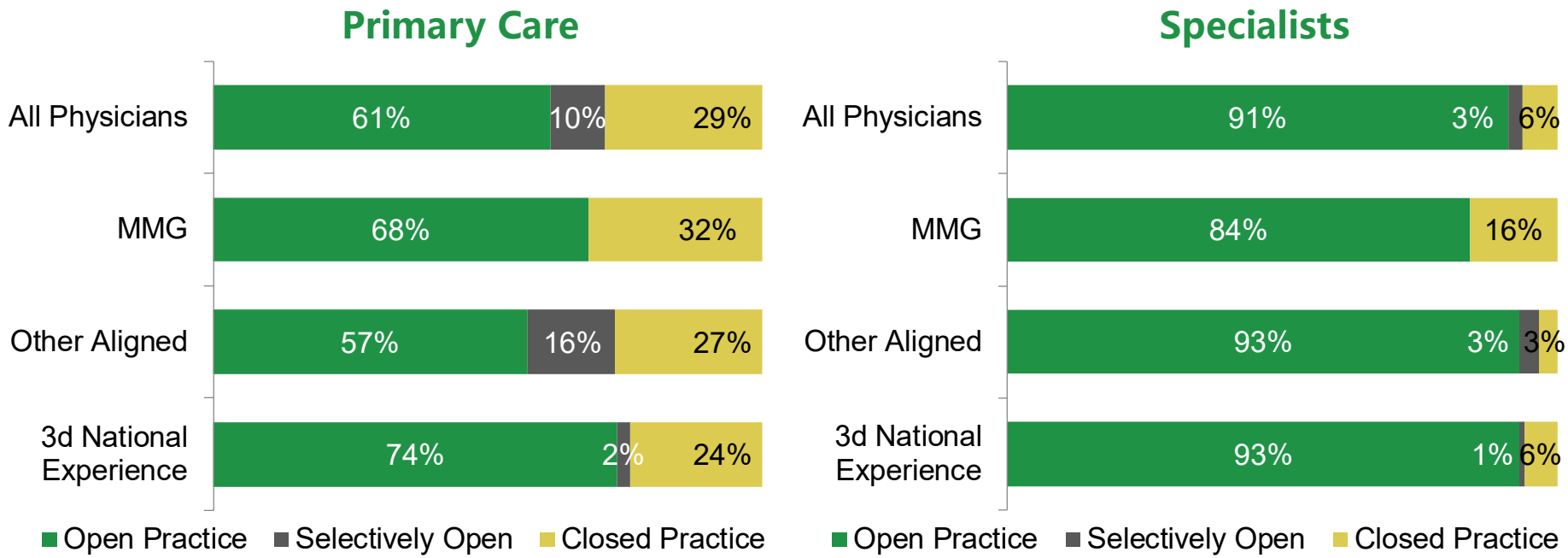
Local Market Reality Findings

Patient Access Study

Patient Access Study Methodology

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

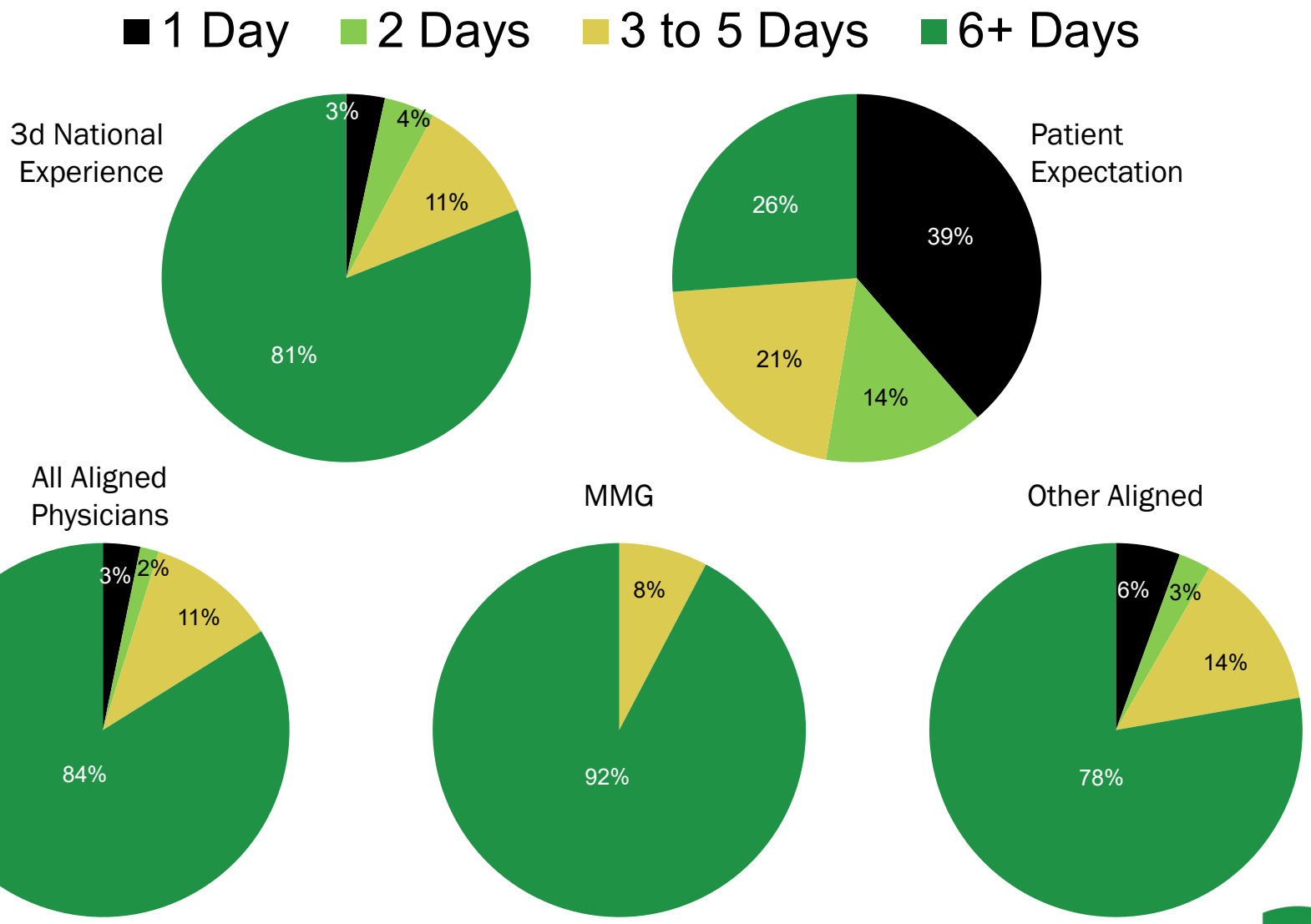
Open vs. Closed Physicians



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

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

New Patient Appointment Wait Times: Primary Care



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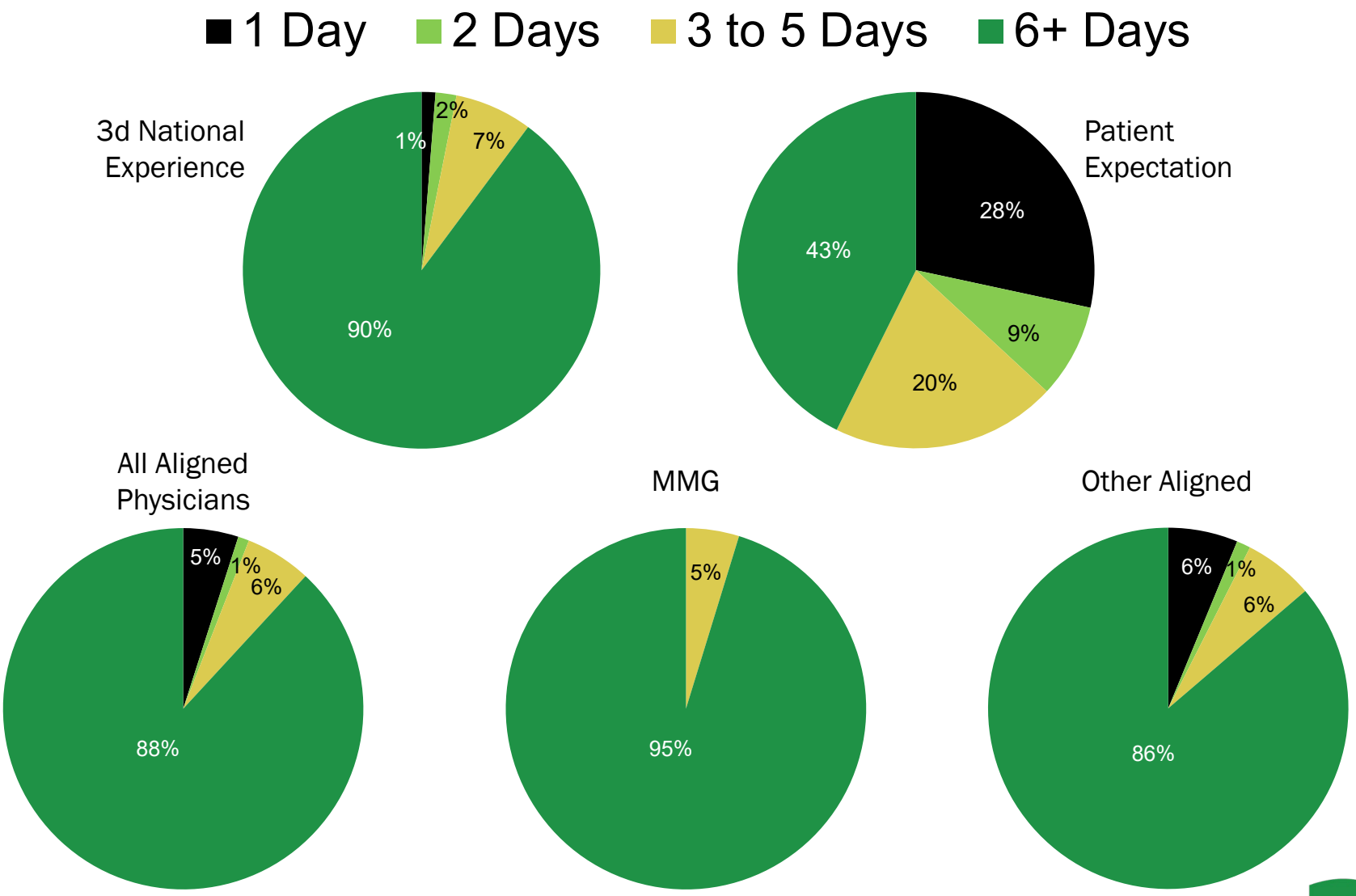
New Patient Appointment Wait Times: Specialist



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New Patient Appointment Access by Specialty

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

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

> *National Average*

Local Market Reality Summary

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

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

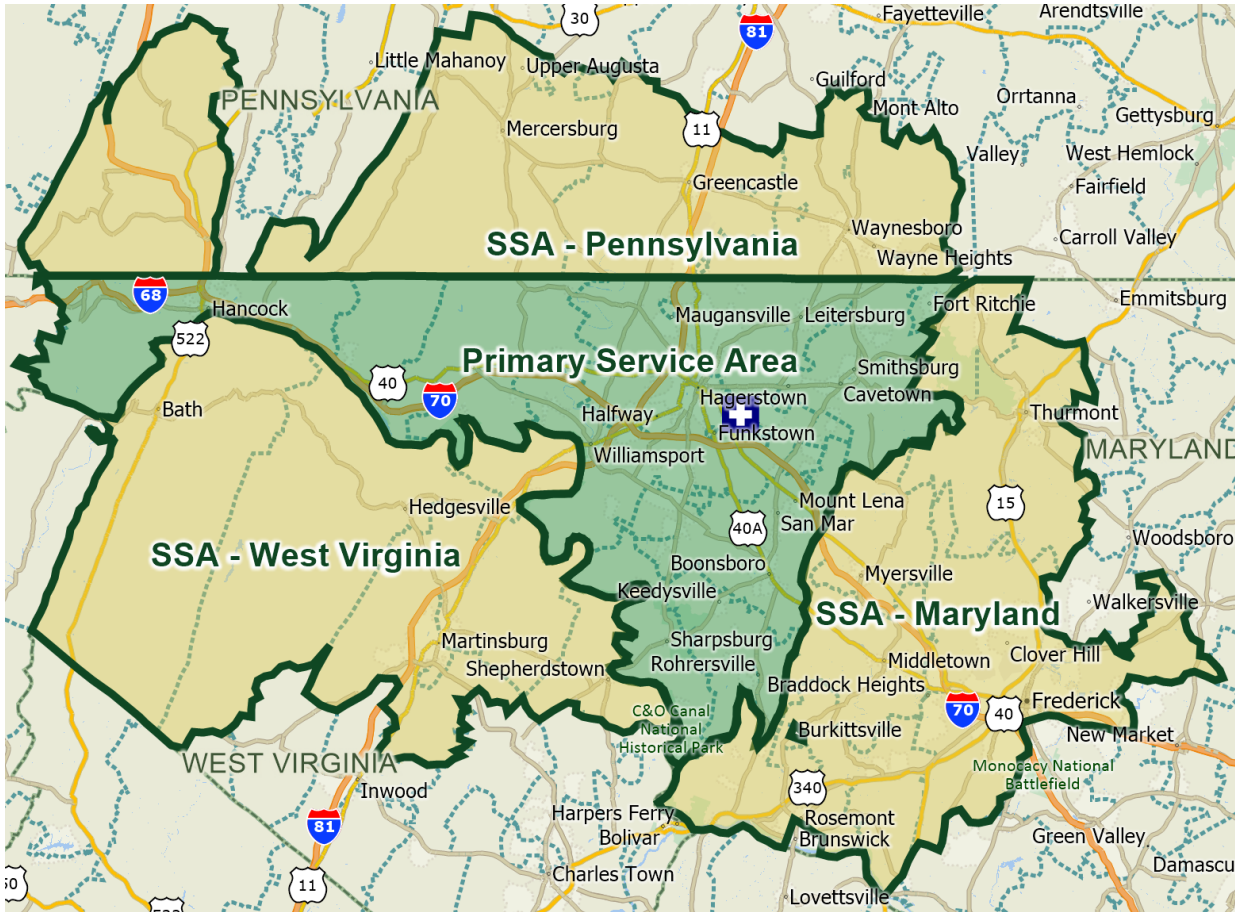
Identified as a need by 50% or more of the respondents; average wait time greater than the 3d National Experience

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

Market Definition

Meritus Health Planning Service Area

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



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

Primary Care Analysis

Current & Projected Market Need

Primary Care Market Surplus/(Deficit)

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

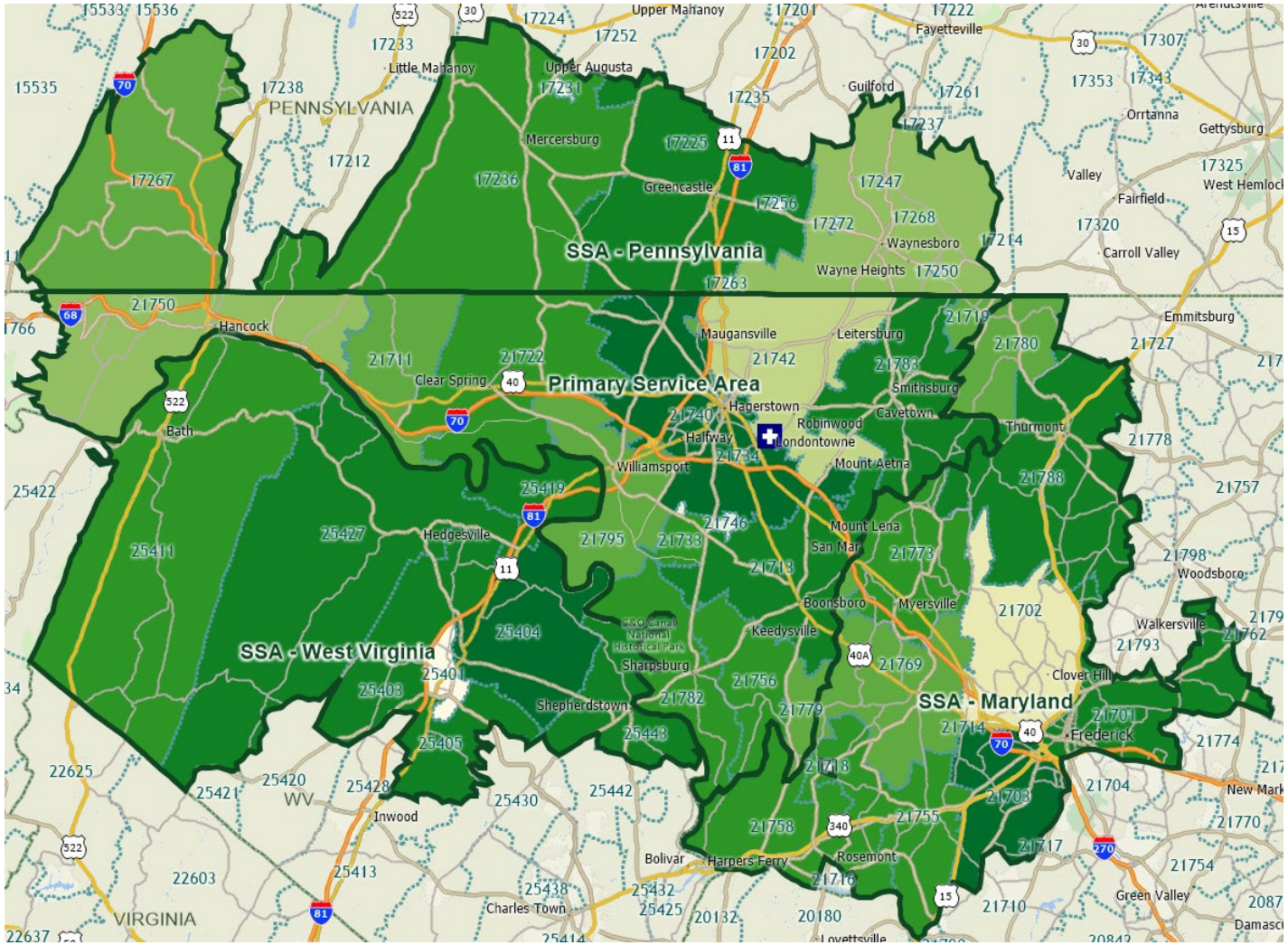
Specialty	Current Market FTEs			PSA	SSA - MD	SSA - PA	SSA - WV
	Supply	Demand	Surplus / (Deficit)				
Primary Care							
Family Medicine	*128.7*	*161.5*	*(32.8)*	*(15.1)*	*(4.5)*	*1.0*	*(14.4)*
Internal Medicine	*74.3*	*98.8*	*(24.5)*	*(10.4)*	*(8.1)*	*(6.3)*	*0.3*
Advanced Care Provider	*49.7*	*66.0*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

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

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

Primary Care Market Need by ZIP Code

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



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Primary Care Analysis

Meritus Health Primary Care Served Lives

Meritus Health Primary Care Served Lives Today

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

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

Projected (FY 2022) Meritus Served Lives

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

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

Projected Meritus Primary Care Need

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

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

Specialist Analysis

Market Need

Medical Specialist Market Surplus/(Deficit)

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

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

Surgical Specialist Market Surplus/(Deficit)

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

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

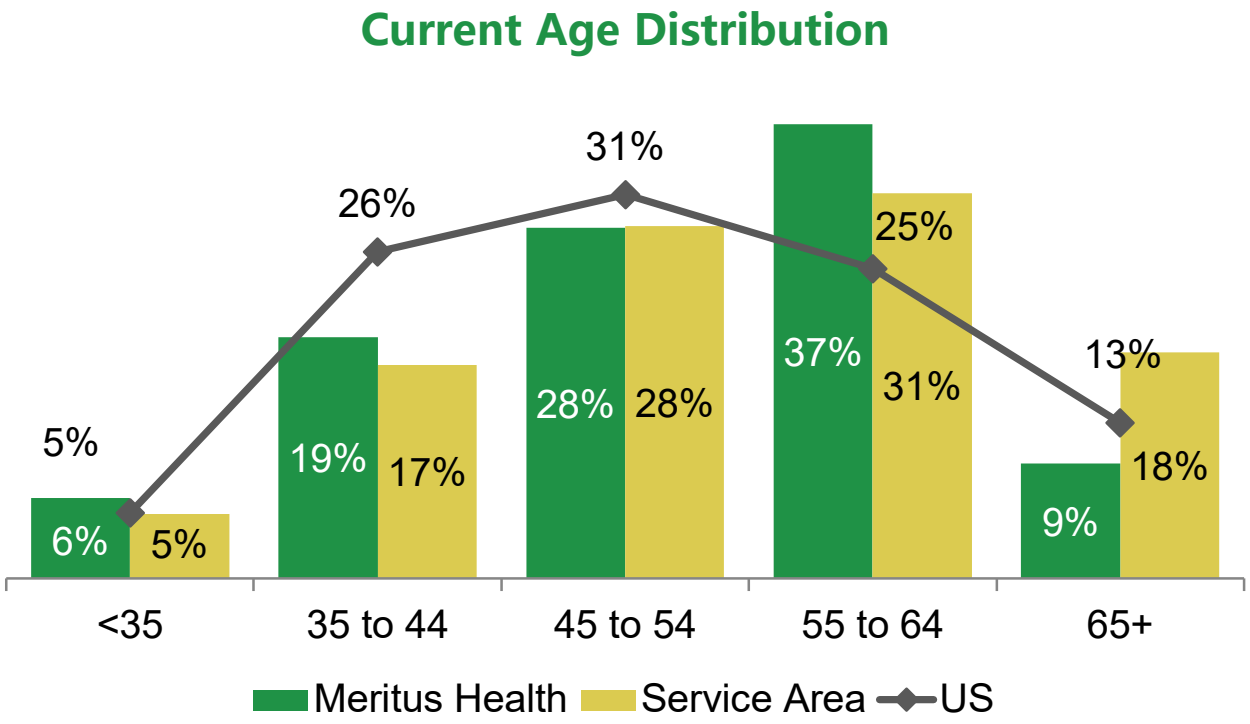
Projected Surgical Specialists in the Market

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

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

Succession Planning

Service Area Physician Age Distribution



Average Physician Age	
Meritus Health	52.2
Service Area	56.1
US	51.1

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

3d Health, Inc.

Projected Meritus Health Physician Supply

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

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

Market Demand Calculation

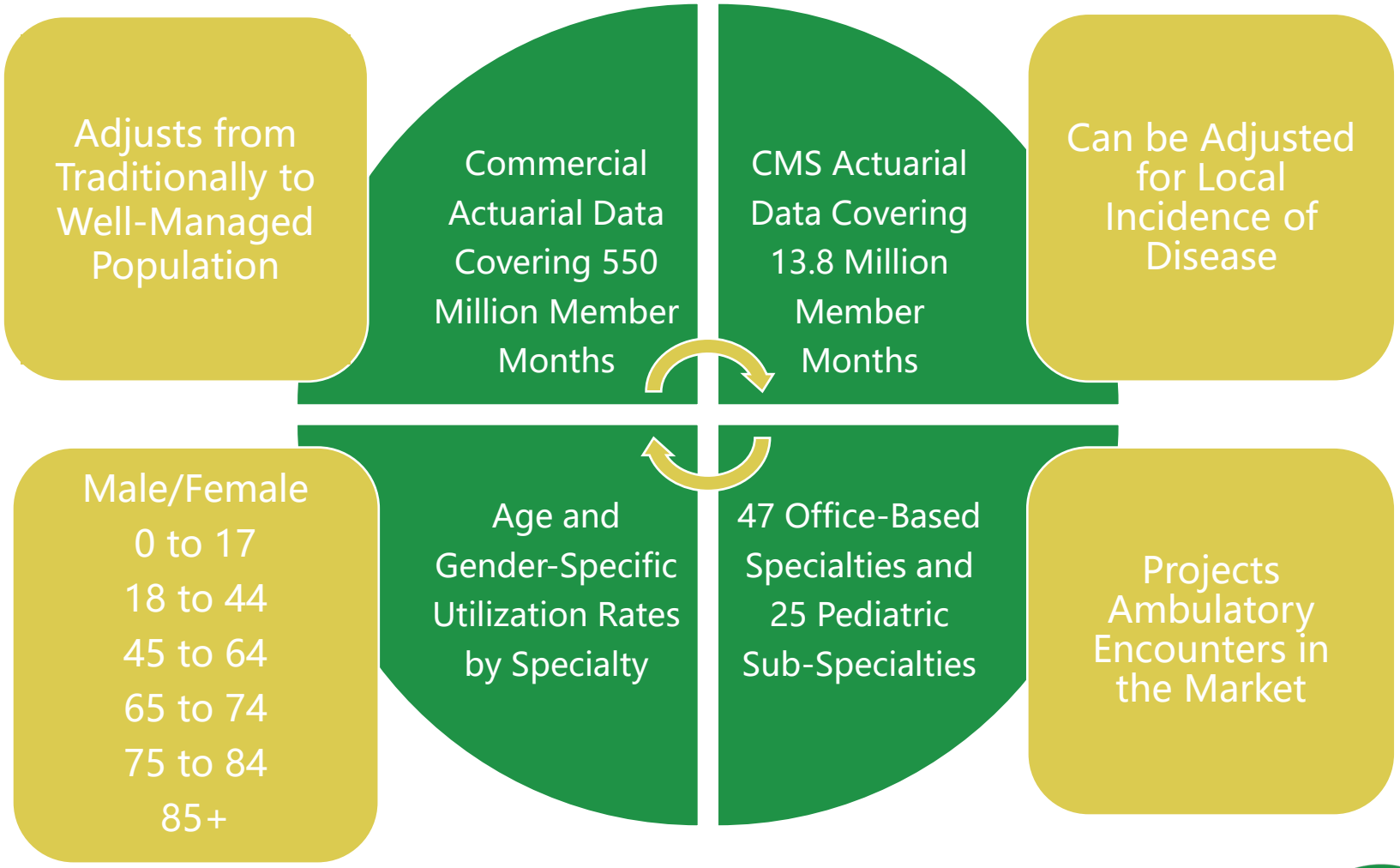
Specialty	Gender	Age Cohort	Population		Use Rate		Encounters		AMGA Median Office Encounters		FTE Demand
Family Medicine	Female	Under 18	52,546	X	0.7334	=	38,539	/	3,652	=	10.55
		18 - 44	80,074		1.3211		105,784				28.97
		45 - 64	67,212		1.6954		113,952				31.20
		65 - 74	25,710		1.5050		38,693				10.60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

Total ***487,080***

Total Family Medicine FTE Demand **161.49**

Physician Demand Methodology

3d Health's Actuarial Demand Model:



DEPARTMENT:	Patient Financial Services
POLICY NAME:	Financial Assistance
POLICY NUMBER:	0436
OWNER:	Patient Financial Services
EFFECTIVE DATE:	02/23, 09/23

SCOPE

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

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

PURPOSE

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

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

POLICY

A. OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within thirty (30) days.
    a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a discount to qualifying patients.
    b. Only providers employed by Meritus are covered under this policy and are indicated on the provider list. However, patients approved for financial assistance and having treatment by a Meritus employed provider outside of Meritus, where a non-Meritus facility fee is incurred, may have their financial assistance extended by Meritus to cover the facility fees associated with that procedure or treatment.

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

2. Notice of the Availability of Financial Assistance:

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

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

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

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

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

f. Meritus' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish. On an annual basis, Meritus shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

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

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

b. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

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

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

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

B. PROGRAM ELIGIBILITY

1. Meritus strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Meritus reserves the right to grant financial assistance without formal application being made by patients. These patients may include the homeless or individuals with returned mailed and no forwarding address.
2. Patients who are uninsured, underinsured, ineligible for a government programs, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for Meritus' Financial Assistance Program.
3. All residents of Meritus' service area, and all Maryland residents, will be considered for financial assistance regardless of United States immigration status. Financial assistance consideration is available to non-service area residents requiring medically necessary care at Meritus.
4. For medically necessary care for patients residing outside of Meritus' service area, including patients traveling to the United States to obtain health care services, Meritus reserves the right to screen patients for insurance coverage and ability to pay. Meritus may only offer financial assistance to non-service area residents for medically necessary services on a case-by-case basis.
5. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:
   a. Emergency medical services provided in an emergency room setting;
   b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual;
   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

   d. Medically necessary services, including elective procedures that are medically necessary.
      1) Medically Necessary Care- means that the service or benefit is: (a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition; (b) Consistent with current accepted standards of good medical practice; and (c) Not primarily for the convenience of the consumer, family or the provider.
      2) A service or item is not medically necessary if there is another service or item that is equally safe and effective and substantially less costly, including, when appropriate, no treatment at all.
      3) Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary.

6. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance Program include the following:
    a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);

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

C. PRESUMPTIVE ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance Application and/or supporting documentation on file. Often there is adequate information, provided by the patient or other sources, that is sufficient for determining financial assistance eligibility.
    a. In the event there is no evidence to support a patient's eligibility for financial assistance, Meritus reserves the right to use outside agencies or propensity to pay modeling in determining financial assistance eligibility.
    b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service.
2. Presumptive eligibility will be determined on the basis of individual life circumstances that may include:
    ~~a.~~ Households with children in the free or reduced lunch program;
    ~~b.~~ Low-income-household energy assistance program;
    c. Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
    d. Homelessness;
    e. Maryland Public Health System Emergency Petition patients;
    f. Participation in Women, Infants and Children Programs ("WIC");
    g. Supplemental Nutritional Assistance Program (SNAP)~~;~~
    ~~h.~~ Other means-tested social services programs deemed eligible for hospital free medically necessary care policies by the Maryland Department of Health and the HSCRC, consistent with [HSCRC regulation COMAR 10.37.10.26]
    i. Deceased patient with no known estate.
3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
4. Exclusions from consideration for presumptive eligibility include:
    a. Purely elective procedures (e.g., cosmetic procedures).
    b. Uninsured patients seen in the Emergency Department under Emergency Petition unless and until the Maryland Behavioral Health Administration (BHA) has been billed.
5. All Amish and Mennonite patients will be extended a 25% reduction to charges. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health coverage.

D. FINANCIAL MEDICAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Medical Hardship Program.
    1) Patients may qualify under the following circumstances:
        (a) Combined household income less than 500% of the current federal poverty level; or
        (b) Having incurred collective family hospital medical debt at Meritus exceeding 25% of the combined household income during a 12-month period.

    Exception - Medical debt excludes co-payments, co-insurance, and deductibles.
2. Meritus applies the criteria above to a patient's balance after any insurance payments have been received.
3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines.
4. If determined eligible, patients and their immediate family qualify for reduced-cost, medically necessary care for a 12-month period effective on the date the medically necessary care was initially received.
5. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Program, Meritus is to apply the greater of the two discounts.
6. The patient is required to notify Meritus of their potential eligibility for reduced cost-care due to financial medical hardship.

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

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

F. ASSET CONSIDERATION

1. Assets are generally not considered part of the financial assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. The following assets are excluded from consideration:
    a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families;
    b. Up to $150,000 in primary residence equity;

c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal;

d. One motor vehicle used for the transportation needs of the patient or any family member of the patient;

e. Any resources excluded in determining financial eligibility under Maryland Medicaid; and

f. Prepaid higher education funds in a Maryland 529 Program account

3. Monetary assets excluded from the determination of eligibility shall be adjusted annually for inflation in accordance with the Consumer Price Index.

G. APPEALS

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

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

   https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx
3. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
4. Appeals are documented and reviewed by the next level of management above the representative who denied the original application.
5. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
6. Appeals can be escalated up to the Chief Financial Officer, who will render the final decision.
7. Patients who have formally submitted an appeal will receive a letter of the final determination.
8. If a patient, or a patient's representative, feels Meritus is in violation of the financial assistance requirements as detailed in Maryland Code, Health-General §19-214.1 and §19-214.3, they may file a complaint with the Health Services Cost Review Commission (HSCRC) by emailing hscrc.patient-complaints@maryland.gov.

H. PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under Meritus' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $25.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where Meritus' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for financial assistance after Meritus has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, Meritus will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

I. OPERATIONS

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

(f) Reasonable proof of other declared expenses; and

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

3. If a patient has not submitted a completed Financial Assistance Application or any required supporting documentation within 30 days after a formal application request, a letter will be sent reminding the patient that financial assistance is available and informing the patient of the collection actions that may be taken if no documentation is received.
   a. A deadline for submission, prior to initiation of extraordinary collection actions, will be included in the letter. Such deadline may not be earlier than 30 days after the date on which the reminder letter is sent.
   b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 180 days after the first post-discharge billing statement (approximately 6 months).
   c. If documentation is received after collection actions have been initiated, but within 240 days after patient receipt of the first post discharge billing statement, Meritus shall cease all collection actions and determine whether the patient is eligible for financial assistance.
4. A Plain Language Summary of this policy shall be included with the letter and Meritus staff shall make a reasonable effort to orally notify the individual of Meritus' Financial Assistance Program.
5. Once a patient has submitted all the required information, appropriate personnel will review the application and forward it to the Patient Financial Services Department for final determination of eligibility based on Meritus guidelines.
   a. For complete applications, the patient will receive a letter notifying them of approval/denial within 14 days of submitting the completed applications.
   b. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information.
   c. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
   d. If a patient is determined to be ineligible after receiving services, a payment arrangement may be obtained, subject to Meritus approval, on any balance due by the patient.
6. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective as of the date treatment is received and the following twelve (12) calendar months.
   a. For those who qualify for reduced-cost care due to medical hardship, such qualification will apply for a twelve (12) month period.
   b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

7. The following may result in the reconsideration of financial assistance approval:
   a. Post approval discovery of an ability to pay; and
   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to Meritus.
8. Meritus will track patient qualification for financial assistance or medical hardship. However, it is ultimately the responsibility of the patient to inform Meritus of their eligibility status at the time of registration or upon receiving a statement.

J. CREDIT & COLLECTIONS POLICY

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

K. PROVIDER LIST

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

RESPONSIBILITY

Vice President, Revenue Cycle and Clinical Support Services

REFERENCES

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

RELATED POLICIES

0444, Credit & Collections