Western Maryland Regional Medical Center

(210027)

FY16

Community Benefit Report - Narrative

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

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

Table I

Bed Designation	Inpatient Admissions	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients	Percentage of the Hospital's Patients who are Medicaid Recipients	Percentage of the Hospital's Patients who are Medicare beneficiaries
Beds- 208 Bassinets- 20	Adults: 11,955 Nursery: 944 Total: 12,899	21502 21532 21562 21539 21536	Garrett County Memorial Hospital (Garrett Regional Medical Center)	13.75% of patients discharged from WMRMC are self-pay (ProDiver FY16) Allegany County: 8.2% uninsured (American Community Survey 2010-2014 5 yr. est.)	19.65% of WMRMC patients are Medicaid recipients (ProDiver FY16)	53.86% of WMRMC patients are Medicare beneficiaries (ProDiver FY16)

2. *For purposes of reporting on your community benefit activities, please use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves*.

Community Benefit Service Area (CBSA)

The Western Maryland Regional Medical Center defines its community benefit service area as Allegany County, MD. As the sole community hospital with over 70% of patients residing in Allegany County, WMRMC is accessible to all and the county population is the CBSA.

As part of the Community Health Needs Assessment, the Community Needs Index (Truven) was used to identify the areas of highest need. At the time of the assessment, 21532 (Frostburg), 21502 (Cumberland), 21562 (Westernport) and 21521 (Barton) were the hot spots. In FY16 as efforts to address population health increased, high utilizers and medical assistance recipients were analyzed more closely. Many of the same zip codes remain target areas and additional data analysis is under way.

Table II provides demographic characteristics and social determinant data. Changes in the data since the initial community health needs assessment in 2011 and this FY are included.

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside	21501, 21502, 21503, 21504, 21505, 21521, 21524, 21528, 21529, 21530, 21532, 21539, 21540, 21542, 21543, 21545, 21555, 21556, 21557, 21560, 21562, 21766 *Most vulnerable are underlined above.	Regional Planning Grant Community Needs Index
Median Household Income within the CBSA	Allegany County: $37,952 (2010) Allegany County: $39,293 (2009-2013 5-Year) Allegany County: $39,794 (2010-2014 5-Year)	US Census Bureau, American Community Survey (ACS)
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Allegany County: 15.2% (2008-2010) Allegany County: 17.4% (2009-2013 5-Year) Allegany County: 18.5% (2010-2015 5 Year)	US Census Bureau, American Community Survey
For the counties within the CBSA, what is the percentage of uninsured for each county?	Allegany County: 13% (2013 Report) Allegany County: 11% (2015 & 2016 Report) Allegany County: 8.2% (2010-14 - 5 yr. est.)	County Health Rankings/Univ. of Wisc. US Census Bureau, ACS
Percentage of Medicaid recipients by County within the CBSA.	Allegany County: 21.9% (2012) Allegany County: 27% (2016)	HRSA Area Resource File 2012 Maryland Medicaid eHealth Statistics (MMIS)
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	Allegany County: (2010-2012) 77.2 White 80.0 Black Allegany County: (2011-2013) 77.6 White 76.8 Black Allegany County: (2012-2014) 77.3 White 76.7 Black	SHIP County Profile (DHMH Vital Statistics

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Allegany County: 2013 7,375 per 100,000 age adjusted Allegany County: 2015 6973per 100,000 age adjusted Allegany County: 2016 7200 per 100,00 age adjusted	County Health Rankings –Univ. of Wisconsin
Limited Access to healthy food.	Allegany County: 17% (2012 Report) Allegany County: 16% (2015 & 2016 Reports)	County Health Rankings –Univ. of Wisconsin
Transportation-Percentage of households without access to vehicles	Allegany County: 11% (2005-2009 5 yr. est.) Allegany County: 10.2% (2009-2013) Allegany County: 10.1% (2010-2014)	U.S. Census Bureau, American Community Survey
Illiteracy	Allegany County: 11.3% (2012 Report)	County Health Rankings/U of Wisc.
Population By Gender, Age, Race & Ethnicity	Population-72,528 • 52% Male 48% Female • Average age 41.5 years • 4.7% under age 5 • 19.4% 65 yrs. and over • 88.7% White • 8.2% Black/African Am • 0.2% Native American • 1% Asian • 1.7% Hispanic or Latino	US Census Bureau, 2015 Estimates
Pop. 25+ With Bachelor's Degree or Above %	Allegany County: 15.9% (2008-2010) Allegany County: 16.8%(2009-2013) Allegany County: 17% (2010-2014)	U.S. Census Bureau, American Community Survey
Children living in Single Parent Households %	Allegany County: 35% (2013 &2015) Report Allegany County: 35% (2016 Report)	County Health Rankings –U of Wisc.
Language Other Than English spoken at home %	Allegany County: 3.8% (2010) Allegany County: 4.7% (2009-2013 and 2010-2014)	U.S. Census Bureau, ACS
Population to Primary Care Provider Ratio	Allegany County: 1746:1 (2013 Report) Allegany County: 1575:1 (2015 Report) Allegany County: 1600:1 (2016 Report)	County Health Rankings –Univ. of Wisconsin
Adults who currently smoke %	Allegany County: 24% Allegany County: 23% (2014 & 2015 Report) Allegany County: 17% (2016 Report)	BRFSS 2008-2010 County Health Rankings –U of Wisc.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

a. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

__x__Yes
____No
Provide date here. 12/31/13 (mm/dd/yy) Please note that this is the date by which the required components of the CHNA were made publically available via the link below.

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

http://www.alleganyhealthplanningcoalition.com/pdf/Community%20Health%20Needs%20Assessment%20FY14%20(final).pdf

b. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

__x_Yes ___No

Enter date approved by governing body here: 05/22/14 (mm/dd/yy) The CHNA and approval of the implementation strategy occurred in FY14.

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

http://www.alleganyhealthplanningcoalition.com/pdf/A.%20LHAP.pdf

In FY16, the format of the implementation strategy was enhanced and can be found at this link.

http://www.alleganyhealthplanningcoalition.com/pdf/Proposed%20New%20Format%20LHAP%20fy15-17.pdf

Based on the results of a community health needs assessment, the Allegany County Health Planning Coalition (Coalition) created the Local Health Action Plan (LHAP) to improve health and wellbeing in Allegany County. The Coalition is charged with implementing the LHAP, measuring progress, and building on best practices already in use in the community. The LHAP addresses all the priority areas under three foci:

1. Access and Socio-economics (children in poverty, primary care access, adult dental access,
   health literacy, homelessness)
2. Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related
   injury and death, healthy weight)
3. Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)

It was agreed that this framework would allow for consideration of both outcomes and root causes. By using overarching themes it is expected that there will be more collaboration across the continuum, less program specific focus, more consistent education, and increased community wide engagement.

Each priority area includes goals, link to the State Health Improvement Process (SHIP), strategies, SMART objectives, responsible parties, timelines, current progress toward the SMART objective, and outcomes including baseline, target, and current status. The LHAP also includes supporting strategies which are underway in the community and may contribute to the achievement of LHAP goals and outcomes, but are not overseen by the Coalition. The LHAP works to build upon, and not duplicate, existing community health improvement efforts.

All the needs identified as a priority are being addressed, though as this document states some are being addressed by a community partner. Health needs that were not prioritized and included in the action plan are described in the CHNA report, including child maltreatment and suicide. Though not specifically addressing maltreatment, the Coalition felt that existing needs will be covered as part of the domestic violence issue and ongoing programs at WMRMC. For suicide there is a standard protocol and community partners agreed that it would be best to focus on the root cause- behavioral health.

III. COMMUNITY BENEFIT ADMINISTRATION

I. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? (Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b)

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

_x__Yes
___No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

The data collected as part of the Community Health Needs Assessment is shared with the WMHS Administrative Team and Board of Directors. This information along with other hospital data and information was utilized to create the hospital's strategic plan. The following are sections of the strategic plan that apply to community benefits.

Strategic Plan FY 2015-2017

Goal 2. Expand patient centered care delivery model

Objective 2.1. Further develop and strengthen strategic relationships with community partners

Strategy2.1.1. Further develop medical and public health integration

Strategy 2.1.2. Develop the network with community agencies to address social determinants and transitions of care

Goal 3. Engage patients and families to improve personal health status

Objective 3.2 Enhance patient and family participation in care

Strategy 3.2.1. Develop and implement consumer driven health initiatives to enhance patient and family engagement

Strategy 3.2.2. Revitalize an external patient transportation program for WMHS

Goal 4. Coordinate care to provide comprehensive population health management

Objective 4.1. Expand pre and post-acute services to reduce utilization of care

Strategy 4.1.3. Further expand the service offerings at the Center for Clinical Resources to include services for hypertension, chronic kidney disease, et al

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

i. Senior Leadership

1. __x_CEO
2. __x_CFO
3. _x__Other (please specify) –System Management Team

Describe the role of Senior Leadership.
The CEO, CFO, and System Management Team oversee compliance with the IRS and HSCRC regulations related to community benefits. They review the CHNA and implementation strategy with Board of Directors, and incorporate community benefits into the WMHS strategic plan and strategic transformation plan. The CFO reviews the annual community benefits spreadsheet and narrative prior to submission. The CEO provides updates to the Board of Directors, and with their approval allocates funding to support the areas of need. Senior Leadership is also directly engaged in various board and community activities.

ii. Clinical Leadership

1. _x__Physician
2. _x__Nurse
3. _x__Social Worker
4. __x_Other (please specify)Allied Health

Describe the role of Clinical Leadership
Some of the Clinical Leaders are involved with committees that review the community needs and develop implementation strategies. Others are more involved with oversight and direct implementation of community benefit activities, such as support groups, disease management, motivational interviewing, and addressing social determinants. The mission driven services and some of the healthcare support services are completely managed by the Clinical Leadership.

ii. Population Health Leadership and Staff

1. ___x_ Population health VP or equivalent (please list)
   Vice Presidents- Michele Martz and Jo Wilson
2. __x__ Other population health staff (please list staff)
   Karen Howsare, Director of Care Coordination
   Jeff O'Neal, Executive Director of Clinical Practices and Behavioral Health
   Nancy Forlifer, Director of Community Health & Wellness

Describe the role of population health leaders and staff in the community benefit process.
In FY16, the focus on population health increased significantly at WMHS. Through the regional transformation planning process and creation of a clinically integrated network, there was increased analysis of the care continuum and transition points. The Population Health leaders and staff listed above participated in numerous efforts to

further analyze the needs of specific populations and to learn about the resources available across the continuum. The information gained was used to guide some of the actions in the implementation strategy (such as depression screening) and will be considered in the next community health needs assessment. By having the population health staff more aware of both needs and resources across the continuum, they have and will continue to be more engaged in the implementation strategy going forward.

iv. Community Benefit Operations

1. _x__Individual (0.1 FTE) Seventeen individuals assisted with the tracking and documentation of community benefit activities included in the 206 hours.

2. _x__Committee (please list members) (Amber Ruble -Director of Finance, Nancy Forlifer- Director of Community Health & Wellness, Kathy Rogers- Director of Community Relations, and Kim Repac- CFO)

3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Members of the Community Benefit Committee collectively stay abreast of the regulations and reporting requirements related to community benefits. They are all engaged in collection of community benefit data or related expenses and participate in compilation of the annual spreadsheet and narrative. The Finance Director oversees the financial aspects of the community benefit report, and its connection to the 990 Schedule H. She compiles and calculates the expenses and revenue for numerous activities, including contributions from administration and mission driven services. The Community Health and Wellness Director is co-chair of the Local Health Improvement Coalition and facilitates the community health needs assessment and implementation strategy. She serves as a liaison between the hospital and many of the community partners to plan and track community benefit activities. Together with the Director of Community Relations, she compiles the narrative. The Community Relations Director assists with data compilation, distribution of information to the public, and tracking of financial contributions by WMHS for community benefit. The other individuals are focused on tracking and data entry of community benefit activities.

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

Spreadsheet	___x__yes	_____no
Narrative	___x__yes	_____no

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

The internal audit consists of a series of checks and balances. There are a collection of reporters that enter occurrences into CBISA, each of these entries is reviewed and imported by the System Administrator/Director of Community Health & Wellness. After each fiscal year closes, the Finance Director and System Administrator collaborate to obtain the missing data and the Finance Director compiles the expenses for numerous activities. This information is all entered into CBISA by the

System Administrator and then several reports are pulled for review by the System Administrator and Finance Director (including a 3 year comparison). All members of the Community Benefits Committee review the narrative to ensure its accuracy. The CFO has the final review and sign off before it is shared with the WMHS Board of Directors Finance Committee for review and action.

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

Spreadsheet ___x__yes _____no
Narrative __x___yes _____no

If no, please explain why.

IV.**COMMUNITY BENEFIT EXTERNAL COLLABORATION**

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

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

_____ Other hospital organizations
___x__ Local Health Department
___x__ Local health improvement coalitions (LHICs)
___x__ Schools
___x__ Behavioral health organizations
___x__ Faith based community organizations
__x___ Social service organizations

b. *Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)*

Organization	Name of Key Collaborator	Title	Collaboration Description
Founding Partners			
Allegany County Health Department	Jenelle Mayer Dr. Sue Raver	Director Community Health, Health Officer	Co-Chair of LHIC, Assist with CHNA & LHAP
Allegany Health Right	Sandi Rowland	Executive Director	Active review of data and selection of strategies
Tri-State Community Health Center	Susan Walter	CEO	Active review of data and selection of strategies
Western MD Area Health Education Center (now AHEC West)	Susan Stewart	Executive Director	Active review of data and selection of strategies
Allegany Human Resource Development Comm.	Courtney Thomas	Executive Director	Active review of data and selection of strategies

County United Way	Mary Beth Pirolozzi	Executive Director	Active review of data and selection of strategies
Allegany Board of Education	Kim Green	Chief Academic Officer	Active review of data and selection of strategies
Advisory Board			
Media-Allegany Radio	Joe Caporale	Sales Manager	Assist with monitoring and evaluating progress of implementation. Promote and distribute agreed upon education.
Housing	Steve Kesner	Executive Director	
Business/Economic Development-Chamber of Commerce	Stu Czapski	Executive Director	
Chapman & Assoc.	Cathy Chapman	CRNP-somatic provider	
Pressley Ridge -Provider (behavioral)	Mary Beth DeMartino	Executive Director	
Case Management	Casey Sinclair	Case Manager	
Law Enforcement	Steve Schellhaus	Officer	
Affiliates			
Office of Consumer Advocate	Yvonne Perret	Executive Director	Participate in the community health needs assessment process. Participate in the development & implementation of the LHAP. Assist in developing and promoting health solutions to identified health problems
Salvation Army	Jim Dillingham	Officer	
YMCA	Donald Enterline	Executive Director	
Western MD Food Bank	Diana Loar	Executive Director	
Local Management Board	Courtney Thomas	Chairperson	
Cumberland Ministerial Association	Rabbi Stephen Sniderman	Chairperson	
Parish Nursing Program	Joyce Hedrick	Coordinator	
Community Unity in Action	Virginia Jesse	Member	
Carver Community Center	Tawnia Austin	Chairperson	
NAACP	Ava Joubert	Board Member	
University of MD Extension	Kathy Kinsman	EFNEP Educator	
Maryland Physicians Care	Terry Hillegas	Marketing and Community Outreach Liaison	
Priority Partners	Lisa Moran	Community Health Advocate	
United Healthcare	Tracy Curry	Community Development Specialist	
Fort Recovery	Chip Bosley	Director	
Allegany College of Maryland	Kathy Condor	Coordinator	
Allegany Transit	Chris Howard	Director	
Express Medical Transporters of Baltimore	Abby Mensinger	Director	
Friends Aware	Rhonda Blubaugh	Human Resources	
Allegany County Dept. Social Services	Richard Paulman	Executive Director	
Associated Charities	Kristan Fazenbaker	Executive Director	
Pharmacies	Bill McKay	Pharmacist	
Drug Abuse Alcohol Council	Chris Delaney	Director	
Tobacco Free Coalition	Kathy Dudley	Coordinator	

Family Junction	Melanie McDonald	Executive Director
Frostburg State University	Jesse Ketterman	
Sheriff's Office	Craig Robertson	Sheriff
Make Healthy Choices Easy	Jen Thomas	Health Educator
County Govt-Board of Health	Mike McKay	County Commissioner
Park & Recreation Department	Diane Johnson	Director
Mental Health Advisory Board	Lesa Diehl	Chairperson
Workgroup on Access to Care	Nancy Forlifer	Chairperson
Transportation Advisory Board	Ryan Davis	Member
Dental Society	Diane Romaine	Chairperson
Hyndman Health Center	Samantha Walls	Social Workdr
Community Wellness Coalition	Marion Leonard	Chairperson
Overdose Prevention Task Force	Becky Meyers	Director

The following list highlights the specific responsibilities of the parties in the Allegany County Health Planning Coalition, as written in the MOU. The Local Health Action Plan lists the partners associated with each of the actions.

A. The specific responsibilities of the Western Maryland Health System under this agreement are as follows:

- Co-Chair the Coalition which will guide Community Health Needs Assessment and Local Health Action Planning as required by the Health Services Cost Review Commission and IRS
- Jointly report with the Allegany County Health Department on the needs assessment, local health action plan, and Coalition activity
- Oversee with ACHD, the monitoring of progress on health status and implementation plan
- Coordinate the various departments of the health system that are involved in this project
- Link Coalition priorities with the WMHS Community Benefits and Strategic Planning
- Provide staff support for the needs assessment, action planning and implementation

B. The specific responsibilities of the Allegany County Health Department under this agreement are as follows:

- Co-Chair the Coalition which will guide Community Health Needs Assessment and Local Health Action Planning as required by Maryland Department of Health and Mental Hygiene
- Maintain and oversee the Coalition website
- Jointly report with the Western Maryland Health System on the needs assessment, local health action plan, and Coalition activity
- Oversee with WMHS, the monitoring of progress on health status and implementation plan
- Coordinate the various units of the health department that are involved in this project
- Facilitate linkages to the State Health Improvement Plan
- Provide staff support for the needs assessment, action planning and implementation

C. The specific responsibilities of the Advisory Board (including Founding Partners) under this agreement are as follows:

- Jointly agree on publicity regarding Allegany County Health Planning Coalition
- Actively participate in the Allegany County Health Planning Coalition by attending meetings and responding to requests
- Monitor and evaluate progress on health status and implementation plan
- Support data development and sharing of information to improve population health
- Engage in shared development and use of resources to improve care coordination across the continuum
- Assist in engaging support for and participation with the Coalition
- Identify a potential replacement to represent your sector or organization when withdrawing from the Coalition
- Leverage additional funds to support the vision and ensure sustainability of the Coalition's plans

D. The specific responsibilities of the Affiliates under this agreement are as follows:

- Participate in an identified component of the local health action plan
- Assist with tracking of progress and outcomes when requested
- Support dissemination of consistent resources to enhance care and health outcomes
- Serve as a conduit to the targeted populations in the community

E. All parties agree to:

- Participate in the community health needs assessment process
- Participate in the development & implementation of the LHAP
- Assist in developing and promoting health solutions to identified health problems thru:
    - Grants
    - Coordination with local community partners;
    - Provider and partner trainings

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

___x__yes _____no

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

__x___yes _____no

V.HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

a. *1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.*
   2. Please indicate whether the need was identified through the most recent CHNA process.
b. *Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)*
   (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)
c. *Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?*
d. *Total number of people reached by the initiative (how many people in the target population were served by the initiative)?*
e. *Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.*
f. *Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)*
g. *Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.*
h. *Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.*
   - *What were the measurable results of the initiative?*
   - *For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.*
i. *Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.*
j. *Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?*
k. *Expense:*
   A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
   B. of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

<table>
<tr>
<td>Table III
a.
1. Identified Need
2. Was this identified through the CHNA process?</td>
<td>Access to Care:
In Allegany County, access to care (primary, dental, and behavioral health) was identified as a priority need. Poverty, transportation and other social determinants were felt to be key contributing factors. WMHS partnered with numerous community organizations to assess and implement activities to improve access to care and address the contributing factors.
The table below includes a comparison of baseline to current data, and whether the change is positive ▲ or not ● .
<table>
<tr><th>Data</th><th>Baseline</th><th>Current Status</th><th>Source</th></tr>
<tr><td>FTE needs for PCPs</td><td>4.8</td><td>5.1 ●</td><td>WMHS Physician Needs Asmt. 2011, 2014</td></tr>
<tr><td>FTE needs for MH providers</td><td>3.8</td><td>4.2 ●</td><td>Same as above</td></tr>
<tr><td>Ratio of people per dentist</td><td>1766:1</td><td>1490:1 ▲</td><td>County Health Rankings 2011,2016</td></tr>
<tr><td>Number of level 1 and 2 visits to the ED</td><td>15,501</td><td>8291 ▲</td><td>WMHS Discharge data 2011, 2016</td></tr>
<tr><td>% children living in households below poverty</td><td>24%</td><td>23% ▲</td><td>County Health Rankings 2011,2016</td></tr>
<tr><td>%of adults who report missing appointments due to transportation</td><td>25%</td><td>16% ▲</td><td>Community Transportation Survey,2011, 2016</td></tr>
</table>
Yes this was identified through the CHNA process.</td>
</tr>
<tr><td>b. Hospital Initiative</td><td>Address contributing factors to improve access to appropriate care</td></tr>
<tr><td>c. Total Number of People Within the Target Population</td><td>Based on most recent 5 year estimate from the US Census Bureau, American Community Survey, of the 72,538 county population:

18.5% of the households are living in poverty=13,419 residents
8.2% are without health insurance= 5,951 residents
10.1% lack transportation=7,326 residents</td></tr>
<tr><td>d. Total Number of People Reached by the Initiative Within the Target Population</td><td>The number of people that were reached through access interventions in FY16, include:

1,751 new patients provided PCP home
561 unique people served by Community Health Workers
698 (455+ 243 new) individuals were provided rides to health care</td></tr>
<tr><td>e. Primary Objective of the Initiative</td><td>It is our goal to increase access to health care services by increasing provider availability and addressing social determinants.

Objective 1: Enhance Community Health Worker Program to increase linkages to needed community services

Objective 2: Reduce transportation barriers to accessing health and human services</td></tr>
<tr><td>f. Single or Multi-Year Initiative –Time Period</td><td>Multi Year
Provider recruitment and provision of services to address the needs of the underserved in ongoing. CHW started in Dec. 2013 and will be ongoing. Transportation efforts and MHFA began in 2012 and are anticipated to be ongoing.</td></tr>
</table>

g. Key Collaborators in Delivery of the Initiative	Western Maryland Health System (WMRMC) Allegany County Health Department Western Maryland AHEC (AHEC West) Allegany Health Right Human Resource Development Commission Tri State Community Health Center Mental Health Systems Office Allegany Transit Allegany County Health Planning Coalition
h. Impact/Outcome of Hospital Initiative?	In FY16, **13** new providers were recruited, including **2** psychiatrists and **2** primary care providers. Metrics for Objective 1: • Between July 1, 2014 and June 30, 2017, community health workers will provide 6,000 resource referrals for high-risk patients. (FY15-2374) In FY16-**3692** resource referrals were made by community health workers for high risk patients Including the following number of referrals to: Transportation-441,Medication Mgmt.-33,Rx Assistance-87,Insurance-80,Tobacco Cessation-21,Food-193,Housing/Utilities-263,Other –not specified-453 • Between July 1, 2014 and June 30, 2017, community health worker clients will make 1,500 healthy lifestyle improvements. (FY15-602) In FY16-**982** healthy lifestyle improvements were made by individuals served by community health workers Including the following number of improvements: Tobacco use reduction documented 348 times, Activity level increase documented 167 times, Goal achievement by 287 patients, 91 patients had reduced ED or hospital visits and 111 patients had reduced red flags for their chronic disease state. Metrics for Objective 2: • Between July 1, 2014 and June 30, 2017, the HRDC Mobility Management Program will provide low-income residents with 6,000 rides to health and human service appointments. (Fy15-3919) In Fy16-**5989** rides were provided to enable low-income residents to access health and human service appointments. WMRMC is a key partner in the Mobility Management Program which provides rides from a variety of sources. In FY16, WMHS provided and additional **2421** rides as patient assistance.
Evaluation of Outcomes:	Availability of providers continued to be an issue, but access to appropriate care increased in Allegany County in FY16 with more care coordination across the continuum. Targeted levels of referrals and health improvements have been met through the community health workers. Though this initiative cannot independently claim the reduction of ED visits that could have been treated in primary or urgent care sites, it seems they contributed to the continued reduction of level 1&2 visits in ED from 15501 in 2011 to 8219 in 2016. Community surveys done in 2011, 2014 and 2016 show a decrease in the percent of adults who report missing appointments due to problems finding transportation from 25% to 16%. Even with this positive trend, there continues to be a need for more coordinated transportation in Allegany County.

i. Continuation of Initiative?	Based on the results, all of these initiatives will be continued. WMHS/WMRMC works collaboratively with community partners on all of these initiatives, and collectively will develop strategies for improvement. Efforts to improve the referral process and documentation across the continuum will expand. Regional efforts with community health workers are underway. Through a Transportation Committee, WMHS and partners are gathering more specific data and best practices in order to develop a more coordinated and efficient system to address identified transportation needs in Allegany County.	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative • Workforce Development: $660,699 • CHW: $180,825 • Transportation: $67,945	B. Direct Offsetting Revenue from Restricted Grants None

<table>
<tr>
<td>a. 1. Identified Need

TABLE III
a.
1. Identified Need
2. Was this identified through the CHNA process?</td>
<td>Healthy Lifestyle and Wellbeing
According to the Community Health Status Reports (DHHS) half of all deaths can be attributed to lifestyle and behavioral risk factors. In Allegany County unhealthy behaviors including tobacco use, domestic violence, and low levels of physical activity contribute to poor health outcomes.
WMHS partnered with numerous community organizations to assess and implement activities to help make healthy choices easier and to enhance overall wellbeing.

The table below includes a comparison of baseline to current data, and whether the change is positive ▲ or not ● .
<table>
<tr><th>Data</th><th>Baseline</th><th>Current Status</th><th>Source</th></tr>
<tr><td>Percent of adults who smoke</td><td>24</td><td>17 ▲</td><td>County Health Rankings (BRFSS 2014- not comparable to prior year)</td></tr>
<tr><td>Percent of adults that report no leisure time physical activity</td><td>32</td><td>29 ▲</td><td>County Health Rankings (CDC Diabetes Interactive Atlas)</td></tr>
<tr><td>Percent of elementary children who are in the 95th percentile or higher for body mass index</td><td>20</td><td>19.3 ●</td><td>Allegany County Public Schools School Health Program</td></tr>
<tr><td>Number of domestic violence crimes per 100,000 population</td><td>437.8</td><td>608.6 ▲</td><td>Maryland Uniform Crime Report</td></tr>
</table>

Yes this was identified through the CHNA process.</td>
</tr>
<tr>
<td>b. Hospital Initiative</td>
<td>Increase healthy choices made in Allegany County, by supporting behavior change through available and affordable programs</td>
</tr>
<tr>
<td>c. Total Number of People Within the Target Population</td>
<td>Based on most recent 5 year estimate from the US Census Bureau, American Community Survey, of the 72,538 county population:

17% of adult population smokes= 12,332 adult residents
29% of adult population are physically inactive=21,036 adult residents
19.3% of elementary children are obese=782 (actual count)
608.6 domestic violence crimes were committed per 100,000 population=441 victims</td>
</tr>
<tr>
<td>d. Total Number of People Reached by the Initiative Within the Target Population</td>
<td>The number of people that were reached through the healthy choices initiative in FY16, include:

5845 participants in healthy lifestyle programs that supported behavior change.
431 victims were supported with violence intervention</td>
</tr>
<tr>
<td>e. Primary Objective of the Initiative</td>
<td>The intent will be to reduce tobacco use, physical inactivity, obesity and domestic violence.

Objective 1: Support behavior change with use of motivational interviewing and low cost, accessible programs

Objective 2: Provide violence intervention programs that promote development of positive, non-abusive relationships for improved health and wellbeing.</td>
</tr>
</table>

f. Single or Multi-Year Initiative –Time Period	Multi-year. Family Fit began in 2014.Change to Win started in 2011.Coaching began in 2006. Community Gardens and Evergreen were piloted in 2015. Parish Nursing has existed since 1997, and FNEP is a long term program as well.
g. Key Collaborators in Delivery of the Initiative	WMHS Make Healthy Choices Easy Allegany County Board of Education Allegany County Health Department Community Wellness Coalition Evergreen Heritage Center Family Junction Life Fitness Management Maryland Physicians Care Priority Partners University of Maryland Extension Western Maryland Area Health Education Center (AHEC West) YMCA In addition, WMHS collaborates with 36 faith based communities, Meritus Health, and the Cumberland Ministerial Association for the Parish Nursing. Law enforcement, the courts, Family Crisis Resource Center and the Family Violence Council collaborate with the Forensic Nurse Examiner Program.
h. Impact/Outcome of Hospital Initiative?	Metrics for Objective 1 • Between July 1, 2014 and June 30, 2017, at least 6,000 residents will participate in low-cost, accessible healthy lifestyle programs. Fy15-2768 In fy16-**5845** residents participated in accessible healthy lifestyle programs • By June 30, 2017, at least 30% of low-cost, accessible healthy lifestyle programs will measure behavior change. Fy15-12 In FY16- **60%** of these programs measured behavior change • Of 63 Change to Win participants, 20 lost five-nine pounds, 24 others lost 10 or more pounds and attended at least 9 of the sessions. 575.5 total pounds were lost. • 1,416 children participated in Family Fit Challenge earning 77,514 points for making healthy choices with nutrition and physical activity, and for engaging adults in a majority of the activities. Average participation for schools was 60.4% • 94% of the parishes were engaged (34/36) with 4,560 volunteer hours and 41,169 encounters, promoting and supporting healthy choices for mind, body and spirit. • 739 Coaching encounters were provided for community members and 93% met an established healthy lifestyle goal. Metrics for Objective 2 • # served by violence intervention programs that improve health and wellbeing **431** people were assisted through the Forensic Nurse Examiner Program
i. Evaluation of Outcomes:	Lifestyle and behavior changes are challenging and take significant support and time. In FY16 the number of participants in the activities of this initiative increased and behavior change was tracked more. There is still a need for better tools and processes for assessing and tracking behavior change. Since 2011, the percent of adults who smoke has decreased from 24% to 17% and the percent of adults that report engaging in no leisure time physical activity decreased from 32% to 29%. (County Health Rankings) BMI data collected by school health nurses for all public elementary children had a

	baseline of 20% in the 95th percentile or higher, and in the 2014-15 school year, this number decreased to 18.8%. In 2015-16 the percentage of children in this category has started to increase at 19.3%. Additional efforts are needed in this area. Decreasing domestic violence crime and providing care to victims are critical steps in violence prevention and keeping individuals well. The rate of domestic violence crimes per 100,000 population is higher in Allegany County than in Maryland. SHIP data over the last two reporting years show a decrease in the county's rate (719.5 to 608.6) but that rate is higher than it was in 2011 (437.8).	
j. Continuation of Initiative?	WMHS will continue to collaborate with community partners on health education using evidence informed/based practices, while increasing the assessment and tracking of behavior change. Based on the success in FY16, the community garden and activities with Evergreen Heritage Center will be expanded. The Parish Nurse program will continue to be linked with wellness. Though the idea of Parish Nurses assisting with support of high utilizers was proposed for FY16 it was delayed due to a staff transition. With the rate of DV crimes, the Forensic Nurse Examiner Program needs to continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $ X # of dollars <u>Health Education</u> Family Fit: $7,393 Change to Win: $4,550 Evergreen: $718 Community Gardens: $55,080 Coaching: $5,623 Parish Nursing: $70,249 Forensic Nurse Examiner Program: $176,616	D. Direct Offsetting Revenue from Restricted Grants Family Fit- $5400 grant from MPC

<table>
<tr>
<td>a. 1. Identified Need

TABLE III
a.
1. Identified Need
2. Was this identified through the CHNA process?</td>
<td>Disease Management
Admission data continues to include patients with multiple chronic conditions, particularly COPD, CHF and diabetes, and these diseases are often linked with PAU/PQIs. Baseline data from SHIP (2010) showed the age-adjusted death rates in Allegany County for heart disease and the rate of ED visits for hypertension, diabetes, and asthma were above state levels.
WMHS partnered with community organizations to provide disease management and care coordination.

The table below includes a comparison of baseline to current data, and whether the change is positive ▲ or not ● .
<table>
<tr><th>Data</th><th>Baseline</th><th>Current Status</th><th>Source</th></tr>
<tr><td>Rate of behavioral health-related ED visits per 100,000 population (Note: includes mental health and addictions)</td><td>7517.9</td><td>6216.5 ▲</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Rate of diabetes-related ED visits per 100,000 population</td><td>379.6</td><td>241.4 ▲</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Age-adjusted death rate from heart disease per 100,000 population</td><td>256.8</td><td>253.2 ▲</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Rate of ED visits for hypertension per 100,000 population</td><td>225.1</td><td>279.1 ●</td><td>SHIP (HSCRC)</td></tr>
<tr><td>Rate of ED visits for asthma per 100,000 population</td><td>68.9</td><td>61.8 ▲</td><td>SHIP (HSCRC)</td></tr>
</table>
Yes this was identified through the CHNA process.</td>
</tr>
<tr><td>b. Hospital Initiative</td><td>Provide disease management targeting individuals with multiple conditions, in conjunction with primary care providers</td></tr>
<tr><td>c. Total Number of People Within the Target Population</td><td>To determine the number of people with multiple chronic conditions including those most prevalent, we used two formulas and project the number to be in between.

According to the US Dept. of Health and Human Services, 1 in 4 Americans are living with multiple chronic conditions, and individuals over the age of 65 or living in poverty are impacted more. Allegany County's population is 72,528. 19.4% are over the age of 65 (14,030) and 18.5% of the population is poor (13,417). 25% (1of 4) of these two subgroups =6872 people or the estimated number of people with multiple chronic conditions in the county</td></tr>
<tr><td>d. Total Number of People Reached by the Initiative Within the Target Population</td><td>In FY16 the Center for Clinical Resources served 2100 new patients and
196 people participated in the support groups for diabetes or respiratory disease.</td></tr>
<tr><td>e. Primary Objective of the Initiative</td><td>The desire is to reduce potentially avoidable readmissions and ED visits

Objective 1: Support coordination of disease management programs, especially those for diabetes, heart disease and asthma.

Objective 2: Increase availability of behavioral health services</td></tr>
<tr><td>f. Single or Multi-Year Initiative –Time Period</td><td>Multi Year- Center for Clinical Resources- opened November 2013
Support Groups-started in 2013 and 2015</td></tr>
</table>

g. Key Collaborators in Delivery of the Initiative	WMHS has collaborated with the Medical staff and area providers on the CCR. Allegany County Health Department American Cancer Society Tristate Community Health Center Western Maryland AHEC (AHEC West) YMCA University of Maryland Extension HRDC –Community Action Allegany County Health Planning Coalition.	
h. Impact/Outcome of Hospital Initiative?	Metrics for Objective 1: • Between July 1, 2014 and June 30, 2017, at least 200 people will participate in chronic disease self-management programs. Fy15-137 In Fy16-**209** people participated in chronic disease management programs (Diabetes Prevention Program and Living Well**.** The Center for Clinical Resources reported: • 1860 referrals • 166 Telephone avoided ER visits COPD, DM, and CHF • 13,907 office and phone encounters COPD, DM, CHF • No show rate: COPD is 18.9%,CHF is 5.6%, DM is 12.8% Metrics for Objective 2: • Between November 1, 2015 and June 30, 2017, 75% of patients in participating practices will be screened for behavioral health needs. Fy15-0 In FY16-**100%** of WMHS practices screen for depression and anxiety. • 100 people were trained in Mental Health First Aid to improve community response to those in need of support until professional help arrives • As stated earlier, two psychiatrists were hired by WMHS this year.	
i. Evaluation of Outcomes:	SHIP data indicates a decrease in the ED visits for behavioral health, diabetes and asthma in Allegany County. Though there continues to be an increase in ED visits for hypertension. (See data in row a) Additional attention will be given to hypertension going forward. The CCR has made a positive impact on the ED visits with a 16% reduction for diabetes and 27% reduction for CHF. The overall readmission rate for CCR patients was also reduced 5%, which has resulted in a cost reduction of $1.5 million. The addition of more respiratory care, risk stratification, and enhanced care coordination across the continuum, helped the CCR maintain its success. The inclusion of behavioral health needs in the process has also been beneficial. WMHS continues to collaborate with the YMCA and other partners on the Diabetes Prevention Program, and with HRDC and others on Living Well. Collaboration to offer evidence based programs provides a solid foundation and will be expanded.	
j. Continuation of Initiative?	WMHS will continue to build on and improve the effectiveness of the CCR, and enhance linkages with community partners to provide a comprehensive continuum of care, meeting the needs of each patient in the most appropriate location. Connections will continue to be made between the somatic and behavioral health needs of each patient. Feedback on the Mental Health First Aid has been positive and trainings will continue.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	E. Total Cost of Initiative $ X # of dollars Center for Clinical Resources: $1,817,162 Support Groups: $1,863	F. Direct Offsetting Revenue from Restricted Grants None

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

   All the needs identified as a priority are being addressed, though as the Local Health Action Plan (implementation strategy) states; some are being addressed by a community partner. Falls were felt to be covered by existing efforts in the hospital and through home care. Health needs that were not prioritized and included in the action plan are described in the CHNA report, including child maltreatment and suicide. Though not specifically addressing maltreatment, the Coalition felt that existing need will be covered as part of the domestic violence issue and ongoing programs at WMRMC. There is a standard protocol to address suicide within WMHS and community partners agreed that it would be best to focus on behavioral health as the root cause.

   The LHAP also includes supporting strategies which are underway in the community and may contribute to the achievement of LHAP goals and outcomes, but are not overseen by the Coalition. The LHAP works to build upon, and not duplicate, existing community health improvement efforts.

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

   With the framework of Access & Socioeconomics, Healthy Lifestyles & Wellbeing, and Disease Management, there are many ways in which the hospitals' community benefit activities support the State's efforts to improve population health. WMRMC works very closely with community partners to incorporate non-clinical community based assets into the care continuum. As discussed in the State Innovation Model, WMRMC uses Community Health Workers to intervene on social and environmental determinants of health with the goal of reducing unnecessary ED visits or hospitalizations.

   The Center for Clinical Resources at WMRMC meets the definition of an Integrated Program as defined on the Health Care Innovations in Maryland site. The CCR combines clinical innovations and care coordination to provide disease management and support at no cost to the patient with the goal of enhancing patient care, reducing cost, and improving population health. Through the CCR services, and various community health education programs, we aim to reduce the number of these unnecessary visits and provide care in a more appropriate setting.

   As part of the community health needs assessment, the SHIP measures were reviewed and considered as part of the process. In the updated LHAP the following SHIP measures are noted:

   - Reduce percent of individuals unable to afford to see a doctor
   - Reduce child maltreatment
   - Increase access to healthy food
   - Increase the percent of adults who are at a healthy weight
   - Reduce the percent of children that are considered obese
   - Reduce the percent of adults who are current smokers
   - Reduce domestic violence
   - Reduce diabetes-related emergency department visits
   - Reduce hypertension-related emergency department visits
   - Reduce emergency visits related to behavioral health

   WMRMC continues to co-chair the LHIC with the local health department. Each year WMRMC assists with reports to the State regarding achievements of the LHIC, progress toward the identified measures, and outreach to the community. We collaborate on enrollment outreach, health fairs, environmental and policy changes, professional education, and behavioral health.

WMRMC has assisted several community partners with their application to the Maryland Community Health Resources Commission and through the LHIC and its associated workgroups we monitor the success and barriers of these efforts. It was funding from the Commission that allowed our community to start the Mobility Management program, helping to address the transportation barrier.

The Allegany County Health Planning Coalition (LHIC) incorporates health literacy, cultural competency, patient engagement, behavior change, and social determinants into many of its initiatives. All of which enhance the quality of care, cost, and overall population health.

VI. PHYSICIANS

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

Allegany County is a designated health professional shortage area (HPSA) for primary care for low-income populations, mental health care for Medical Assistance populations, and dental care for low-income populations. With the aging of primary care providers, a need for recruitment has risen as a concern again. Succession planning may be indicated. According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 1,045 persons; Allegany County has 1 primary care provider for every 1600 individuals. WMHS is also below the US benchmark in dental and mental health providers.

For the most recent analysis by the Healthcare Strategy Group in June 2014, the WMHS's CMS designation was changed from that of a rural facility to an urban facility. Stark III requirements for a CMS-designated urban facility limit the service area to one that consists of the fewest number of contiguous zip codes representing 75% of WMHS patient volume, effectively reducing the size of the regulatory-compliant service area from past studies. Based on retirement trends for physicians, the recent analysis identified older primary care medical staff to be of particular concern. Among WMHS's active medical staff in adult primary care, 19 physicians are currently over age 60 and that number will increase to 21 physicians in 2017, thirteen (13) of which will be over age 65 in 2017. Significant age concerns also exist in Cardiology, Endocrinology, Neurosurgery, and Ophthalmology, for which specialties the current average age is well over age 60 and most of the physicians in those specialties on WMHS's medical staff are currently over age 65.

In FY16, WMHS recruited 13 new providers, including 2 psychiatrists, 2 primary care providers, a cardiologist, electrophysiologist, nephrologist, pulmonologist, gastroenterologist, and three orthopedic surgeons.

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

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	Based on the community health needs assessment and Medical Staff Development Plan, Western Maryland Regional Medical Center has included physician subsidies for: hospitalists, psychiatric physician practice, obstetric physician practice, and primary care physician practice. With a growing number of area physicians electing to concentrate on their office practice and not admit their patients to the hospital, WMHS needed to expand the Hospitalist program to respond to community need. The aging of physicians has created a need for succession planning in primary care, psychiatry and obstetrics. WMHS responded by recruiting and maintaining practices in these areas. Although there are other providers addressing some of these needs there remained a gap and need for these services. As a WMHS practice these physicians align with the WMHS Financial Assistance Policy and help ensure that more patients are provided with care in the most appropriate setting.
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VII. APPENDICES

I. Description of Financial Assistance Policy (FAP)
II. Change in FAP since ACA Coverage Expansion
III. WMHS Financial Assistance Policy (FAP)
IV. Patient Information Sheet
V. WMHS Mission, Vision, and Values

Western Maryland Health System informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's Financial Assistance Policy (FAP) through the following means.

- The FAP policy/information is posted at all registration sites, is available on the WMHS web site, and is included with billing statements.

- Based on a query attached to our registration process, all self-pay patients are offered applications for FAP when they register.

- As part of the registration process, patients are also asked to identify their preferred language, so that accommodations can be made if translation or alternate resources are needed.

- Before discharge, every inpatient and/or their families is visited and offered assistance. Availability of various government benefits, such as Medicaid or state programs, and the qualification for such programs are discussed where applicable. The information is also available in our Patient Handbook.

Appendix II – FAP Change since ACA Coverage Expansion
Western Maryland Health System (WMRMC) FY16

Western Maryland Health System's Financial Assistance Program has always tried to connect patients with insurance or safety net coverage when available. Since the Affordable Care Act's Health Care Coverage Expansion Option became effective in January 2014, there has been increased support from financial counselors in the Patient Accounting Department and more patients are getting enrolled in Medical Assistance. The level of charity care and bad debt has shown some decline.

According to the FAP Policy:

Determination should be made that all forms of insurance are not available to pay the patient's bill. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs offered through Maryland Health Connections or other Healthcare Exchanges. If it is determined that a patient had or has the opportunity to obtain insurance that would have covered all or a portion of the patient's bill for medical services, but the patient failed or refuses to obtain such insurance, WMHS may consider such a decision on the part of the patient in determining whether the patient is eligible to receive Financial Assistance and/or the amount of Financial Assistance available to the patient. Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and copays. All insurance benefits must have been exhausted. Patients must follow participating provider guidelines and seek medical care from their provider network. WMHS will not grant Financial Assistance to patients who violate their provider network regulations. Patients who may qualify for Medical Assistance must apply for Medical Assistance and cooperate fully with the Medical Assistance specialist or its designated agent.

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WESTERN MARYLAND HEALTH SYSTEM DEPARTMENTAL Policy Manual	**Department\Division:** Business Office	**Policy Number:** 400-04
	Effective Date: November 12, 2010	**Reviewed/Revised:** 4/11, 12/11, 5/12, 10/12, 8/13, 6/14, 4/15, 7/15, 4/2015, 6/2016

FINANCIAL ASSISTANCE POLICY

PURPOSE:
The purpose of this policy is to describe the circumstances under which the Western Maryland Health System (WMHS) will provide free or discounted care to patients who are unable to pay for medical services, explain how WMHS will calculate the amounts of potential discounts, describe how patients can obtain and apply for Financial Assistance, and describe the eligibility criteria for Financial Assistance.

POLICY:
WMHS is committed to providing financial assistance to persons who require medically necessary health care services, but who are uninsured, underinsured, ineligible for a government insurance program, or otherwise unable to pay for medically necessary care based on their individual situation. A patient can qualify for Financial Assistance based on indigence or excessive Medical Debt by furnishing the information requested pursuant to this Policy and meeting specified financial and other eligibility criteria.

In addition, WMHS is designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, each tax-exempt hospital is required to adopt and widely publicize its financial assistance policy. WMHS will post notices of its Financial Assistance Policy at patient registration sites, Admissions, Patient Accounting Department and at the Emergency Department. Notices of its Financial Assistance Policy will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information summary will be provided to inpatients as part of the Admission Handbook given to every admitted patient prior to discharge and also upon request. The WMHS web site has Financial Assistance program summary, in addition to the financial assistance application which can be downloaded and printed. Patients may also call the main Patient Accounting phone number at 240-9964-8435 to request an application, patients may also request special assistance with completion of the application. Financial counselors are available to assist with the oral completion of the application.

This policy covers Western Maryland Regional Medical Center and Physician Clinics and Practices owned by WMHS. See attached listing of employed medical providers.

DEFINITIONS:
Medical Debt: A Medical Debt is medical expense incurred by a patient for Medically Necessary Services provided by a hospital or physicians, clinics, and practices owned by WMHS. A Medical Debt does not include a medical expense for services furnished by a non-hospital employee or other independent contractor (e.g., independent physicians, anesthesiologists, radiologists, and pathologists.

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

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

Financial Hardship: Medical Debt incurred by a family over a 12 month period that exceeds 10% of family income. Financial counselors will work closely with eligible parties taking into consideration issues such as

lost wages due to health and any other financial barriers that a patient may face due to a sudden health condition. Assistance plans will be considered using a sliding scale from 3-10% of gross income. (See Medical Debt definition)

Medically Necessary: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

Exclusions: Financial Assistance is not available for certain services, including the following: cosmetic procedures, elective reproductive services, acupuncture, private duty nursing, and other services at WMHS' discretion.

Free Care: Available to patients in households between 0% and 200% of Federal Poverty Level (FPL) and who otherwise meet the requirements to receive Financial Assistance under the Policy.

Reduced-Cost Care: Available to patients in households between 200% and 300% of FPL and who otherwise meet the requirements to receive Financial Assistance under the Policy.

PROCEDURE:

1. Evaluation for Financial Assistance can begin in a number of ways. A patient may present to a hospital service area seeking medical care and inquire about financial assistance; or a patient may notify Patient Accounting personnel or a financial counselor that he/she cannot afford to pay a bill and request Financial Assistance. All hospital registration sites, outpatient diagnostic centers, and system owned clinics and practices will make available to patients the Financial Assistance Policy and application. Registrars are trained to offer the Financial Assistance Policy and applications to self-pay patients. All inpatients are visited by a financial counselor before discharge from the hospital. The Financial Assistance application is available on WMHS web site, and is also on the reverse side of every patient billing statement. Financial counselors are available to assist patients with this process, and can be reached by calling 240-964-8435. Western Maryland Health System will use the Maryland State Uniform Financial Assistance Application.

2. Patients must have United States citizenship to qualify for Financial Assistance. Patients may be required to provide proof documentation such as identification card, birth certificate or lawful permanent residence status (green card).

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

4. Determination should be made that all forms of insurance are not available to pay the patient's bill. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers' compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs offered through Maryland Health Connections or other Healthcare Exchanges. If it is determined that a patient had or has the opportunity to obtain insurance that would have covered all or a portion of the patient's bill for medical services, but the patient failed or refuses to obtain such insurance, WMHS may consider such a decision on the part of the patient in determining whether the patient is eligible to receive Financial Assistance and/or the amount of Financial Assistance available to the patient. Patients with health spending accounts (HSAs) are considered to have insurance if the HSA is used only for deductibles and copays. All insurance benefits must have been exhausted. Patients must follow participating provider guidelines and seek medical care from their provider network. WMHS will not grant Financial Assistance to patients who violate their provider network regulations.

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

6. Determination of income will be made after review of all required documents. The following supporting documents must be provided with the application:
   a. Most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
   b. A copy of the four (4) most recent pay stub (if employed) or other evidence of income of any person whose income is considered part of the family income as defined by Medicaid regulations.
   c. Proof of disability income (if applicable) or workers compensation.
   d. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, or statement from current source of financial support, etc.
   e. Bank statements or brokerage statements.

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

7. When calculating total income for purposes of assessing eligibility for financial assistance, the following will be considered in the calculation of total income:
   a. Earned Income
   b. Social Security
   c. Pension Income
   e. Unemployment Compensation
   f. Business or Farm Income less Business or Farm Expenses
   g. Any other income such as rents, royalties, etc.
   h. Fixed income and savings allowance calculation is based on life expectancy of 85 years, income calculation should be based on age 85 and the applicant's age, allowing the necessary funds for the life of the applicant.

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

   Homeless patients, deceased patients with no known estate and members of a recognized religious organization who have taken a vow of poverty are also considered eligible for Presumptive Financial Assistance. Patients unable to provide sole support and relying on someone else for support may provide a "Letter of Support" for consideration of eligibility. Other documentation may be required and considered on a case by case basis.

A 25% discount will be extended for all Amish and Mennonite patients. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health insurance coverage.

Presumptive Financial Assistance is valid 6 months from date of application, at which time eligibility for Financial Assistance must be demonstrated again.

9. The application, with supporting documents, should be completed by the applicant and returned to the Financial Counseling Department within 10 business days. In the event that the account(s) have been placed in collections status, all extraordinary collection action will be suspended until the application and review process are completed. If partial information is returned, WMHS will provide the applicant with written notice of that describing the missing information and the applicant will be given an additional 10 days to provide the required information and supporting documents. The request for additional information displays contact information for financial counseling support personnel. All extraordinary collection action will suspend during this period. If the applicant does not respond, the applicant's request for Financial Assistance will be considered incomplete and WMHS will provide the applicant with written notice of closed status. WMHS will accept applications up to at least 240 days after the first post-discharge bill statement to the patient.

10. Based on the Federal poverty guidelines published annually in the Federal Register, a patient may be eligible to receive 100% Free Care or Reduced-Cost Care, which is a discount based on a percentage of the patient's Medical Debt according to the patient's income and number of dependents. The patient's responsibility for a Medical Debt may be capped based on a percentage of the patient's income, in which case the patient/ guarantor will be responsible to pay a certain percentage of the Medical Debt and the remainder will be charged to the Financial Assistance Program. Financial counselors will use the WMHS Charity Calculation form to determine level of Financial Assistance available to the patient. Patients receiving partial financial assistance based on calculation will receive a letter stating financial assistance amount granted, and amount owed by the patient. The patient will be given a payment plan to meet their remaining financial obligation. Patients may request a copy of Accounts Receivable Collection policy, by calling Patient Accounting personnel at 240-964-8435.

11. Once the Financial Assistance application is complete, decisions on eligibility will be made within 20 business days by the financial counselor and Director, Patient Accounting. Financial Assistance grants over $5,000 will also require the approval of Chief Financial Officer. The Director and Chief Financial Officer have the ability to make exceptions as circumstances deem necessary for all applications. In the event a patient has medical services scheduled within this 20 day review period, all reasonable measures will be taken to expedite review of the application. The applicant will be notified in writing by the WMHS financial counselor of the determination.

12. If the patient's application for Financial Assistance is approved, it will be made effective for medical services furnished within the 12-month period prior to the approval date and remain effective for 12 months after approval date. The patient will be notified in writing of the approval showing the percentage of assistance granted and any amount owed by the patient.

13. If within a two year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $5.00.

14. If the application for Financial Assistance is denied, the patient has the right to request the application be reconsidered, in which case the application will be reviewed by the Chief Financial Officer for final evaluation and decision.

CHARGES:
Charges for medical care provided to uninsured patients will be same as or equal to patients who have insurance. WMHS determines the amounts generally billed to patients and insurers based on Maryland HSCRC regulations.

EMERGENCY MEDICAL CARE:
Any patient seeking urgent or emergent care [within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)] at WMHS shall be treated without discrimination and without regard to a patient's ability to pay for care or whether the patient may be eligible for Financial Assistance. WMHS operates in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). WMHS' emergency medical care policy prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provision, without discrimination, of emergency medical care. WMHS has separate Emergency Care Policy.

_____
Business Operations – Trivergent Health Alliance

_____
Sr. Vice President, Chief Financial Officer

2016/2017 SLIDING SCALE ADJUSTMENTS
WMHS FINANCIAL ASSISTANCE PROGRAM

Patient Responsibility Percentages

Size of Family Unit	0%	10%	20%	30%	40%
1	$11,880-$23,760	$23,761-$26,611	$26,612-$29,581	$29,582-$32,551	$32,552-$35,640
2	$16,020-$32,040	$32,041-$35,885	$35,886 $39,890	$39,891-$43,895	$43,896-$48,060
3	$20,160-$40,320	$40,321-$45,158	$45,159-$50,198	$50,199-$55,238	$55,239-$60,480
4	$24,300-$48,600	$48,601-$54,432	$54,433-$60,507	$60,508-$66,582-	$66,583-$72,900
5	$28,440-$56,880	$56,881-$63,706	$63,707-$70,816	$70,817-$77,926	$77,927-$85,320
6	$32,580-$65,160	$65,161-$72,979	$72,980-$81,124	$81,125-$89,269	$89,270-$97,740
7	$36,730-$73,460	$73,461-$82,275	$82,276-$91,458	$91,459-$100,640	$100,641-$110,190
8	$40,890-$81,780	$81,781-$91,594	$91,595-$101,816	$101,817-$112,039	$112,040-$122,670
FPL Range	Thru 200%	201%-224%	225%-249%	250%-274%	265%-300%

Scale Effective 6/9/16

WESTERN MARYLAND HEALTH SYSTEM
Employed Providers
March 2016

Western Maryland Health System Corporation TIN# 52-0591531
NPI# 1609831247

12500 Willowbrook Road
Cumberland, MD 21502-6393

- ***(Denotes each practice location within each group)***

WMHS Behavioral Health Services IP NPI# 1285779884

WMHS Behavioral Health Services (Clinic) **OP NPI# 1306092531**

- **12502 Willowbrook Road, Suite 380**

Cumberland, MD 21502-6592
Telephone: (240) 964 -8585
FAX: (240) 964- 8586

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Alan N. Arnson, M.D.	1922083161
Edward M. Ehlers, M.D.	1104883883
Kevin H. Peterson, EdD	1053527895
Jean H. Ruiz, CRNP-PMH	1063471134
Debra N. Schaaf, PhD	1790737195
David K. Strickland, M.D.	1669578688
Jaaneali Mehdi M.D.	

WMHS Specialty Services NPI# 1184769952

- **12502 Willowbrook Road, 3rd Floor, Ste. #470** *(Cardiothoracic Services)*

Cumberland, MD 21502-6593
Telephone: (240) 964 -8724
FAX: (240) 964 - 8735

REMIT: P. O. Box 1671
Cumberland, MD 21501-0539
Telephone: (240) 964-8515
Fax: (240) 964 -8336

WMHS Specialty Services NPI# 1184769952

Continued

Leah Bucci, P.A.	1033469317
Peter Horneffer M.D.	1437145356
Mark G. Nelson, M.D.	1134111743
Heidi N. Race, P.A.	1154512556
Andrea Velandia, P.A.	1467478925
Mark F. Wilt, PA-C	1003975400

- **12502 Willowbrook Road, Ste. # 400** *(Cardiology Services)*

Cumberland, MD 21502-6567
Telephone: (240) 964 -8740
FAX: (240) 964 -8741

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Michael J. Curran, M.D.	1609846476
Christopher Haas, D.O.	1093786436
Mark F. Wilt, PA-C	1003975400
Kenneth G. Judson, Jr D.O.	1770525891
Aje, Temiolu M.D.	1083816987

- **12502 Willowbrook Road, Ste. 360** *(Wound Care)*

Cumberland, MD 21502-6498
Telephone: (240) 964-8711
Fax: (240) 964-8716

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
FAX: (240) 964-8336

Julie F. Bielec, M.D.	1891754370
Debra Dempsey, CRNP	1841298908

- **12502 Willowbrook Road, Ste. # 640** *(Gastroenterology)*

Cumberland, MD 21502-
Telephone: (240) 964 -8717
FAX: (240) 964 -8720

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Nii Lamptey-Mills, M.D.	1689659997
Arya Karki, M.D.	1750532156

Beverly Moser, CRNP

WMHS Specialty Services NPI# 1184769952

Continued

- **12502 Willowbrook Road, Ste. #440** *(Medical Oncology/Int. Med.)*

Cumberland, MD 21502-6567
Telephone: (240) 964 -8680
FAX: (240) 964 -8688

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Blanche H. Mavromatis, M.D.	1336137876
Faye Yin, M.D.	1780879742

- **12502 Willowbrook Road, Ste. # 280** *(Pulmonary)*

Cumberland, MD 21502-6494
Telephone: (240) 964-8750 (Drs. Sagin and Sprenkle)
(240) 964-8690 (Dr. Schmitt)
FAX: (240) 964 -8699

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Mark A. Sagin, M.D.	1750343505
Richard G. Schmitt, M.D.	1336271667
Boyd E. Sprenkle, M.D.	1306808159
Shannon R. Sprenkle CRNP	1013384072

- **Western Maryland Health System**

12500 Willowbrook Road
Cumberland, MD 21502-6393

REMIT: P. O. Box 1671
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Telephone: (240) 964-8515
Fax: (240) 964 -8336

Adegboyega Adejana M.D. (*OB Coverage)*	1316149909
Alex, Biju M.D. (*Gastroenterology Coverage*)	1750558342
Juan A. Arrisueno, M.D. *(General Surgery Trauma)*	1851393565
Kheder Ashker, M.D. *(Neurosurgery Trauma)*	1770561979
Robert Beer, M.D. (*Ortho Trauma Coverage)*	1821061813
Mary Ann Bishop, M.D. (*Nephrology Coverage*)	1609929801

Erin M. Bohen, M.D. *(Nephrology Coverage*) 1538263082
Roy J. Carls, M.D. *(Orthopedic Surgery Trauma)* 1326093634
Roy D. Chisholm, M.D. *(General Surgery Trauma)* 1275550279

WMHS Specialty Services NPI# 1184769952

Continued

Chintamaneni Choudari M.D. (*Gastro Coverage*) 1538148283
Santa D'Allesio M.D. (*Pulmonary Coverage*) 1275591919
Augusto F. Figueroa, M.D. *(Neurosurgery Trauma)* 1740268945
Alison Grazioli M.D. (*Nephrology Coverage*) 1811214596
Tom F. Ghobrial, M.D. *(Ortho Surgery Trauma)* 1518928746
Marie A. Hager CRNP (*Palliative Care*) 1881075802
Rashid Hanif M.D. (*Gastroenterology Coverage*) 1285637116
Isabelle Hertig M.D. (*Pulmonary Coverage*) 1013127695
Elaine Kaime M.D. (*Oncology Coverage*) 1396716114
Rohit Khirbat M.D. (*Pulmonary Coverage*) 1194926063
Milton Lum, M.D. (*General Surgery Trauma*) 1740507433
Norman Martin M.D.(*Oncology Clinic* Coverage) 1811955495
Chetanna Okasi, M.D. (*OB Coverage)* 1356484083
Dhyan Rajan, M.D. (*Gastroenterology Coverage*) 1932351830
Kevin Rossiter M.D. (*Nephrology Coverage*) 1093784332
Cynthia J. Shriver, CRNP *(Radiation Oncology)* 1831485572
Michael W. Stasko, M.D. *(General Surgery Trauma)* 1740365584
Jean Talbert M.D. (*OB Coverage*) 1407918741
William Waterfield M.D. (*Oncology Coverage*) 1871552760
Gregg Wolff, M.D. *(Orthopedic Surgery Trauma)* 1861431561

- **625 Kent Avenue, Ste. 304** *(Infectious Diseases)*

Cumberland, MD 21502-3775
Telephone: (301) 722-0293
FAX: (301) 722-0304

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Aman K. Dalal, M.D. 1750595575

- **1050 Industrial Boulevard** *(Occupational Health)*

Cumberland, MD 21502-4331
Telephone: (240) 964-9355
FAX: (240) 964-9356

REMIT: PO Box 1671
Cumberland, MD 21501-1671
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FAX: (240) 964 -8336

James B. Deren, M.D. 1053310078
Vamsi Kanumuri, M.D. 1542559545

WMHS Specialty Services NPI# 1184769952

Continued

- **12502 Willowbrook Road, Suite 470** *(Nephrology)*

Cumberland, MD 21502
Telephone: (240) 964-8724
FAX: (240) 964-8735

REMIT: PO Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
FAX: (240)-964-8336

Umair Syed Ahmed M.D. 1053310078

- **12502 Willowbrook Road, Ste. 660** *(OB/GYN)*

Cumberland, MD 21502-6579
Telephone: (240) 964-8760
FAX: (240) 964-8769

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
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Leah Bennett, PA 1336557370
Sherilyn Crist, RN,CNM 1174962849
Beth H. Jelinek, M.D. 1689700023
Tom Hartsuch, M.D. 1306830252
Victoria Willey, CRNP 1972695070

- **12502 Willowbrook Road, Ste. # 640** *(General Surgery)*

Cumberland, MD 21502-
Telephone: (240) 964 -8717
FAX: (240) 964 -8720

REMIT: P. O. Box 1671
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Telephone: (240) 964-8515
Fax: (240) 964 -8336

Birat Dhungel, M.D. 1316142656

WMHS Specialty Services NPI# 1184769952

Continued

- **12502 Willowbrook Road, 3rd Floor, Ste. # 590** *(Ortho Surgery)*

Cumberland, MD 21502-6594
Telephone: (240) 964 -8631
FAX: (240) 964 -8689

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

- **217 Glenn Street, Ste. 300** *(Plastic Surgery)*

Cumberland, MD 21502-6594
Telephone: (301) 724-0874
FAX: (301)724-1051

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Emme Chapman-Jackson, M.D. 1740487727

- **12500 Willowbrook Road** *(Pain and Palliative Care)*

Cumberland, MD 21502-6393
Telephone: (240) 964-8907
FAX: (240) 964-8901

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Marie Hager, CRNP 1881075802

- **12502 Willowbrook Road, Ste 330** *(Endocrinology)*

Cumberland, MD 21502
Telephone: (240) 964-8900
FAX: (240) 964-8901

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Smriti Manandhar M.D. 1801109095

WMHS Specialty Services NPI# 1184769952

Continued

- 12502 **Willowbrook Road, Ste. # 300** *(Heart Failure Clinic)*

Cumberland, MD 21502-6498
Telephone: (240) 964 -8787
FAX: (240) 964 - 8687

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Brandi L. Clark, CRNP	1558790485
Dawn M. Snyder, CRNP- F	1932343456

- **Center for Clinical Resources** *(Diabetes Program)*
- **12502 Willowbrook Road, Suite 300**

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FAX: (240) 964-8687

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FAX: (240) 964-8336

Joni Brode, R.D.	1427310101
Jennifer Perrin, R.D.	1073834685
Tammy Keating, CRNP	1902104060
Allison Lutz, R.D.	1205122421
Mary Tola, CRNP	1588717367

- **12501 Willowbrook Road, 2nd Floor** *(Outpatient Nutritional Counseling)*

Cumberland, MD, 21502-2506
Telephone: (240) 964 -8425
FAX: (240) 964-8415

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Meredythe Barrick, R.D.	1841611449
Melody Lindner R.D.	1205232824
Allison Lutz, R.D.	1205122421

Theresa A. Stahl, R.D. 1447520770

WMHS Primary Care Services NPI# 1902926686

- **625 Kent Avenue, Ste. 204** *(Internal Medicine)*

Cumberland, MD, 21502-3799
Telephone: (301) 777-7300
FAX: (301) 777-7121

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Muhammad Naeem, M.D. 1710186291

- **1313 National Highway** *(Family Practice)*

La Vale, MD 21502-7618
Telephone: (240) 362-0288
FAX: (240) 362-0052

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
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Fax: (240) 964 -8336

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Barbara Pyle, CRNP 1861498412
Mary Ann Riley, D.O. 1174736441
Nancy White, CRNP 1336545466

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Cumberland, MD 21502
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FAX: (240) 964-8901

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Telephone: (240) 964-8515
Fax: (240) 964 -8336

Rameet Thapa, M.D.

WMHS Specialty Services NPI# 1184769952

Continued

- **1050 W. Industrial Blvd, Ste. 17** *(South Cumberland Marketplace)*

Cumberland, MD 21502-4331
Telephone: (240) 964-9200
Fax: (240) 964-9210

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Anupama Khandare, M.D. 1255610580 Rizwan Sadiq, M.D. 1447365887

WMHS Urgent Care Services

- **Frostburg Health Center 1952495079**

10701 New Georges Creek Road
Frostburg, MD 21532-1457
Telephone: (301) 689-3229
FAX: (301) 689-1129

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Gregory L. Beyer, M.D. 1740381201
David Carkin PA-C 1205814035
Jeremy Hunt, CRNP 1144465600
Zahra Kiran, M.D. 1700069234
Jason Layman CRNP 1811942147
Beena Nagpal, M.D. 1598746588
Ju-un J. Park M.D. 1871858191
Rory Price, PA-C 1942201991
Darin Adiar PA-C 1265428569
Thomas Kidd PA-C 1265428569
Matt Hurley PA-C 1174519482
Robert Ryan PA-C 1750306049
Jamie Detrick PA-C

WMHS Urgent Care Services

- **Hunt Club Medical Clinic** **1346341716**

11 Hunt Club Plaza
Ridgeley, WV 26753-5213
Telephone: (304) 726-4501
FAX: (304) 726-4051

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8515
Fax: (240) 964 -8336

Matt Hurley, PA-C	
Mark A. Myers, M.D.	1710986658
John G. Stansbury, M.D.	1023017027
Beena Nagpal, M.D.	1598746588
Robert Ryan PA-C	1750306049
Jesssica Steward, CRNP	1336563089
Gregory L. Beyer, M.D.	1740381201
Rizwan Sadiq M.D.	1447365887
Thomas Kidd PA-C	1265428569
Kristen Lopez PA-C	
Lois Metcalfe PA-C	

WMHS Termed Providers

- **WMHS Behavioral Health Services**

Herbert G. Chissell, M.D. 1982659728 01/01/11
Eduardo R. de la Cruz, M.D. 1942309810 01/01/11
Naciye Kalafat, M.D. 1861459612 01/31/11
Hye Kyung Lee, M.D. 127577218 07/05/13
Ashley N, Miller, CRNP 1346501616 04/12/15
Deirdre Mull, CRNP 1235315599 10/1/20015
Linda Calvacca, PhD, PNP 1932386125 10/27/2015
Abishek R. Rizal, M.D. 1518132067 11/15/2015

- **WMHS Primary Care Services**
- Manpreet Arshi, M.D. 1861552036 11/7/14
- Cathy S. Chapman, CRNP 1023100120 12/13/12

Kristen S. Hileman, CRNP 1942554787 05/10/13
Sailaja Malla, M.D. 1619154671 01/14/14
Faye Martin, CRNP 1912284050 08/10/12
Katherine A. McKenney, CRNP- F 1295778207 08/16/12
Connie Jo Morris, CRNP, FNP-BC 1013224534 09/20/13
Lindsey M. Staggers-Gardner, CRNP 1841545506 08/21/14
Willie L. Stertz, M.D. 1003888777 06/30/14
Bhavani Vaddey, M.D. 1336374255 10/11/13
Carissa J. Vea, M.D. 1952516619 10/18/13
Ruben Villeda M.D. 1659431831 12/5/14

WMHS Specialty Services

Tarek Abou-Ghazala, M.D. 1609867381
Christine Abbata, PA-C 1730303603 12/18/11
Asit N. Bhatt, M.D. 1184839854 01/31/13
Katherine S. Berkowitz, 1588911887
George M. Breza, M.D. 1033109822 04/01/13
J. Nicholas Casto, M.D. 1437288651 03/01/13
Robert Chou, M.D. 1639145931 12/01/12
Kenneth Costner, CRNP 1578597100 04/18/14
Subrato J. Deb, M.D. 1548240765 07/29/13
Jeremy J. Duanne, CRNP 1427347384 03/26/13
Cliff Evans, D.O. *(Ortho Sur)* 1669521522 01/20/12
Victor R. Felipa, M.D. *(Int. Med.)* 1053311639 04/01/13
Amanda L. Ferrante, PA-C 1841427085 11/23/12
Mark Fleming, D.O. *(Ortho Sur)* 1881638583 12/01/10
Nadim S. Jafri, M.D. (Gastro) 1326173386
Keith Joe, M.D. *(Orthopedic* 1346462603
Nanette Kelly, CRNP 1477717551 06/29/12
Steven Mackay, D.O. 194225483 06/20/14
Mark McCubbin M.D. 1831322932
Karen L. Menser, CRNP 1851698294 04/12/13
Sepideh Moghadam, M.D. 1508020017 09/08/15
Mary Murphy, P.A. 1043598030 10/05/12

Alida I. Podrumar, M.D.	1427059609	10/26/12

WMHS Termed Providers (continued)

Ronald J. Quam, D.O. *(Orthopedic*	1306908033	
Gary L. Schmidt, M.D.	1922041128	12/03/12
Jeffrey Shultz, M.D.		07/31/14
Heidi Shrock-Race, PA	1154512556	05/05/11
Lisa J. Simmons M.D. (*Oncology*	1790773737	
Cindy S Stafford, CRNP	1902906928	05/2013
Angie N. Sutphin R.D.	1013140920	03/26/12
Douglas Tice, M.D.	1942314620	02/04/16
Diana M. Webb, R.D.	1588903223	
Frances Weber, CRNP	1275850638	07/01/12
James Williams, PA-C	1306143326	11/1/2015
Dale E. Wolford, D.O.	1417902164	02/19/15
Yuanjue L. Zhang, M.D.	1124236286	07/2013

- **Urgent Care**

Susan M. McMullen, CRNP	1194858266	02/01/12
Jillian L. Rogers, M.D.	1699063750	02/08/15
Glynn Wells, M.D.	1275599888	
Mikela Swenson, M.D.	1407878655	
Isagani O. Laurencio, M.D.	1730164492	10/1/2015

WMHS Hospitalist Services NPI# 1477632990

- **Western Maryland Regional Medical Center** **TERMED 4/1/13**

12500 Willowbrook Road
Cumberland, MD 21502-6393
Telephone: (240) 964-8564
FAX: (240) 964-8563

REMIT: P. O. Box 1671
Cumberland, MD 21501-1671
Telephone: (240) 964-8343
Fax: (240) 964 -8337

Ama Awuah-Asamoah, CRNP	1669754131
Amit Bhandari, M.D.	1598929176
Denise K. Bittner, CRNP	1902983687
Harshad S. Bokil, M.D.	1134120231
Abdul H. Cheema, M.D.	1326246349
Venumadhav Chirunomula, M.D.	1528292406
Janette M. Clark, CRNP	1962661900
Aman K. Dalal, M.D.	1750595575
Jeremy J. Duanne, CRNP	1427347384
Ardalan Enkeshafi, M.D.	1003000126
Nazish Ismail, M.D.	1619105962
Rohit Jain, M.D.	1861699696
Laura Kelleher, CRNP	1912251729
William D. Lamm, M.D.	1639156938
Kelly Liu, M.D.	1982896361
Danita Packard, CRNP	1285901132
James M. Raver, M.D.	1477760486
Husam B. Semaan, M.D.	1881670594
Steven R. Smith, M.D.	1205812013
Christopher S. Vagnoni, M.D.	1093791097
Bruce G. Vanderver, M.D.	1083669964

Revised 3/23/16 BJW

Appendix IV – Patient Information Sheet
Western Maryland Health System FY16

Hospital Financial Assistance

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

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

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

Patients' Rights and Obligations

Patients' Rights:

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

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

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

Patients' Obligations:

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

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

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

If you fail to meet the financial obligations of this bill, you may be referred to a collection agency. In

determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office to provide updated/corrected information.

Contacts:

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

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

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

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

Important Billing Information

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

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

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

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

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

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Mission Statement

We are dedicated to providing patient-centered care and improving the health and well-being of people in the communities we serve.

Vision Statement

Shaping dynamic partnerships in advancing health and well-being.

Core Values – i2care

- **Integrity** – Demonstrate honesty and straightforwardness in all relationships
- **Innovation** – Pursue continuous improvement through creative new ideas, methods, and practices
- **Compassion** – Show care and kindness to all we serve and with whom we work
- **Accountability** – Ensure effective stewardship of the community's trust
- **Respect** – Demonstrate a high regard for the dignity and worth of each person
- **Excellence** – Strive for superior performance in all that we do