Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: UPMC Western Maryland	◉	○	
Your hospital's ID is: 210027	◉	○	
Your hospital is part of the hospital system called N/A	○	◉	UPMC
The primary Narrative contact at your hospital is Amber Ruble	○	◉	Jennifer Thomas
The primary Narrative contact email address at your hospital is rublear@upmc.edu	○	◉	thomasj39@upmc.edu
The primary Financial contact at your hospital is Amber Ruble	◉	○	
The primary Financial email at your hospital is rublear@upmc.edu	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

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

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

UPMC Western Maryland defines its community benefits service area as Allegany County and reviews the demographics for the county as part of the community health needs assessment every three years. Sources include the following: Maryland Vital Statistics, US Census Bureau - American Community Survey, County Health Rankings, YBRFSS, and Maryland SHIP. The data is examined with internal metrics for use in community benefit efforts.

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

Demographic Characteristic fy21.docx
20.2KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

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

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

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

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

- [x] 21501
- [x] 21502
- [x] 21503
- [x] 21504
- [x] 21505
- [x] 21521
- [x] 21524
- [x] 21528
- [x] 21529
- [x] 21530
- [x] 21532
- [x] 21539
- [x] 21540
- [x] 21542
- [x] 21543
- [x] 21545
- [x] 21555
- [x] 21556
- [x] 21557
- [x] 21560
- [x] 21562
- [x] 21750
- [x] 21766

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

☐

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

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

UPMC Western Maryland is the only community hospital in the county. Since over 70% of our patients reside in Allegany County, we selected the county as the Community Benefit Service Area.

- [ ] Other. Please describe.

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

https://www.wmhs.com/about/

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

06/29/2020

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://alleganyhealthplanningcoalition.com/

Q42. Please upload your hospital's most recently completed CHNA.

CHNA-Narrative-FINAL-62920.pdf

1.1MB
application/pdf

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

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

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☑	Provide oversight and facilitate integration with the strategic
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☐	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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

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

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

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

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Tracking Community Benefit activities.
Community Benefit staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Reviewed the narrative prior to submitting.
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☑	Physicians were engaged through clinical leadership, Executive Team and the Population Health Council.
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☑	Through Director of Quality Initiatives.
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☐	☑	Engaged through the Population Health Council.
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify) Strategic Planning Committee	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	

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

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement	Recommended Practices

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

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

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

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

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

- (●) Yes
- ( ) No

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

06/29/2020

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

https://health.alleganymedia.com/wp-content/uploads/2020/07/Local-Health-Action-Plan-7-20-to-6-23-final-1.pdf

Q222. Please upload your hospital's CHNA implementation strategy.

Local-Health-Action-Plan-7-20-to-6-23-final-1.pdf
212.6KB
application/pdf

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

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

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

This question was not displayed to the respondent.

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

This question was not displayed to the respondent.

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

	Health Conditions - Chronic Pain Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Chronic Pain Self-Management Program	To help people with one or more chronic conditions learn the strategies to manage their condition and have the confidence to carry them out.	Feedback from program participants revealed increased confidence in carrying out activities of daily living.	Action planning and goal setting with accountability measures.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

This question was not displayed to the respondent.

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

This question was not displayed to the respondent.

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

This question was not displayed to the respondent.

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

	Health Conditions - Mental Health and Mental Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Mind Body Skills Groups (Adolescents)	Improve the mental health of youth through prevention and risk reduction focused on resilience.	In FY21, Allegany College of MD (ACM) trained 142 participants were trained through the Opioid Operational Command Center Tackling the Opioid Crisis Project. Those trained were obligated to facilitate workshops and groups throughout 2020 and 2021. In addition, two full-day workshops for facilitators working with children and teens were held. An ACM group was facilitated in the spring of 2021 for 7 high risk ACM students. Mind-Body Skills were provided at Frostburg State University to the Maryland Accelerates Summer 2021 Leadership Institute as a half-day virtual workshop on June 24, 2021 reaching 26 college students. Frostburg State employees trained under our grant held four 8-week Mind-Body Skills Groups reaching 26 FSU students. Eleven teens from all three-local high-schools participated in the Center for Mind Body Medicine (CMBM) Professional and Advanced trainings through Allegany County Public Schools. An 8-week Mind-Body Skills Group for teens was facilitated online by HS students trained under our grant in the spring of 2021. 7 teens participated. A second group for teens was facilitated through a local church for 4 high-school students. Multiple presentations were made by the teens trained under our grant in health classes in all three public high schools. Estimated reach: 200. Workshops were conducted for 32 ACPS teachers and counselors. In addition, three 8-week MBSG's were held for 26 ACPS staff. A pilot K-12 Mind-Body enriched Health Curriculum will be piloted in ACPS this fall. A pilot for early college, Allegany Rising, and ACM Orientation are also planned. Mind-Body Resource Page on Facebook was created by 4 ACPS guidance counselors who were trained by the CMBM through our grant. The page is designed for students and their families - but is a great community resource too. Videos created for the site have been viewed more than 5,300 times.	Attendance; Mindfulness Scale - pre-post survey
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

This question was not displayed to the respondent.

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

	Health Conditions - Overweight and Obesity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Health Coaching	Work with patients/clients to establish clear and concise goals; support motivation; and provide accountability.	In FY21, 124 patients/clients were served with 233 encounters.	Quality of Life Scale; self-reported changes; UPMC perceived stress scale.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

This question was not displayed to the respondent.

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

This question was not displayed to the respondent.

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

This question was not displayed to the respondent.

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Farmers Market Produce Vouchers	Provide fresh produce to underserved individuals and families living in community located in a food dessert.	In FY 21 served 699 individuals.	Number of vouchers distributed; self-reported satisfaction with program.
Initiative B	Community Gardens	Utilize information obtained through food system mapping to identify and establish five sites per cycle year where healthy food choices or local food sources will be increased.	In FY21 provided over 60 garden plots to the community. Community partners adopted gardens to increase interaction with gardeners.	Number of active gardeners; yield of produce; pounds donated to the local food bank.
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

	Health Behaviors - Physical Activity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Healthy Parks Healthy People HIIT Classes and Community Fitness Classes	The program involves DNR staff working with healthcare providers to encourage them to give their patients a prescription to increase physical activity and take part in programs offered at nearby State parks. Certified personal trainers/health coaches engage with the public to offer free fitness classes to increase physical activity and promote healthy weight among participants.	In FY21, the classes had 117 individuals participate and a total of 327 encounters.	Increased awareness Increased activity level of participants.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

This question was not displayed to the respondent.

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

	Health Behaviors - Tobacco Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Prevention and risk reduction focused on substance use (vaping).	Prevent and/or reduce tobacco usage, specifically vaping.	FY21: # of Students educated on tobacco and vape prevention: 4,473; # of Teachers/school staff trained/educated on tobacco and vape prevention: 1,209;# of Youth (Community) Educated on Electronic Smoking Device Prevention/Awareness: 406;	Number of trainings and materials distributed.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

This question was not displayed to the respondent.

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

This question was not displayed to the respondent.

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

This question was not displayed to the respondent.

Q217. Please describe the initiative(s) addressing Populations - Infants.

This question was not displayed to the respondent.

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

This question was not displayed to the respondent.

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

This question was not displayed to the respondent.

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

This question was not displayed to the respondent.

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

This question was not displayed to the respondent.

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

This question was not displayed to the respondent.

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

This question was not displayed to the respondent.

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

This question was not displayed to the respondent.

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Patient Transportation	Cab vouchers, bus passes etc. to enhance patient access to care, support for patients and families.	In FY21, 14,466 total rides were provided to patients for appointments. Of all rides, about 27 percent required wheelchair transportation.	Annual cost savings based on projected ambulance spend/missed appointments.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

This question was not displayed to the respondent.

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

This question was not displayed to the respondent.

Q243. Please describe the initiative(s) addressing other priorities.

	Other Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Wellness Ambassadors	Wellness Ambassadors are members of faith based or community groups who volunteer to promote an atmosphere of healthy living in their organization. They create a culture of wellness, provide encouragement and connect people to information and resources for the mind, body and spirit.	FY 21 782 Community members connected to resources.	Monthly reports from ambassadors with detail of referrals and services provided.
Initiative B	Path2Help	the hospital and several organizations adopted a platform to provide community organizations and community members access to resources through an online resource guide and referral system. » Leveraging technology to increase access to resources: Path2Help is an online tool that makes it easy for people to find appropriate programs and services for food, shelter, health care, work, financial assistance and more.	To date, 200 seekers were referred, there were 94 closed loop referrals,	Reports taken from database; number of community partners trained.
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Chronic Pain, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Overweight and Obesity, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Tobacco Use, Settings and Systems - Transportation, Other (specify)
Other: Home and Community Safety

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

Our Center for Clinical Resources addresses chronic disease management and financial assistance for patients whose income is 300% above the poverty level. They are able to receive all services offered there including case management, Social Worker, education, smoking cessation, medication assistance, and CRNP management of disease. The Center For Hope and Healing is designed to help prevent or provide an alternative to psychiatric inpatient admission, and help shorten the length of inpatient stay. We also connect patients to addiction services, inpatient and outpatient services, Medication Assisted Treatment programs, addictions Intensive Outpatient Program and Alcoholics Anonymous/Narcotics Anonymous. Efforts related to Diabetes include our Food Farmacy which provides patients with healthy food, PCP initiatives targeting A1c >9; lists are pulled weekly. PCP initiatives targeting Hypertension; lists are pulled weekly for patients who out of compliance (B/P >140/90). Five community gardens are located within the community along with an orchard and walking path to address food insecurity and lack of resources to healthy food to the underserved population.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe) _____

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

- [ ] No

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

The internal audit consists of a series of checks and balances. There is a group of reporters that enter occurrences into CBISA, each of their entries is reviewed and imported by the System Administrator/Director of Community 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 entered into CBISA by the System Administrator and then several reports are pulled for review by the System Administrator and Finance Director (including a three-year comparison). Since the Manager of Community Health serves as the CBISA System Administrator and is engaged with the CHNA and implementation plan, this position is responsible for compiling the draft narrative. All members of the Community Benefits Committee review the narrative to ensure its accuracy. The Chief Financial Officer has the final review and sign off before it is shared with the UPMC WESTERN MARYLAND Board of Directors for review and action.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

The Population Health Council reviews the findings to identify key opportunities for involvement of UPMC Western Maryland internally and with the Local Health Improvement Coalition (LHIC) regarding the community. As a cycle of learning, these opportunities are then considered in the strategic planning process. Once priorities, plans and metrics are approved and aligned with the budget process, the CHNA and implementation plan are presented to the Board for approval, then implemented, tracked and measured.

Q70. If available, please provide a link to your hospital's strategic plan.

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [ ] Diabetes - Reduce the mean BMI for Maryland residents
- [ ] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	○	
Anesthesiology	○	○	
Cardiology	○	○	
Dermatology	○	○	
Emergency Medicine	○	○	
Endocrinology, Diabetes & Metabolism	○	○	
Family Practice/General Practice	○	○	
Geriatrics	○	○	
Internal Medicine	○	○	
Medical Genetics	○	○	
Neurological Surgery	○	○	
Neurology	○	○	
Obstetrics & Gynecology	○	○	
Oncology-Cancer	○	○	
Ophthamology	○	○	
Orthopedics	○	○	
Otololaryngology	○	○	
Pathology	○	○	
Pediatrics	○	○	
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	○	○	
Radiology	○	○	
Surgery	○	○	
Urology	○	○	
Other, (Describe)	○	○	

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

Financial-Assistance.pdf
320.8KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

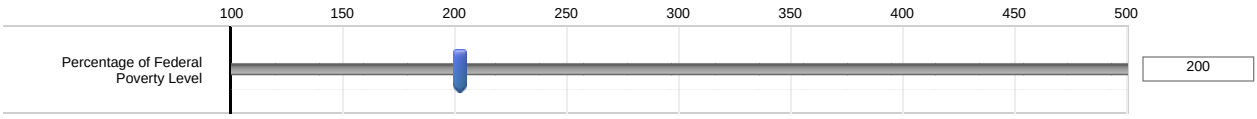
https://www.wmhs.com/patients-and-visitors/patients/financial-assistance/

Q147. Has your FAP changed within the last year? If so, please describe the change.

- ○ No, the FAP has not changed.
- ◉ Yes, the FAP has changed. Please describe: It was revised in 2021 to change the name from WMHS to UPMC WMD.

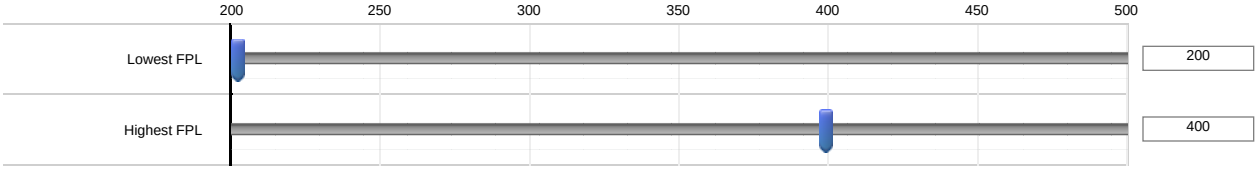
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



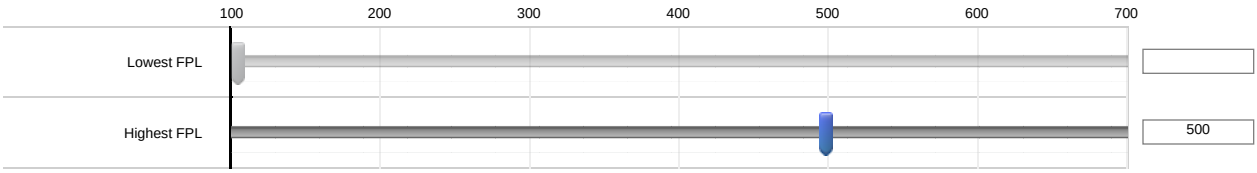
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

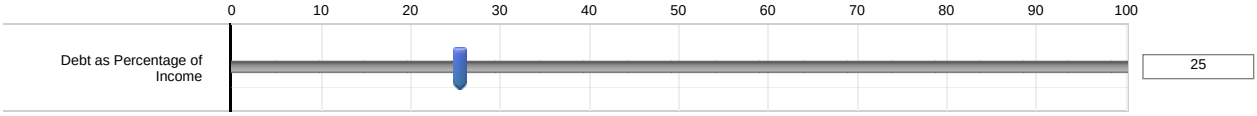


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

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

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (39.599502563477, -78.846099853516)

Source: GeoIP Estimation

Demographic Characteristic CBSA=Allegany County	Description	Source	Notes
Median Household Income within the CBSA	$45,893 median household income vs. $83,076 Maryland; $65,712 US	US Census Bureau (2019)	Below State and Nation
Percentage of households in the CBSA with household income below the federal poverty level	16% household income below poverty level vs. 9.4% Maryland	U.S. Census Bureau, American Community Survey (2019)	slight decrease, however prior to pandemic
For CBSA, what is the percentage of uninsured?	6% 1.3% (Payor Mix- private pay and Charity Care)	County Health Ranking Univ. of Wisc. (2020), UPMC Western Maryland 2020	Stable
Percentage of Medicaid recipients within the CBSA.	15.5%	UPMC Western Maryland 2020	57.6% Medicare
Life Expectancy within CBSA (including by race and ethnicity.	76.7 All Races/Ethnicities 76.4 White 75.3 Black	DHMH Vital Statistics (2017-2019)	Below state in all categories (MD 79.2), Black in county down from 80.4
Mortality Rates within CBSA (including by race and ethnicity where data are available).	Crude death rate 1223.0 All Races, 465.2 Non-Hispanic Black, 1338.3 Non-Hispanic White	Maryland Vital Statistics Report (2018 Report)	Above state except for black race (MD all- 838.5 and 807.0 black), County rates down, except black (up from 302.5)
Transportation-Percentage of households without access to vehicles % of respondents missing medical appointments due to transportation	Allegany County: 9% Allegany County: 2011- 25%, 2014-23%, 2016-16%, 2019-19%	U.S. Census Bureau, American Community Survey (2019) Local survey (July 2019)	 Increase in number of people missing appts.
Illiteracy	Allegany County: 11.3%	County Health Rankings/U of Wisc. (2012 Report)	New data not available
Population By Gender, Age, Race & Ethnicity	Population-71,445 52.3% Male 47.7% Female 4.5% under age 5 19.6% 65 yrs. and over 88.2% White 8.1% Black/African Am .1% Native American .9% Asian 1.8% Hispanic or Latino	U.S. Census Bureau, American Community Survey (2019)	No significant changes
Pop. 25+ With Bachelor's Degree or Above %	Allegany County: 18.3% Maryland: 40.9% USA: 33.1%	U.S. Census Bureau, American Community Survey (2019)	Below State (MD 39.6%)
Children living in Single Parent Households %	Allegany County: 36%	County Health Rankings –U of Wisc. (2020)	Continue with increasing trend
Language Other Than English spoken at home %	Allegany County: 4.0%	U.S. Census Bureau, ACS (2014-18)	

Population to Primary Care Provider Ratio	Allegany County: 1650:1	County Health Rank/UW (2020)	Slight improvement since last year

Community Health Needs Assessment

Allegany County Health Department
and
UPMC Western Maryland
(Formerly Western Maryland Health System - WMHS)

To be Released June 2020

Table of Contents **Page**

Allegany County Community Health Needs Assessment

Executive Summary

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act (known together as the Affordable Care Act) require non-profit hospitals to conduct a community health needs assessment and implementation strategy in conjunction with public health entities every three years. These requirements are codified as Internal Revenue Code (Section 501(r)(3)(A). The creation, implementation and ongoing support of a health improvement plan are also required for local health department accreditation through the Public Health Accreditation Board (PHAB).

The Allegany County Health Department (ACHD) and UPMC Western Maryland (formerly Western Maryland Health System -WMHS) co-chair the Allegany County Health Planning Coalition and lead the community health needs assessment process through the Local Health Action Plan (LHAP) Workgroup. The mission of the Allegany County Health Planning Coalition is 'Healthy Lifestyles through collaborative partnerships, evidence-based practices and personal commitments'. Over the years, various community stakeholders have partnered to improve the health of our community. Through the assessment and planning process the Coalition creates a unified plan to collectively address the community needs that impact health.

Prior CHNAs were completed in 2011, 2014 and 2017. The assessment being completed in fiscal year 2020 will be the fourth cycle and build upon improvements made and lessons learned in prior cycles. The community health needs assessment is used to develop a Local Health Action Plan, also referred to as the implementation strategy. The process includes engaging partners in shared priorities, defining target populations, aligning policies and programs, utilizing evidence-based practices and ensuring accountability with identified metrics.

Each CHNA cycle has related to State and National efforts, including the State Health Improvement Process (SHIP) and Healthy People 2020. The County Health Ranking Model created by the University of Wisconsin and Robert Wood Johnson Foundation helps guide the local framework by showing the impact of behavior and socioeconomic factors on health status.

After reviewing the results from prior community health needs assessment cycles, updating secondary data sources, and gathering input through a community survey, a community forum was held. The forum was open to the public and community organizations. A broad spectrum of community partners participated in the event. During the forum data were presented, participants ranked the needs using an assessment tool created by Kanawha County, WV, and aggregate totals were compiled to draft a priority list. Participants discussed the findings, existing community resources, and gap areas. There was consensus on the following three priority areas:

1. Transportation
2. Social Determinants of Health
3. Prevention-Youth Risk Reduction

The supporting strategies already in existence to address these priorities were reviewed along with evidence-based practices. For each priority area the following were created: goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The Local Health Action Plan will be reviewed for approval by the UPMC Western Maryland Board of Directors and the Allegany County Health Planning Coalition before both the needs assessment and action plan are made available to the public before June 30, 2020.

Defined Community Demographics: Allegany County

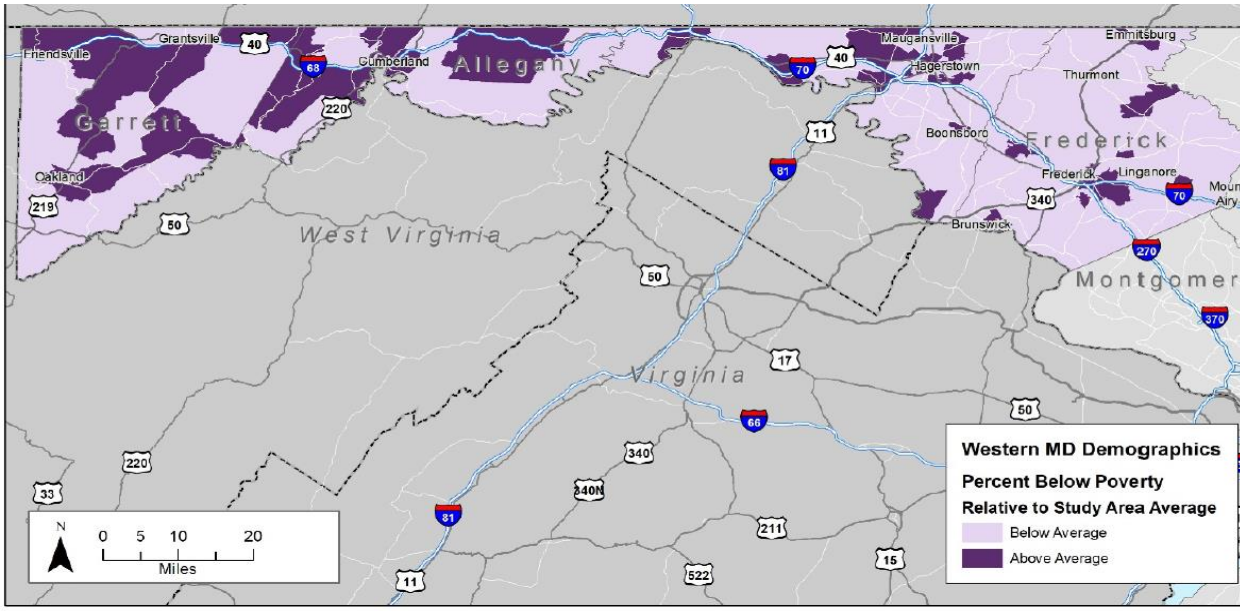
Allegany County, Maryland is the defined community for this CHNA. It is located in rural Western Maryland and has a population of 71,977 (ACS, 5yr. est. 2014-18). As part of the Appalachian region, the county has a larger elderly population, less racial diversity, and lower household incomes and education levels than the state of Maryland as a whole.

In Allegany County, 19.6% of the population is age 65 and older (compared to 14.6% in Maryland) and 17.5% of the county population is under age 18 (compared to 22.4% in Maryland). In Allegany County, 89% of the population is white, 9.6% is black, and 1.8% is Hispanic or Latino. Only 4% of residents speak a language other than English at home compared to 18.4% in Maryland (ACS, 5yr. est. 2014-18).

The median household income in Allegany County is $42,564, well below the state median of $80,711 and the national median of $60,336 (SAIPE 2017). The unemployment rate in Allegany County is 4.4% compared to 3.8% in Maryland (ACS, 5yr. est. 2014-18), and the percent of single parent households continues to rise, to current level of 36% (CHR, 2020).

Socioeconomic factors contribute to poor health outcomes in Allegany County. According to the American Community Survey (ACS, 5yr. est. 2014-18), the percent of county residents living below the federal poverty level is 16.4% compared to 9.4% in Maryland and 14.1% in USA. The percent of children under age 18 living in poverty in Allegany County is 23%, which is decreased since the last cycle. Based on the United Way ALICE (Asset Limited, Income Constrained, Employed) Project, another 25% of Allegany County residents had incomes above the federal poverty level but not high enough to afford a basic household budget including housing, child care, food, transportation, and health care.

The map below shows the Relative Density of Below Poverty Populations (WMD Coordinated Public Transit and Human Services Transportation Plan, 2019).



Allegany County has a high school graduation rate of 90% but the county continues to have low numbers of adults age 25 and over with a bachelor's degree or higher (18.3% compared to 39.6% in Maryland). In addition, 11.3% of Allegany County residents age 16 and over are illiterate.

There were no significant demographic changes found in Allegany County since the last community health needs assessment. However, according to Maryland Vital Statistics 2018 report, the life expectancy for black residents in the county decreased from 80.4 to 75.5 and the mortality rate for non-Hispanic blacks increased from 302.5 to 465.2. These data points will require further investigation and discussion with the impacted population. Meetings have been set up with NAACP to start the discussion.

Process and Methods to Conduct CHNA

Prior CHNA and Progress to Date

There was no written input received on the prior CHNA or implementation strategy. However, through the process and methods utilized to conduct the CHNA and local plan, input was received from public health entities, medically underserved, low income and minority populations, and other representatives of the community.

The first step was to review the successes and remaining opportunities in the current cycle. Based on outcome data, the following areas showed some improvement:

- Heart Disease Death Rate
- Mental Health Provider Ratio
- Dental Provider Rati
- Mental Health Visits to the ED
- Homelessness at Point In Time
- Food Index
- Child Maltreatment Rate

Opportunities for improvement continued in the following areas and were used to direct further investigation.

- Drug Induced Deaths
- Substance Exposed Newborns
- Children Living in Poverty
- Transportation
- Hypertension- ED Visits
- Level 1 & 2 ED Visits
- PCP Ratio
- Sepsis (# Inpatient Discharges)
- Domestic Violence Crimes

In addition to looking at the current cycle, we compared the priority areas over the last three cycles. The table below lists the identified priorities from each cycle.

<table>
<tr><th>2011</th><th></th><th>2014</th><th>2017</th></tr>
<tr><td>Tobacco Cessation (especially during pregnancy)</td><td></td><td rowspan="5">Access and Socioeconomics (children in poverty, primary care access, adult dental access, health literacy, homelessness)</td><td>Substance Abuse</td></tr>
<tr><td>Obesity</td><td></td><td rowspan="4">Poverty</td></tr>
<tr><td>Access to Care and Providers</td><td></td></tr>
<tr><td>Emotional and Mental Health (suicide rate / depression)</td><td></td></tr>
<tr><td>Substance Abuse (alcohol and drugs)</td><td></td></tr>
<tr><td>Screening and Prevention (diabetes, hypertension, cancer)</td><td></td><td rowspan="4">Healthy Lifestyles and Wellbeing (smoking, physical inactivity, domestic violence, fall-related injury and death, healthy weight)</td></tr>
<tr><td>Heart Disease and Stroke</td><td></td><td rowspan="3">Heart Disease</td></tr>
<tr><td>Health Literacy</td><td></td></tr>
<tr><td>Healthy Start (prenatal care)</td><td></td></tr>
<tr><td>Dental</td><td></td><td rowspan="4">Disease Management (behavioral health, diabetes, heart disease, hypertension, asthma)</td><td rowspan="4">Access to Care and Health Literacy</td></tr>
<tr><td>Cancer</td><td></td></tr>
<tr><td>Immunizations (flu)</td><td></td></tr>
<tr><td>Chronic Respiratory Disease</td><td></td></tr>
</table>

Throughout each three-year cycle, progress on the Local Health Action Plan was monitored and its impact on the identified outcome measures was evaluated. The next table shows the key measures and the changes seen over time.

Comparison of Progress Made and Continued Challenges from 2011-2019

Measures/Source	2011	2014	2017	Latest	+ or -
Percentage of children (under age 18) living in poverty (CHR)	19%	26%	27%	23%	
ED visits for hypertension primary diagnosis per 100,000 population (SHIP)	225.1	231.6	279.1	453.3	-
Drug induced death rate per 100,000 population which illicit or prescription drugs are underlying cause (SHIP)	14.2	17.0	18.7	52.6	-
Age-adjusted mortality rate from heart disease (per 100,000 population (SHIP)	256.8	259.8	253.2	230.6	+
% elementary public-school students with BMI at 95th percentile or above (ACPS-Elementary BMI)	20% (799)	17% (699)	20.5% (864)	21.2% (872)	-
% Adults report smoking (CHR)	26%	24%	17%**	16%	+
% of uninsured residents (CHR)	15%	12%	8%	6%	+
Rate of behavioral health related ED visits per 100,000 population (SHIP)	7517.9	6846.8	4723	NA	?
Average number of poor mental health days in last 30 days (CHR)	4.2	3.8	4.1	4.3	-
Average number of poor physical health days in last 30 days (CHR)	4.5	4.5	4.0	3.8	+
% of respondents missing medical appointments due to transportation (local survey)	25%	23%	16%	19%	
Number of level 1 and 2 visits to the ED (WMHS- Meditech)	15,501	8219	6476	7345	-
Population to Primary Care Provider Ratio (CHR)	1023	1698	1620	1900	-
Sepsis-number of inpatient discharges with primary diagnosis (WMHS)	1050 fy16	1123 fy17	692 fy18	863 fy19	
Decrease the number of individuals known to be homeless, receiving homeless services, or at risk of being homeless (PIT)	492	356	304	200	+
Ratio of people per dentist (CHR)	1766 (2013)	1638	1580	1400	+

**Data not comparable to prior years due to change in definition or method

Secondary Data Sources

After reviewing progress and areas for improvement in both prior and the current Local Health Action Plan, a variety of secondary data sources were compiled and reviewed by the LHAP Workgroup. The Workgroup includes representatives from the hospital, health department, community action agency and area health education center. Each of these representatives was tasked with pulling sources available to them and sharing them for review.

The metrics and sources included:

- Maryland's State Health Improvement Process (SHIP)
- Community Commons
- Allegany County Youth Risk Behavioral Survey (YRBS)
- American Community Survey
- Allegany County Public School BMI data
- Community Needs Index
- State Cancer Profile
- WMHS Dental ED Visits
- Drug and Alcohol Related Deaths- BHA, MDH
- Top 10 reasons WMHS ED visits and Admissions
- County Health Ranking
- US News Civic Ranking
- Kids Count
- Healthy People 2020
- Opportunity Nation
- Feeding America
- Local Transportation Survey
- MD College Survey
- Homeless Data-HRDC
- WMHS Dimensional Insight

Needs trending in the wrong direction or off target compared to the state or nation were compiled for review by the Allegany County Health Planning Coalition. The County Health Ranking data from 2010-2019 were reviewed and compared over time when valid. Data points were eliminated from continued review if the sample size was too small, need appeared stable, or issue was represented by another metric. The data table specifying why each measure is a concern can be found in the Appendix.

The Coalition was asked for missing elements and/or corrections. Updated YRBS data was desired but unavailable until after the community forum. Information from the American College Health Assessment was obtained via Frostburg State University regarding vaping use by college students and shared at the forum.

Updated YRBS (2018) data for Allegany County became available after priorities were identified and the first draft plan was compiled. These data were reviewed by members of the LHAP Workgroup and then shared with the Coalition at the March meeting. The data supported selection of Prevention-Youth Risk Reduction priority and several of the YRBS metrics will be utilized as outcome measures in the local health action plan.

<u>Community Input (Primary Data)</u>

Two surveys were conducted in order to obtain input from a broader spectrum of the community, including low income, medically underserved, and minority populations. Coalition members were engaged in the survey design, distribution and review.

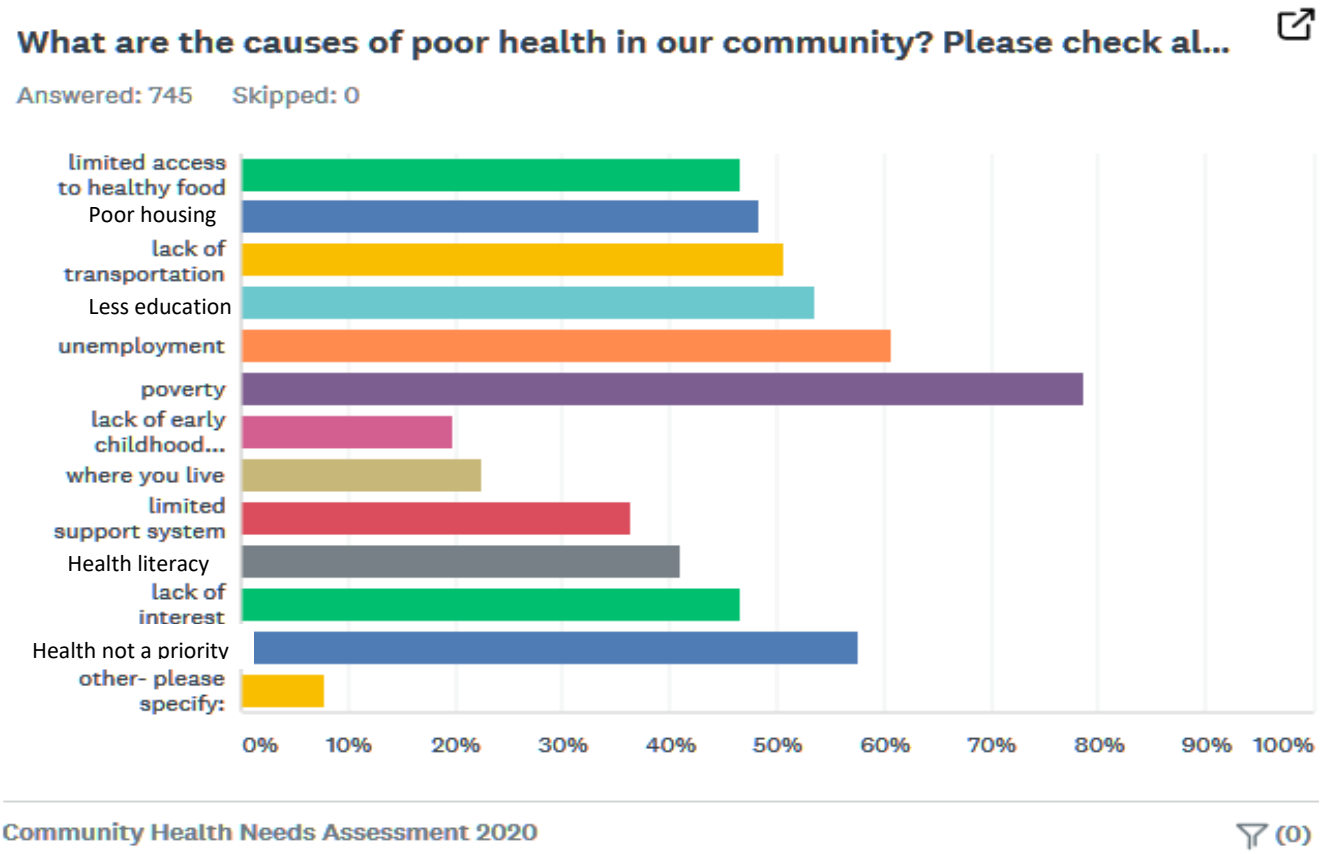
The transportation survey was a paper survey collected at the UPMC Western Maryland Emergency Department, Tri State Community Health Center- Cumberland Primary Care, and the Allegany County Health Department Clinics throughout July 2019. These locations were utilized this year and every other year we conducted this survey based on the target population they serve. A total of 599 responses were received this round and 19% of the respondents reported missed appointments because of problems finding transportation. This was a three percent increase since 2017. 14% of the respondents reported lack of transportation regularly impacted their ability to get to grocery store and 6% noted challenges getting to the food pantry.

Survey monkey was utilized to conduct the other survey, online and in a paper version for those without computer access. The survey link was shared on hospital and health department websites and posted by many other Coalition members. Paper copies were distributed to lower wage employees without easy access to computers, at community outreach events and to participants in Getting Ahead classes. The questions were developed based on utilization of survey results in the last CHNA cycle. One question was multiple choice with the option to check all that apply and to add others. The second question was ranking of defined categories, and the third major question was open ended.

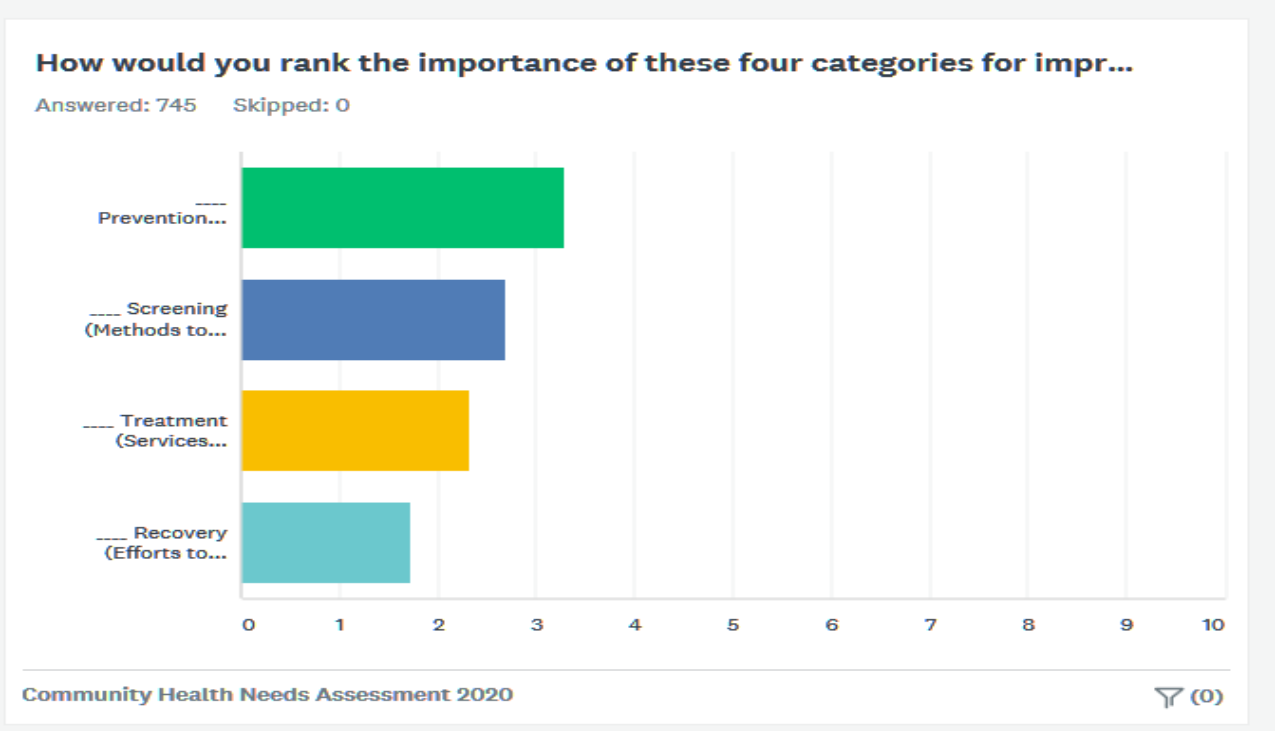
The survey questions were as follows:

- What are the causes of poor health in our community?
- How would you rank the importance of these four categories for improving health?
    - Prevention -Activities to avoid development of disease or disability such as: medical and dental check-ups, youth programs, social involvement, coaching, vaccines, access to health insurance, tobacco cessation, and education on healthy eating, sleep, physical activity
    - Screening -Methods to identify diseases and risks in the earliest stages, before the onset of signs and symptom such as: mammogram, blood pressure, cholesterol, PSA, eye exams, risk assessments for substance use, physical and mental health issues, and social needs assessment
    - Treatment -Services provided to help with a disease or disability such as self-management workshops, social activities, medication management, counseling, dialysis, chemotherapy, drug and alcohol treatment, holistic therapy, and physical/occupational therapy
    - Recovery -Efforts to increase the ability to cope such as housing, job training, social engagement, support groups, childcare, NA and AA meetings, and community education
- What services/resources are needed in our community?

Survey responses were received from 745 individuals. Respondents were also asked to provide Residence, Age, and Level of Education. A summary of the responses follows.



Seventy-eight percent of respondents felt poverty causes poor health in our community, followed by unemployment at 60% and 58% selecting health not being seen as a priority.

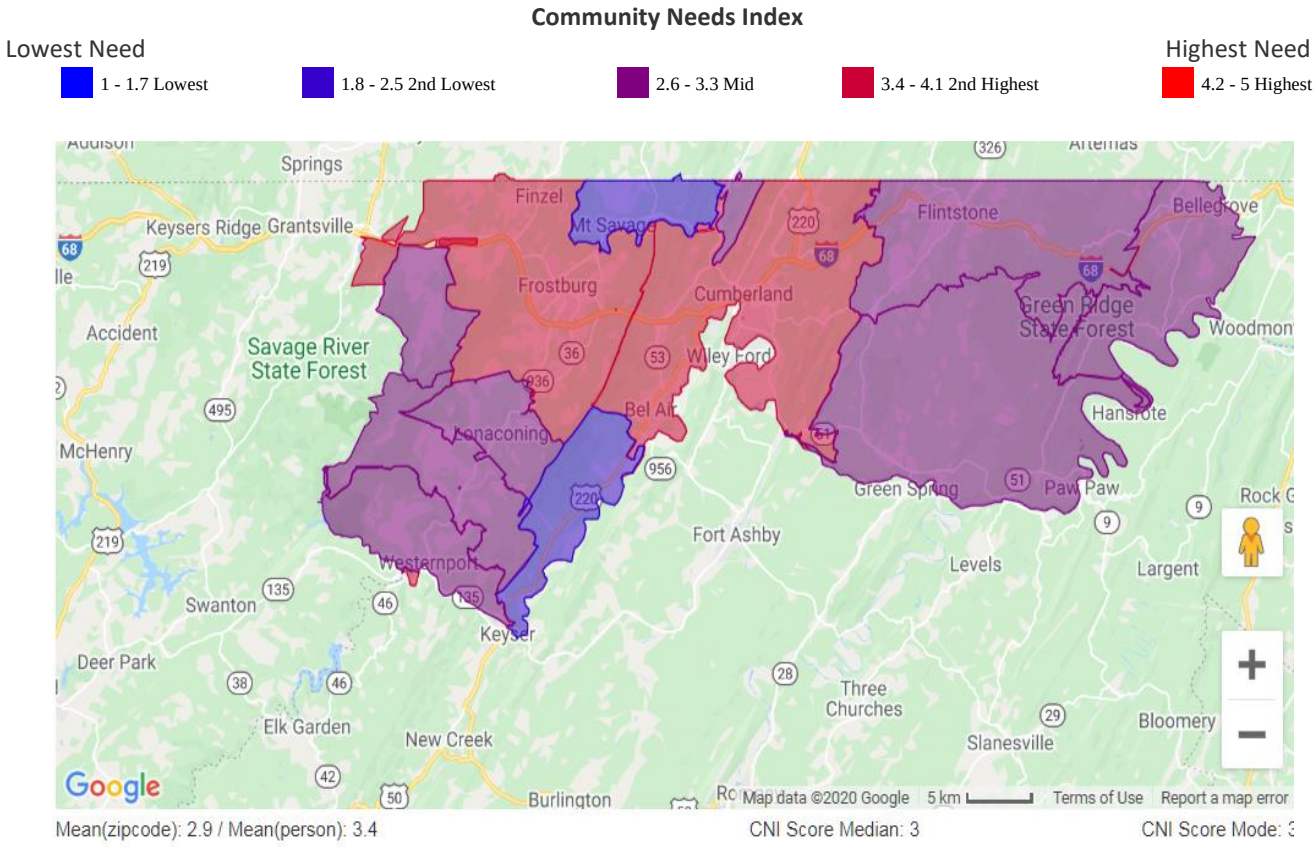


Key words were tagged in the open-ended responses and the tally of such can be found below.

There were no new resource or service needs identified through the community survey. The responses reinforced needs already noted.

Thirty nine percent of the respondents reported Cumberland as their place of residence and 18% noted a Frostburg residence. The remaining 43% were distributed through various locations in the county. Age distribution of respondents was in a bell curve with 25% being the largest age bracket (age 45-54). The level of education reported by respondents did not reflect the education level of the community overall. An exceeding number of college graduates responded to the survey. After doing a separation of the respondents by education level, there did not seem to be significant differences in the overall outcome.

To identify the highest overall need based on geography we looked at the Community Needs Index. The map below shows the Community Needs Index for Allegany County with the highest overall need in shades of red. The CNI scores for various zip codes are listed below the map



Mean(zipcode): 2.9 / Mean(person): 3.4 CNI Score Median: 3 CNI Score Mode: 3

Zip Code	CNI Score	Population	City	County	State
21502	3.6	42311	Cumberland	Allegany	Maryland
21521	3.2	1159	Barton	Allegany	Maryland
21529	3	517	Ellerslie	Allegany	Maryland
21530	3	1493	Flintstone	Allegany	Maryland
21532	3.4	15752	Frostburg	Allegany	Maryland
21539	3	2709	Lonaconing	Allegany	Maryland
21540	3.4	88	Luke	Allegany	Maryland
21545	2.2	2000	Mount Savage	Allegany	Maryland
21555	2.6	1777	Oldtown	Allegany	Maryland
21557	2.4	1791	Rawlings	Allegany	Maryland
21562	2.8	2779	Westernport	Allegany	Maryland
21766	2.6	656	Little Orleans	Allegany	Maryland

All community survey respondents that requested results were sent the summary and invited to participate in a community forum. If unable to attend the forum we invited respondents to submit written or verbal comments.

Identification of Priorities

Community Forum: Ranking Priorities – Criteria and Process

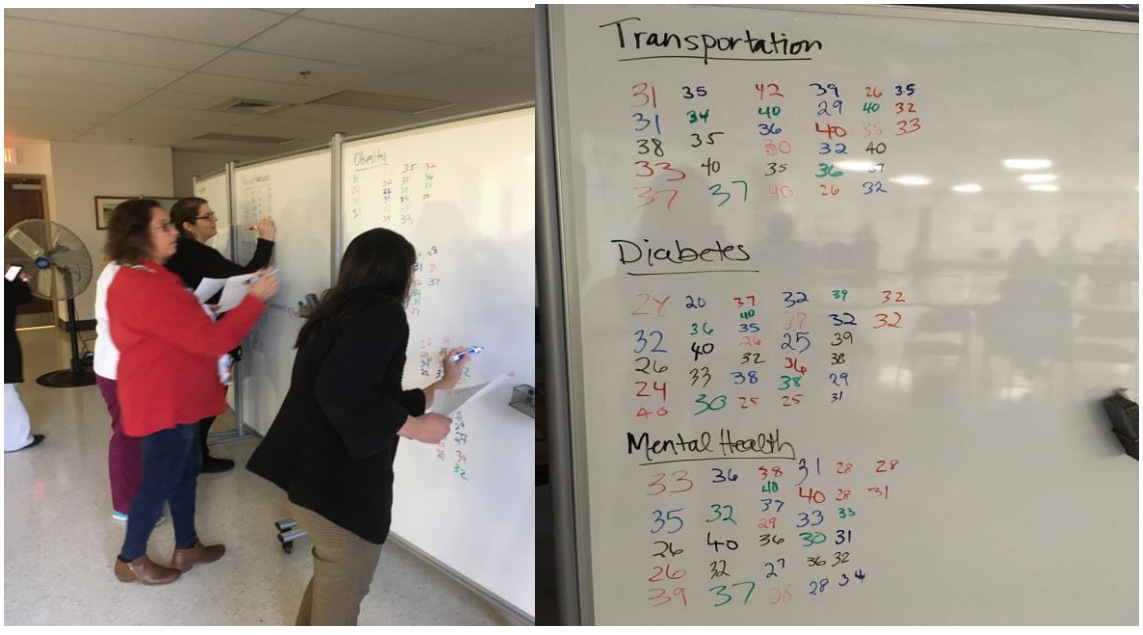
The data and survey results noted previously in this report were presented at a Community Forum on December 5, 2019. A total of 33 coalition partners, affiliates and members of the public participated. The presentation included a review of the following:

- Demographics
- Success and Opportunities for Improvement within Current Cycle
- Comparisons from 2011-2020
- County Health Ranking Trends
- Community Survey Results
- Next Steps

Based on discussions at prior Coalition and Workgroup meetings, there was a more focused assessment of need related to: transportation, diabetes, mental health, hypertension, access to care, poverty & social determinants of health, obesity, substance use, sepsis, and sexually transmitted infection. An assessment tool created by Kanawha County, WV was used to have participants score each of the need areas on a scale of 1-7 (with 7 being completely agree) regarding the following criteria:

- Problem is greater in Allegany County compared to State or region
- We can create an improvement in the quality of life by addressing this problem
- We can make progress on this problem in the short term (3 years)
- The progress we make over the 3 years can be sustained long term
- We can do something about this problem with existing leadership and resources
- We can reduce long term cost to the community by addressing this problem

After the participants rated the needs individually, their total scores for each need were collected. A total ranking score for each need was then calculated.



Participants discussed the needs in order of the total ranking scores. The priority areas were examined more closely regarding the criteria in the assessment tool, and existing community resources were noted. The table below provides a snapshot of the initial results and preferred actions.

Priorities	Total Ranking Score	Priority Order	Selected Yes or No	Notes
Transportation	1089	1	yes	All agreed transportation was the top priority.
Diabetes	1008	6	no	State Plan will involve action focused on diabetes and Coalition will be engaged in creation of local diabetes plan. Action for other priorities will also impact diabetes.
Mental Health	1022	5	*Prevention	There was a desire to focus on mental health resources for youth and prevention with services supporting resilience.
Hypertension	837	10	No	It was felt that BP screenings, care of comorbidities, and Living with Hypertension workshops would address this need.
Access to Care	1070	2	no	The group agreed that access to care will be addressed by other root causes (SDOH).
Poverty and SDOH (food insecurity, housing, etc.)	1061	3	yes	All agreed poverty is a significant need. Focus on addressing the SDOH was recommended. Aspects noted: childcare, education, jobs, poverty, food and/or housing
Obesity (includes physical inactivity)	990	7	*Prevention	Majority felt obesity will be impacted by action for other priorities. Agreed to merge it with other prevention efforts targeting youth (healthy living)
Substance Use (opioids, alcohol, and tobacco)	1027	4	*Prevention	With the numerous community initiatives already underway related to substance use, the group felt the Coalition could do more with prevention, especially vaping.
Sepsis	916	9	no	WMHS has a committee that focuses on sepsis and can share updates and education with partners as appropriate. No additional action recommended.
Sexually Transmitted Infection	932	8	no	ACHD STI Clinic noted as resource for the small numbers. Will explore Title X services for county but not as part of action plan.

The consensus at the close of the Forum was to develop a plan focused on the following priorities.

- Transportation
- Social Determinants of Health
- Prevention- Youth Risk Reduction

An offer was made to email a copy of the presentation slides to participants upon request. Copies of the data tables from which the presentation were compiled will be posted on the Coalition website as part of this report.

Needs not Addressed and Why

Through the Community Health Needs Assessment process, there were some community needs identified which will not be included in the Local Health Action Plan. The Coalition felt that many of these community needs were already being addressed by or planned to be addressed by other partnerships in the community. Some of these efforts are noted as a supporting strategy in the Local Health Action Plan. The reasons needs are not addressed in the LHAP are explained below.

- Diabetes: With the recent release of a Diabetes Action Plan by the State and several grant opportunities, there are efforts underway and being planned to address this need. In addition to the Center for Clinical Resources with diabetes as a focus area, there are self-management programs for both individuals with diabetes and people with prediabetes. There are also two grants underway that bring partners together to impact diabetes (Bridging the Gap-Merck, and SunLife Financial). These grants have produced positive outcomes. During this CHNA cycle, the county will need to create a local diabetes action plan that supports the State plan. The Coalition will oversee the local diabetes action plan, but it will be kept separate from the LHAP.

- Hypertension: Though not an identified priority in the plan, hypertension will be addressed through blood pressure screenings that are offered by the health system and various other partners. High blood pressure is also addressed as a risk factor in many education programs and is the focus of a workshop called Living With Hypertension. This workshop will be offered at least annually in the area.

- Access to Care: It was decided by the Coalition that access to care will be addressed indirectly by other root causes, including transportation and other social determinants of health.

- Sepsis; Though Septicemia continues to be the top inpatient discharge by APRDRG, the number has decreased since its peak in FY17. It is important to maintain a focus on sepsis so that the numbers do not increase. UPMC Western Maryland has a sepsis committee that will focus on this area and will share education with partners as appropriate.

- Sexually Transmitted Infections: Though the number of chlamydia cases per 100,000 population have a negative trend, the percentage of change has been negative in the last two years. The rate of gonorrhea cases has had a 36.7% increase in the last two years, but the number of cases is low (41). Substance abuse was felt to be a major contributing factor for the increase in STI, and the services available through ACHD STI Clinic could address the need. It was noted that there is no longer Title X Family Planning in the county, and this should be explored.

Obesity and substance abuse will be addressed as part of the Prevention-Youth Risk Reduction priority area and include healthy living. The Social Determinants of Health priority will address the root cause of poverty. Though food, housing, childcare, education and employment were all mentioned at the Forum, the Coalition agreed to start with a focus on food and home/community safety, then proceed to the other areas as feasible in later years.

Priorities into Plan

Results from the Community Forum were reviewed at the following Coalition meeting and additional clarification was obtained. A compilation of the discussions at the Coalition meeting were reviewed by the Workgroup. The Local Health Action Plan Workgroup was then tasked with drafting a plan based on these priorities and discussion of community capacity, feasibility, impact, existing resources, and root causes.

It was agreed that SHIP metrics would be incorporated as outcome measures where appropriate. For each priority area the focus was defined, and potential outcome measures identified. Connections to County United Way's Strategy Map were also discussed.

For transportation, it was felt that the Coalition could help with education of options and changes, as well as address the reverse transport options including delivery services, telemonitoring and more. Outcomes would link to the primary transportation survey and look at not only % of missed appointments but also % unable to get groceries.

For social determinants of health, it was agreed to focus on increasing access to healthy food sources. There was some concern about the food insecurity outcome and whether it addressed only the income side of access. Additional review revealed that the metric also includes ability to provide balanced meals. Though housing was an important issue, the group was uncertain about what role the Coalition can play. It was also known that a comprehensive housing survey is underway in the county and next steps might best be decided after hearing the results. The final decision was to focus on home and community safety including security and fire. Additional input will be requested from the Coalition.

For prevention youth risk reduction, the group proposed education regarding stigma and prevention. It was also suggested to offer mind body skills groups and opportunities to connect youth outside of school. Select YRBS data were recommended as outcome metrics for the plan.

To address the changes in mortality and life expectancy seen in the non-Hispanic Black population, discussions were scheduled with the local NAACP. An infographic of Non-Hispanic Black Health Disparities in Maryland was circulated and will be shared at the NAACP meeting along with the data from the CHNA.

In February, a draft plan was shared with the Population Health Council at UPMC Western Maryland and a few edits were recommended; mainly adding to the responsible parties. Through April, the draft plan will continue to be revised by the Coalition and Workgroup. Once the Coalition approves the plan it processed through UPMC Western Maryland Population Health Council and Strategic Planning to the WMHS Board of Directors for input and approval by June 2020. A final draft of the plan can be found in the Appendix and the approved plan will be posted to the Coalition website. Implementation will occur starting July 1, 2020 and extend through June 30, 2023.

Collaborative Plan of Action

<u>Available Resources to Address Needs</u>

Strong partnerships exist in Allegany County to address community health needs. Organizations are working together to implement a variety of strategies. UPMC Western Maryland (previously Western Maryland Health System) provides a continuum of care. Service includes acute care, a Center for Clinical Resources focused on the individuals with multiple chronic conditions, community health and wellness, clinical prevention, care coordination, home care, Community Health Workers, and provider recruitment. With a focus on value-based care it has a vested interest in population health and prevention. UPMC Western Maryland and several community partners participate in the Regional Transformation Grant with Trivergent Health Alliance. During the last three years this effort has increased the regional focus on complex care and behavioral health case management.

The Allegany County Health Department provides screening and prevention programs, care coordination, WIC, inpatient and outpatient behavioral health services, mental health care management, dental services, public health emergency preparedness, and food and water protection. The health department continues to host the

Prescribe Change campaign with a mission to create awareness and educate the citizens of Allegany County about the growing crisis of opioid prescription drugs, and heroin misuse and abuse in our community. In addition to this community outreach, ACHD offers provider education regarding the Prescription Drug Monitoring Program.

In addition to the lead agencies, there are a variety of organizations that collaborate to build resources and improve the overall health of Allegany County. The Maryland Area Health Education Center West (AHEC West) facilitates continuing education and training for health professionals, supports clinical education, facilitates interprofessional experiences, provides community health workers and is a partner of Maryland Health Connection. The Human Resources Development Commission (HRDC) a community action agency provides services for all ages and targets low income populations. HRDC oversees Head Start and the Senior Centers, as well as several assistance programs (transportation, energy assistance, food, etc.). Allegany College of Maryland and Frostburg State University train local health care providers in nursing, psychology, dental hygiene, respiratory therapy, and other areas and support continuing education for health care professionals. The Coalition engages two federally qualified health centers, a few healthcare providers, numerous non-profits, managed care organizations, and other entities providing direct care or addressing the social determinants of health.

The Allegany County Health Planning Coalition continues to build upon the various workgroups that come together to address specific needs in the community. Examples include: Tobacco Free Coalition, Opioid and Overdose Prevention Task Force, Transportation Committee and Bridges to Opportunity. Launched in 2014, *Bridges to Opportunity* is a community initiative to reduce poverty by helping individuals and the community 'get ahead' through relationships and resources. Through outreach and poverty simulations, Bridges to Opportunity has brought together people from various classes to discuss identified barriers and potential strategies to address the social determinants of health.

The Allegany County Health Planning Coalition has pursued and received several grants collectively. With funding from the Maryland Community Health Resources Commission, the Coalition launched Healthy Allegany which included Community Health Worker training and community outreach, a mobility manager and transportation vouchers, cultural competency trainings, as well as efforts to strengthen the Coalition. A comprehensive community resource guide was compiled in 2013 and annual updates were made until the online resource directory replaced it in 2019 (Path2Help.com). In addition to this public facing directory, several of the partners are connected to the expanded online platform- Aunt Bertha and can use it for closed loop referrals.

The Memorandum of Understanding (MOU) was updated this year as part of this CHNA cycle. We continue to insure representation from the following sectors of the community: media, housing, law enforcement, economic development, physical and behavioral health providers, and case management. Some members are more engaged than others. The Coalition continues to reach out to new community members to represent additional sectors and populations. As of January 2020, there are 52 agencies/organizations signed on to support the Coalition mission of healthy lifestyles through collaborative partnerships, evidence-based practices and personal commitments. The Coalition Membership can be found in the Appendix.

As we develop a plan to address the new priorities, we are also identifying available resources. When appropriate the Coalition will guide action with partners, and other times the Coalition will monitor existing resources as a supporting strategy in the plan.

The following are the assets identified to date:

- The Transportation Committee was reactivated this year and involves numerous partners. It was determined their efforts will be a supporting strategy in the plan. The Committee will also be asked for input on the education component in the plan.

- Through efforts to address poverty, the community has increased food resources to include: Groceries to Go, Brown Bag Program, Emergency Food Packs, Discharge Meal Program, Food Farmacy, Veggie Van, and school nutrition programs by UM Extension.

- Several initiatives are underway or in the planning stage which will support the Prevention and Youth Risk Reduction priority. Allegany College of Maryland received a grant from the Maryland Opioid Operational Command Center to bring training from the Center for Mind-Body Medicine to our community. The grant will fund the CMBM Professional & Advanced training for 150 participants. Upon completion of the Advanced Training, participants are committed to facilitate Mind-Body Skills group and information workshops in the community. The goal is to reach 2,000 individuals with the groups and workshops. Several of these groups will target youth.

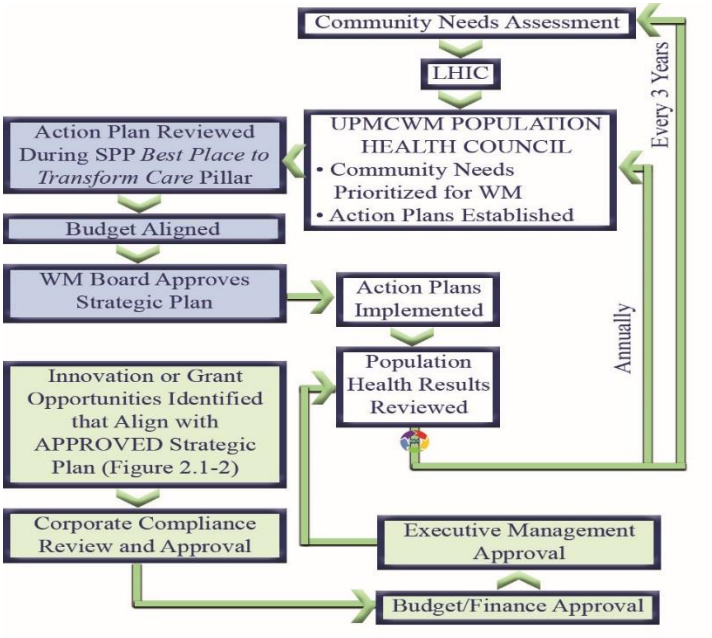
- The Local Management Board has spearheaded efforts to expand training in Trauma Informed Care and has applied to get staff trained in Family Functional Therapy. These are both supporting strategies to the plan.

- The County United Way Impact Grant Strategy Map includes many of the same priorities as the LHAP. As they progress with grant selection and implementation, we will be able to identify potential connections.

- The NAACP is a member of the Coalition. With the negative changes in the mortality rate and life expectancy for black residents, it is anticipated that this group will be engaged more in developing strategies.

<u>Link to Community Benefit</u>

In addition to collaborating with public health entities on the Community Health Needs Assessment, hospitals are encouraged to align their community benefit operation in some way with the implementation strategies selected to address priority needs. UPMC Western Maryland does this by sharing the data collected as part of the Community Health Needs Assessment with its Population Health Council.



Community Support Process

The Population Health Council reviews the findings to identify key opportunities for involvement of UPMC Western Maryland internally and with the Local Health Improvement Coalition (LHIC) regarding the community. As a cycle of learning, these opportunities are then considered in the strategic planning process. Once priorities, plans and metrics are approved and aligned with the budget process, the CHNA and implementation plan are presented to the Board for approval, then implemented, tracked and measured.

The following are some of the strategic objectives for 2018-2020 in the UPMC Western Maryland Strategic Plan that have a connection to the Coalition's Local Health Action Plan.

- Improve health status and social determinants of health
- Expand pre-hospitalization and post-acute care services to reduce utilization
- Transform care delivery models

One example of this process is UPMC Western Maryland utilizing the findings from Aunt Bertha (on-line closed loop referral network), Voice of Customer, secondary data, and the community survey to identify food insecurity and transportation as significant needs in our community. Realizing that the health system cannot combat these needs alone, we applied a ecosystems approach to clarify the needs and processes, align stakeholders and build strategies to address social needs in a complex system. We are leading an initiative with community partners to map the existing food resources, streamline the intake process, identify gaps and opportunities for increased efficiency in the food system, and to establish a collective approach to address food insecurity. Through the local health action planning process additional strategies will be defined for addressing the priority needs.

Alignment of activities and investments to improve population health is essential. Through common measures the impact of collaborative efforts can be evaluated. With the UPMC Western Maryland Director of Community Wellness serving as co-chair of the Local Health Improvement Coalition, and coordinator of the hospital's community benefit reporting the process is coordinated. Progress on strategies in the Local Health Action Plan will be tracked and reported to the HSCRC and IRS as required, noting the specific role of UPMC Western Maryland.

<u>Hospital Role</u>

In addition to the role UPMC Western Maryland plays in coordination of the CHNA and implementation strategy with the Allegany County Health Planning Coalition, it takes on responsibility for numerous activities within the plan. UPMC Western Maryland currently plays a significant role in addressing social determinants of health and will continue to do so in the next CHNA cycle. It also has an interest in prevention and improving population health.

The following is a list of the roles and functions that UPMC Western Maryland will assume with the new plan.

Transportation:

- Facilitate the Transportation Committee advocating for improved coordination of services
- Partner in Mobility Management and fund additional transportation support for patients
- Provide transportation education
- Maintain relationships with numerous transportation providers to help patients with access
- Guide exploration of delivery services and reverse transportation options

Social Determinants of Health:

- Oversee the workgroups creating food systems maps and solutions
- Support establishment of more healthy food sources in the community
- Coordinate development of education and assessment process to improve home and community safety
- Assist with locating funds to support needed resources to address safety issues
- Continue to serve as the anchor institution for Bridges to Opportunity and strive to build resources
- Host Aunt Bertha and Path2Help and engage Community Health Workers and Care Coordination in addressing social needs of patients

Prevention- Youth Risk Reduction:

- Implement mind body skills groups and workshops collaboratively via ACM
- Share in the schools the expertise of respiratory staff regarding vaping
- Organize cross sector forums on risk behaviors and prevention strategies
- Identify and implement a program to increase healthy choices which will reduce obesity

UPMC Western Maryland will also communicate with NAACP and County United Way to insure integration of efforts.

Summary of Plan Development and Approval Process

As stated in the County Health Ranking process, "evidence of effectiveness is one of many factors to consider when choosing a strategy to solve a community health challenge. Community 'fit,' readiness, priorities, capacity, and resources are also important considerations." Starting with the Community Forum and several of the Coalition and Workgroup meetings that followed, existing strategies and recommended practices to address the priority needs were explored.

The LHAP Workgroup compiled the various data points and information noted throughout this report and identified best practices both underway in the community and those which may contribute to achievement of the goals and address the priority needs. For each objective a lead partner is identified and assumes responsibility to implement and monitor activities with the key partners.

Progress reports are given at least every six months and the outcomes are reviewed annually. As issues arise or innovative solutions are identified, the LHAP Workgroup reviews the information and presents it to the Coalition for discussion and decision. At least one a year, the Allegany County Health Planning Coalition updates the data in the Community Health Needs Assessment, incorporates new or changing needs, and alters the Local Health Action Plan as appropriate.

A final draft of the Local Health Action Plan is included in the Appendix. By June 30, 2020, the approved Plan will be posted to the Allegany County Health Planning Coalition website at www.alleganyhealthplanningcoalition.com. For questions, please contact one of the Allegany County Health Planning Coalition Co-Chairs, Jenelle Mayer at 301-759-5001 or Nancy Forlifer at 240-964-8422.

Appendix

Allegany County Health Planning Coalition
Community Health Needs Assessment FY20
Measures for Review

Measures	Allegany Co	Why is this measure a concern?	Source
Sexually Transmitted Infections Chlamydia cases / Population * 100,000	336.4	• Continuing Increase in County (236, 262,325.6, 336.4) • See trend chart • Chlamydia rate 24.7% increase between 2018 and 2019 (20 cases)	County Health Ranking 2019
Substance exposed newborns	16.8% of deliveries	• About the same number of cases at WMHS • 161 substance exposed newborns of which 40 were dependent	WMHS CY18
Physically Active Adults (self-report 150/75 minutes.wk)	46.1%	• (2011 -52.2%,41.2%-2014, 46.1%-2017) • Below state and nation levels • Adult obesity rate is getting worse • CHR 27% of adults physically inactive compared to 21% MD	SHIP
Child Maltreatment rate- Number of total indicated findings for physical and sexual abuse, mental injury-abuse, neglect, and mental injury-neglect among children, rate per 1000 >18yrs	19.6	• Baseline was 23.3, last year 21.1 and now 19.6 • Does anecdotal data reflect the same?	SHIP
Domestic Violence- Number of domestic violence crimes per 100,000	653.5	• Increasing after dropping a couple years (719.5, 608.6, 610,653.5)	SHIP
ED visits for diabetes primary diagnosis per 100,000 population	286.1	• Trending in wrong direction-2010 (185.2) 2017-286.1 • Above State at 243.7	SHIP (2017)
ED visits for mental health related diagnosis per 100,000 population	3309.6	• Decrease from last year (2320.6, 4722.9, 3309.6) still above baseline • Current measure does not include addiction related visits	SHIP
Teen Birth rate -ages 15-19 years (per 1,000 population	23.5	• Trending downward in County (31.8 – 2010) • Above MD at 14.2	SHIP (2017)
% students ever using e-vapor products	27.1% middle school 55.4% high school	• Above state in use of e-vapor products • More than double the Healthy People target (21%) in high school • Increased since last local survey-18.4% middle school 48.7% high school	YBRS2018 SHIP
% FSU students have tried e-cigs at least once % FSU students using e-cigs in last 30 days	23.1% 14%	• MD Survey adds that 28% of alcohol or marijuana users indicate using e-cigs in last 30 days. • 51% of past year marijuana users indicate using e-cigs as method to consume THC	2019 American College Health Asst. 2019 Md College Survey
Alcohol Impaired Driving Deaths - Percentage of driving deaths with alcohol involvement	48%	• Negative Trend in County (29,34,44. 39,56,48) • MD 30% and top performers in US 13%	County Health Ranking

Measures	Allegany Co	Why is this measure a concern?	Source
Food insecurity -% population who lack access to adequate food	13.0%	• 29.8% County population without access to large grocery store, (MD, US and Peer Groups- 22%) • MD 11% food insecure, of this group 69% below SNAP threshold • Percentage of population who are low-income and do not live close to a grocery store 13% in county and 3% for MD • With 10 as best Food Environment Index, County score has improved from 6.4 to 7.3, still below state at 9.1	County Health Ranking 2019 US News Civic Ranking
Sepsis-number of inpatient discharges with primary diagnosis	863	• Septicemia was top reason for inpatient discharges in FY19 • Had decreased to 692 last year, now going back up, still below baseline 1050	WMHS FY19
Diabetes Prevalence-Percentage of adults aged 20 and above with diagnosed diabetes.	15%	• MD-11% and top US performers 9%	County Health Ranking 2019
Adult Obesity (over age 20, BMI 30 and over	38%	• MD- 30% and top US performers 26%	County Health Ranking 2019
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	15%	• MD at 17% and top US performers at 9% • Majority due to cost, 14% of county population (3606 households) spends more than 50% of income on housing, MD 15% and top US at 7% • 69% homeownership in county, MD at 67%	County Health Ranking 2019
Primary Care Doctor Availability/100K pop.	52.7%	• MD-87.7%, US-75.6%, Peer Group 58.3% • Reflects the PCP ratio in County Health Rankings	US News Civic Ranking
Deaths of Despair	46.7%	• MD-32%, US 36% and Peer Group 42.1% • Poor Mental Health days increase in County (4.3) compared to 3.5 in MD, 3.8 in US and 4.2 in Peer Group	US News Civic Ranking
Percentage of students entering Kindergarten ready to learn	39%	• 45% MD	SHIP 2017
Age adjusted Cancer mortality rate	164.8	• Above MD at 154.5 and MD is above the US rate	SHIP (2015-17)

Assessment and Ranking Tool

Scale: 1=Completely Disagree 2=Strongly Disagree 3=Disagree 4=Neither Agree nor Disagree 5=Agree 6=Strongly Agree 7=Completely Agree	Problem is greater in Allegany County compared to state or region	We can create an improvement in the quality of life by addressing this problem	We can make progress on this problem in the short term (3 years)	The progress we make over the 3 years can be sustained long term	We can do something about this problem with existing leadership and resources	We can reduce long-term cost to the community by addressing this problem	TOTAL
Transportation							
Diabetes							
Mental Health							
Hypertension							
Access to Care							
Poverty and SDOH (food insecurity, housing, etc.)							
Obesity (includes physical inactivity)							
Substance Use (opioids, alcohol, and tobacco)							
Sepsis							
Sexually Transmitted Infection							

Source: Kanawha County

Based on the results of a community health needs assessment, the Allegany County Health Planning Coalition (Coalition) created the following 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 three priority areas:

Transportation

Social Determinants of Health

Prevention- Youth Risk Reduction

Each priority area includes goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The LHAP is a three-year plan and progress is reviewed in six-month phases: Phase 1 is July-December 2020, Phase 2 is January-June 2021, Phase 3 is July-December 2021, Phase 4 is January-June 2022, Phase 5 is July-December 2022, Phase 6 is January-June 2023. 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.

Acronyms and Abbreviations

ACHD = Allegany County Health Department
AHEC = Area Health Education Center
AHR = Allegany Health Right
Assoc. Ch. = Associated Charities
Bd of Ed = Board of Education
CHW = Community Health Worker
CMA = Cumberland Interfaith Ministerial Association
CUW = County United Way
DSS = Department of Social Services
ED = Emergency Department
FCRC = Family Crisis Resource Center
FTE = Full-time Equivalent
FVC = Family Violence Council
HRDC = Human Resources Development Commission
LMB = Local Management Board
MH = Mental Health
MHA = Mountain Health Alliance
MHCE = Make Healthy Choices Easy
MHSO = Mental Health System's Office
OB= Obstetrics
PCP = Primary Care Provider
TSCHC = Tri-State Community Health Center
TSWHC =Tri State Women's Health Center
UM = University of Maryland
WMd = Western Maryland
WMHS = Western Maryland Health System now UPMC Western Maryland

Transportation

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to safe, affordable and reliable transportation	Each year of this cycle educate at least 100 transportation users or service providers about the transportation options and system changes. Each year of this cycle identify existing transportation alternatives (including delivery services and reverse transport options) and seek at least one new option to reduce the transportation barrier.	**Transportation Committee,** UPMC WMd Mobility Mgmt.- HRDC Med Trans- NEMT ACHD or Statewide vendor, All Trans- County Transit Taxi (Crown, Yellow, QCity) County Medical Transport, Bay Runner Garrett Transit Mineral County - Logisticare, PVTA CUW, Communities for Life, Service Providers	Reduce % of respondents missing medical appointments due to transportation Reduce % of respondents not getting to grocery store	25 14 grocery 6 foodbank	10 12 total	19 14 grocery 6 foodbank

Supporting Strategies

Transportation Committee-

- One Call One Click-shared system (Trip Master- CTS Software) for scheduling and tracking rides
- Linking of dispatch services
- Streamline the rules across services Planned coordination of transports to outlying areas
- Coordination of rides during off hours cross agency
- Collaborate on grants for transportation
- Increased education for users and staff assisting people with transportation
- Establishment of Express Loops with certain days and routes- use geo- mapping of historic use rides

Social Determinants of Health

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to healthy foods and local food sources	Utilize information obtained through food system mapping to identify and establish 5 sites per cycle year where healthy food choices or local food sources will be increased.	Bridges to Opportunity-poverty SunLife Partners- Aramark, WMFC, food bank, ACM, AHEC, As. Ch, HRDC, **UPMC W MD**., UM Ext., FSU, ACHD, Funders-CareFirst, Singer, etc.	% population who lack access to adequate food (CHR)	12	9	13
Improve home and community safety (fire, security, safety)	Each year of cycle provide education and assessment process focused on improving home and community safety for 100 or more people. By June 2023, assess and assist 100 individuals with home or community safety need	Cumberland Housing Authority and Alliance, HRDC, ACHD, Law Enforcement and Fire Dept. Home Care and CHW, FSU, AHEC **Committee-** Brittany, Julie, Heather, Allison	Reduce # of poor mental health days (CHR)	4.7	3.8	4.7

Supporting Strategies

SunLife Partners- Food Insecurity- Systems mapping and identification of key strategies to overcome the gaps and increase efficiency
WMHS- Food Farmacy

County United Way -Safe, Affordable Housing: Everyone deserves home with basic amenities- space, heat/cooling, water/sewer, secure roof and safe entry
Bridges to Opportunity- Home sharing

Prevention- Risk Reduction Youth

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Improve the mental and physical health of youth through prevention and risk reduction focused on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity).	By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community Each cycle year host at least 3 cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community (such as-stigma-Distorted Perception, vaping-Don Swogger, family needs and trauma informed care- Family First).	ACHD and Frostburg Coalition- Vaping-Don Swogger ACPS, ACHD, LMB, DJS- Youth Mental Health **ACM**- CMBM-healthy living **UPMC W MD**--Wellness and Resp. Dept healthy living AHEC Families First Family Junction, 4H UMExt- MDROTA.org	% students ever using e-vapor products YRBS -2018 % students ever seriously thought about killing self YRBS % students not physically active 60 min. 5 or more days/wk. YRBS % elementary public school students with BMI at 95th percentile or above	27.1 ms 55.4 hs 22.3 ms 20.5 hs 41.9 ms 72.9 hs 20	25.1 ms 53.4 hs 21.3 ms 19 hs 39 ms 49 hs 13.6	27.1 ms 55.4 hs 22.3 ms 20.5 hs 41.9 ms 72.9 hs 21.2

Supporting Strategies

ACPS- Vaping addressed in all school levels

LMB-Trauma Educational series and FFT Multisystemic Therapy (DJS)

County United Way- Impact Grant- Strategy Map

- Prevent ACEs from contributing to life-long outcomes for current and future generations
- Provide trauma-informed care and accessible evidence-based treatments from trained and knowledgeable specialists
- Ensure a continuum of services exist to meet behavioral health needs

Other Supporting Strategies

<u>Eliminate Health Disparities</u> **–** NAACP, County United Way,

Allegany County Health Planning Coalition Membership List

Name of Organization/Group	Sector	Contact
Allegany County Health Department	Public Health	Jenelle Mayer (Health Officer) Jennifer Corder (Medical Director) Brenda Caldwell (Preparedness/Website) Lynn Kane (Accreditation) Tricia Evix (WIC/Nutrition) Paula McKenzie (Cancer) Lisa Beardsley (MedTrans) Margaret Wright Catherine Parish Leann Frank Trish Tichnell
Western Maryland Health System	Non-profit Hospital	Nancy Forlifer (Director Community Wellness) Jo Wilson (VP Population Health) Ben Kosewski
Tri-State Community Health Center	FQHC	Mandy Blackburn (Site Manager) Susan Walter (CEO) Sheila DeShong (COO) Ashley Barnes (Case Mgr.-Women's Health)
AHEC West	Non-profit Health Education	Susan Stewart (Exec. Director)
Allegany Human Resource Development Comm.	Community Action	Wendolyn McKenzie
County United Way	Community Development	Michele Walker Juli McCoy
Allegany Board of Education	Education	Kim Green (Administration) Tracey Leonard (Health & PE)
Allegany Radio	Media	Annette Wolford Patrick Sullivan
Cumberland Housing Alliance	Housing	Jaime Thomas Steve Kesner (CEO)
Allegany Chamber of Commerce	Economic Development	Stu Czapski (Executive Director)
Chapman & Associates	Medical Provider	Cathy Chapman (CRNP)
Mountain Laurel Medical Center	FQHC	Sandra Moore Jonathan Dayton

Name of Organization/Group	Sector	Contact
Pressley Ridge	BH Provider	Mary Beth DeMartino (Executive Director)
Allegany County Sheriff's Office	Law Enforcement	Craig Robertson (Sheriff)
Office of Consumer Advocate	Behavioral Health	Margaret Paul (Executive Director)
Salvation Army	Non-profit	Ronnette Smith (Administration) Karen Wells (Social Worker)
YMCA	Non-profit	Julie O'Neal (CEO)
Western MD Food Bank	Non-profit- Food	Amy Moyer (Executive Director)
Local Management Board	Non-profit	Renee Kniseley (Executive Director)
Cumberland Area Interfaith Ministerial Association	Faith Based	Rebecca Vardiman (President)
Aetna	MCO	Sarah Bush
NAACP	Non-profit	Carmen Jackson (President)
University of MD Extension	Higher Education	Lisa McCoy
Maryland Physicians Care	MCO	Shannon Jones Christie Staubs
Priority Partners	MCO	Lisa Moran
Allegany College of Maryland	Higher Education	Kathy Condor
Allegany Transit	County-Transportation	Elizabeth Robison-Harper
Friends Aware	Non-profit- Human Service	Robert Godfrey
Allegany County Dept. Social Services	County Social Service	Courtney Thomas (Director) Kim Truly
Associated Charities	Non-profit-Prescription & Emergency Svs	Deanna Clark (Executive Director)
----	Pharmacies	Bill McKay
Drug Abuse Alcohol Council	Coordinating Entity	Kathy Dudley
Tobacco Free Coalition	Prevention Coordinating Entity	Kathy Dudley
Family Junction	Non-profit	Melanie McDonald
Frostburg State University	Higher Education	Doug Brown (PA Medicine)
Board of Health	County Govt.	Jacob Shade

Name of Organization/Group	Sector	Contact
Park and Recreation Department	City Govt.	Diane Johnson
Mental Health Advisory Board	Coordinating Entity	Becki Clark
Family Crisis Resource Center	Non-profit	Sarah Kaiser
Tri County Council	Regional Coor. transportation	Ryan Davis
Dental Society	Dental Profession	Dorian Birkholz Diane Romaine
Opioid and Overdose Prevention Task Force	Coordinating Entity	Becky Meyers
Western Maryland Food Council	Coordinating Entity	Dan Fiscus
Mountain Health Alliance	Coordinating Entity	Catie Wampole
Western Maryland Health Connection	Insurance	David Stewart Carol Morgan
Homeless Resource Board	Coordinating Entity	David Nedved
Workforce Development	Workforce, Govt.	Matt Shipway
Jane's Place	Child Protection, Non-profit	Marlene Oleksak Alexis Jackson
Archway Station	Non-profit	Jim Raley
SurgCenter of Western Maryland, LLC	Provider	Raghu Reddy
Apples for Children	Childcare	Heather Glass
Hororwitz Center for Health Literacy, University of MD	Health Literacy	Anna Shao, MPH, CHES
Community Trust Foundation	Funder	Leah Shaffer

Allegany County Health Planning Coalition
Local Health Action Plan July 2020-June 2023

Based on the results of a community health needs assessment, the Allegany County Health Planning Coalition (Coalition) created the following 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 three priority areas:

Transportation

Social Determinants of Health

Prevention- Risk Reduction

Each priority area includes goals, SMART objectives, responsible parties, and outcomes including baseline, target, and current status. The LHAP is a three-year plan and progress is reviewed in six-month phases: Phase 1 is July-December 2020, Phase 2 is January-June 2021, Phase 3 is July-December 2021, Phase 4 is January-June 2022, Phase 5 is July-December 2022, Phase 6 is January-June 2023. 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.

Acronyms and Abbreviations

ACHD = Allegany County Health Department
AHEC = Area Health Education Center
AHR = Allegany Health Right
Assoc. Ch. = Associated Charities
Bd of Ed = Board of Education
CHW = Community Health Worker
CMA = Cumberland Interfaith Ministerial Association
CUW = County United Way
DSS = Department of Social Services
ED = Emergency Department
FCRC = Family Crisis Resource Center
FTE = Full-time Equivalent
FVC = Family Violence Council
HRDC = Human Resources Development Commission
LMB = Local Management Board
MH = Mental Health
MHA = Mountain Health Alliance
MHCE = Make Healthy Choices Easy
MHSO = Mental Health System's Office
OB= Obstetrics
PCP = Primary Care Provider
TSCHC = Tri-State Community Health Center
TSWHC =Tri State Women's Health Center
UM = University of Maryland
WMd = Western Maryland
WMHS = Western Maryland Health System **now UPMC Western Maryland**

Transportation

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to safe, affordable and reliable transportation	Each year of this cycle, educate at least 100 transportation users or service providers about the transportation options and system changes. Each year of this cycle, identify existing transportation alternatives (including delivery services and reverse transport options) and seek at least one new option to reduce the transportation barrier.	**Transportation Committee** UPMC W Md. Mobility Mgmt-HRDC Med Trans- NEMT-ACHD or statewide vendor, All Trans- County Transit Taxi (Crown, Yellow, QCity) County Medical Transport, Bay Runner, Garrett Transit Mineral County - Logisticare, PVTA CUW, Communities for Life, Service Providers	Reduce % of respondents missing medical appointments due to transportation Reduce % of respondents not getting to grocery store	25 14 grocery 6 foodbank	10 12 total	19 14 grocery 6 foodbank

Supporting Strategies

Transportation Committee-

- One Call One Click-shared system (Trip Master- CTS Software) for scheduling and tracking rides
- Linking of dispatch services
- Streamline the rules across services Planned coordination of transports to outlying areas
- Coordination of rides during off hours cross agency
- Collaborate on grants for transportation
- Increased education for users and staff assisting people with transportation
- Establishment of Express Loops with certain days and routes- use geo- mapping of historic use rides

Social Determinants of Health

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Increase access to healthy foods and local food sources	Utilize information obtained through food system mapping to identify and establish 5 sites per cycle year where healthy food choices or local food sources will be increased.	Bridges to Opportunity-poverty SunLife Partners-Aramark, WMFC, food bank, ACM, AHEC, As. Ch, HRDC, **UPMC W Md**, UM Ext., FSU, ACHD, Funders-CareFirst, Singer, etc.	% population who lack access to adequate food (CHR)	12	9	13
Improve home and community safety (fire, security, safety)	Each year of cycle, provide education and assessment process focused on improving home and community safety for 100 or more people. By June 2023, assess and assist 100 individuals with home or community safety needs	Cumberland Housing Authority and Alliance, HRDC, ACHD, Law Enforcement and Fire Dept., Home Care and CHW **Committee** (Julie, Brittany, Heather)	Reduce # of poor mental health days (CHR)	4.7	3.8	4.7

Supporting Strategies

SunLife Partners- Food Insecurity- Systems mapping and identification of key strategies to overcome the gaps and increase efficiency
UPMC W MD- Food Farmacy

Bridges to Opportunity- Home sharing
County United Way -Safe, Affordable Housing: Everyone deserves home with basic amenities- space, heat/cooling, water/sewer, secure roof and safe entry

Prevention- Risk Reduction Youth

GOAL	SMART OBJECTIVE	WHO	OUTCOMES	BASELINE	TARGET	CURRENT STATUS
Improve the mental and physical health of youth through prevention and risk reduction focused on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity).	By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community Each cycle year host at least 3 cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community (such as- stigma-Distorted Perception, vaping-Don Swogger, family needs and trauma informed care- Family First).	ACHD and Frostburg Coalition- Vaping- Don Swogger ACPS, ACHD, LMB, DJS- Youth Mental Health **ACM**- CMBM- healthy living **UPMC W MD**- Wellness and Resp. Dept healthy living AHEC Families First Family Junction, 4H UMExt- MDROTA.org	% students ever using e-vapor products YRBS -2018 % students ever seriously thought about killing self YRBS % students not physically active 60 min. 5 or more days/wk YRBS % elementary public school students with BMI at 95th percentile or above	27.1 ms 55.4 hs 22.3 ms 20.5 hs 41.9 ms 51.5 hs 20	25.1 ms 53.4 hs 21.3 ms 19 hs 39 ms 49 hs 13.6	27.1 ms 55.4 hs 22.3 ms 20.5 hs 41.9 ms 51.5 hs 21.2

Supporting Strategies
ACPS- Vaping addressed in all school levels

LMB-Trauma Educational series and FFT Multisystemic Therapy (DJS)

County United Way- Impact Grant- Strategy Map

- Prevent ACEs from contributing to life-long outcomes for current and future generations
- Provide trauma-informed care and accessible evidence-based treatments from trained and knowledgeable specialists
- Ensure a continuum of services exist to meet behavioral health needs

Other Supporting Strategies
Eliminate Health Disparities – NAACP, County United Way,

UPMC WESTERN MARYLAND Business Office 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, 2/2017, 6/2019, 4/2020, 3/2021

FINANCIAL ASSISTANCE POLICY

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:
UPMC Western Maryland is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, color, national origin or creed. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the Code of Maryland Regulations 10.37.10.26 and has been adopted by "UPMC Western Maryland' Board of Directors.

POLICY:
This policy applies to all patients seeking emergency or other medically necessary care at UPMC Western Maryland. This policy also applies to patients seeking treatment at any UPMC Western Maryland owned physician practice. These entities are hereinafter collectively referred to as "UPMCWM."

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

PROCEDURE:
OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient.
    a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
        i. A list of our health care service providers is available at. https://www.wmhs.com/find-a-provider. Only providers employed by UPMCWM are covered under this policy and are indicated on the provider list.
    b. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.
    c. Should a patient need assistance applying for Financial Assistance; help is available at our physical location 12500 Willowbrook Road, Cumberland, MD 21502. Patients can also call 240-964-8435 with any inquiries regarding the Financial Assistance application process.

2. Notice of the Availability of Financial Assistance:
    a. UPMCWM will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available at UPMCWM' locations.
    b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Billing Office, website, and other key patient access areas.

c. A statement on the availability of financial assistance will be included on patient billing statements.
d. A Plain Language Summary of UPMCWM' Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.
e. UPMCWM' Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at UPMCWM or via mail as well as on UPMCWM' website at https://www.wmhs.com/patients-and-visitors/patients/financial-assistance
f. UPMCWM' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in a different language upon request.

3. Availability of Financial Assistance: UPMCWM' retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.
   a. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.
   b. All patients presenting for emergency services will be treated regardless of their ability to pay.
      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).
   a. UPMCWM' rate structure is governed by the HSCRC rate setting authority. As an "all-payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.
   b. Charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

5. Payment plans are available to uninsured patients with family income between 200 and 500 percent of the Federal Poverty Level for those patients who request assistance.

PROGRAM ELIGIBILITY

1. UPMCWM strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. UPMCWM reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or returned mailed with no forwarding address.
2. Patients who are uninsured, under insured, ineligible for a government program, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for "UPMCWM' Financial Assistance Program.
3. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:
   a. Emergency medical services provided in an emergency room setting.
   b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual.
   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
   d. Medically necessary services.

4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
   a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid)
      i. Exceptions to this exclusion may be made, in UPMCWM' sole discretion, considering medical and programmatic implications.
   b. Unpaid balances resulting from cosmetic or other non-medically necessary services;

c. Patient convenience items.

5. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:
   a. After being notified by UPMCWM, refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).
   b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to UPMCWM due to insurance plan restrictions/limits.
   c. Failure to make appropriate arrangements on past payment obligations owed to UPMCWM (including those patients who were referred to an outside collection agency for a previous debt).
   d. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless UPMCWM can readily determine that the patient would fail to meet the eligibility requirements.

6. Patients who become ineligible for the program may be required to pay any open balances and may be submitted to a bad debt agency if the balance remains unpaid in the agreed upon time periods.

7. Patients who indicate they are unemployed and have no insurance coverage may be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section C.2 below)
   a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums may be reviewed by appropriate personnel and recommendations may be made to Senior Leadership for approval.
   b. Individuals with the financial capacity to purchase or receive government sponsored health insurance may be encouraged to do so as a means of assuring potential coverage for health care services.

8. Coverage amounts will be calculated using a sliding scale fee scale based on federal poverty guidelines. An example of the sliding scale included in this policy.

9. 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.

PATIENT ASSISTANCE GUIDELINES

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section; additionally, payment plans based on patient's ability to pay are available on an individual basis.

2. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services at https://aspe.hhs.gov/poverty-guidelines. Below is an example of the sliding scale UPMCWM shall use to determine patient eligibility for financial assistance.
   a. Patients whose family income is at or below 200% of the Federal Poverty Level (FPL) are eligible to receive free care.
   b. Patients whose family income is above 200% but not more than 250% of the FPL are eligible to receive a discount of 80% of their account balance.
   c. Patients whose family income is above 250% but not more than 300% of the FPL are eligible to receive a discount of 60% of their account balance.
   d. Patients whose family income is above 300% but not more than 350% of the FPL are eligible to receive a discount of 40% of their account balance.
   e. Patients whose family income is above 350% but not more than 400% of the FPL are eligible to receive a discount of 20% of their account balance

PRESUMPTIVE FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining financial assistance eligibility.
   a. In the event there is no evidence to support a patient's eligibility for financial assistance, UPMCWM reserves the right to use outside agencies, or propensity to pay modeling information in determining Financial Assistance eligibility.
   b. Patients who are determined to satisfy presumptive eligibility will receive free care.

2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
   a. Active Medical Assistance pharmacy coverage;
   b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low-Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
   c. Homelessness;
   d. Maryland Public Health System Emergency Petition patients;
   e. Participation in Women, Infants and Children Programs ("WIC");
   f. Food Stamp eligibility;
   g. Eligibility for other state or local assistance programs;
   h. Patient is deceased with no known estate; and
   i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.

4. Exclusions from consideration for presumptive eligibility include:
   a. Purely elective procedures (e.g., cosmetic procedures).

FINANCIAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Financial Hardship program.
   a. Patients may qualify under the following circumstances:
      ii. Combined household income less than 500% of Federal Poverty Guidelines; or
      iii. Financial Hardship is having incurred collective family hospital medical debt exceeding 25% of the combined household income during a 12-month period.

2. UPMCWM applies the criteria above to a patient's balance after any insurance payments have been received.

3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of this sliding scale is provided at our website; https://www.wmhs.com/patients-and-visitors/patients/financial-assistance

4. If determined eligible, patients and their immediate family are certified for a reduced-cost medically necessary care, for a 12-month period effective on the date the medically necessary care was initially received.

5. In situations where a patient is eligible for both Financial Hardship and the standard Financial Assistance programs, UPMCWM is to apply the greater of the two discounts.

6. Patient is required to notify UPMCWM of their potential eligibility for this component of the financial assistance program.

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

1. The eligibility, duration, and discount shall be patient-situation specific.

2. Patient balance after insurance accounts may be eligible for consideration.

3. Cases falling into this category require management level review and HSCRC approval.

ASSET CONSIDERATION

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

2. The following assets are exempt from consideration:
   a. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
   b. Up to $150,000 in primary residence equity.
   c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

APPEALS

1. Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: UPMCWM Willowbrook Office Complex Attn: Financial Counseling Team P.O Box 539 Cumberland, MD 21502.

2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

3. Appeals are documented and reviewed by the next level of management for additional reconsideration.

4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.

PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free care under UPMCWM' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.00.
   a. The two (2) year period may be reduced to 30 days after receipt of the first post-discharge billing statement where UPMCWM' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.

2. If a patient is found to be eligible for financial assistance after UPMCWM has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, UPMCWM will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

OPERATIONS

1. UPMCWM will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.

2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage where appropriate.
      i. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations).
   b. UPMCWM will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
      i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
         a) A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
         b) Proof of disability income (if applicable);
         c) A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
         d) Proof of social security income (if applicable);
         e) A Medical Assistance Notice of Determination (if applicable);
         f) Reasonable proof of other declared expenses; and
         g) If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, this will result in a denied application.
   a. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.
   b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).
   c. If documentation is received after collection actions have been initiated, but within the 240 day after patient receipt of the first post discharge billing statement, UPMCWM shall cease all collection actions and determine whether the patient is eligible for financial assistance.

4. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UPMCWM guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.
   b. For complete applications, the patient will receive a letter notifying them of approval/denial within 30 days of submitting the completed applications.
   c. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information
      i. If a patient is determined to be ineligible prior to receiving services, efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
      ii. If a patient is determined to be ineligible after receiving services, efforts to obtain a payment arrangement will be made, subject to UPMCWM' approval, on any balance due by the patient.

5. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective eight (8) months prior to date eligibility determined and the following twelve (12) calendar months.
   a. For those who qualify for reduced-cost care due to financial hardship, such qualification will apply for a twelve (12) month period.
   b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

6. The following may result in the reconsideration of Financial Assistance approval:
   a. Post approval discovery of an ability to pay; and
   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to UPMCWM.

7. UPMCWM will track patients' qualification for financial assistance or financial hardship. However, it is ultimately the responsibility of the patient to inform UPMCWM of their eligibility status at the time of registration or upon receiving a statement.
8. The Health Service Cost Review Commission establishes a process for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of 19-214.1 or 19-214.2 of this subtitle. The email address for the Health Service Cost Review Commission patient complaint (hscrc.patient-complaints@maryland.gov)

CREDIT & COLLECTION POLICY

1. UPMCWM maintains a separate Credit & Collection Policy that outlines what actions UPMCWM may take in the event a patient fails to meet their financial responsibility.

2. A copy of the Credit & Collection policy may be obtained by requesting a copy from UPMCWM staff, or by visiting UPMCWM website

3. UPMCWM maintains a list of all non-UPMCWM providers who may care for patients while at UPMCWM. Non-UPMCWM providers bill separately for their services and not all participate in UPMCWM' Financial Assistance Program.

4. A copy of this list may be obtained by requesting a copy from UPMCWM staff or by visiting UPMCWM' website at https://www.wmhs.com/find-a-provider

APPROVAL PROCESS:
Manager, PFS Hospital (editor)
Executive Director, Revenue Cycle
Chief Financial Officer
UPMCWM Board of Directors

2020 SLIDING SCALE ADJUSTMENTS

UPMCWM FINANCIAL ASSISTANCE PROGRAM

Patient Responsibility Percentages

Size of Family Unit	0%	20%	40%	60%	80%
1	$0.00 -	$25,761	$32,201	$38,641	$45,081
12880	$25,760	$32,200	$38,640	$45,080	$51,520
2	$0.00 -	$34,841	$43,551	$52,261	$60,971
17420	$34,840	$43,550	$52,260	$60,970	$69,680
3	$0.00 -	$43,921	$54,901	$65,881	$76,861
21960	$43,920	$54,900	$65,880	$76,860	$87,840
4	$0.00 -	$53,001	$66,251	$79,501	$92,751
26500	$53,000	$66,250	$79,500	$92,750	$106,000
5	$0.00 -	$62,081	$77,601	$93,121	$108,641
31040	$62,080	$77,600	$93,120	$108,640	$124,160
6	$0.00 -	$71,161	$88,951	$106,741	$124,531
35580	$71,160	$88,950	$106,740	$124,530	$142,320
7	$0.00 -	$80,241	$100,301	$120,361	$140,421
40120	$80,240	$100,300	$120,360	$140,420	$160,480
8	$0.00 -	$89,321	$111,651	$133,981	$156,311
44660	$89,320	$111,650	$133,980	$156,310	$178,640
FPL Range	**Thru 200%**	**201% - 250%**	**251% - 300%**	**301% - 350%**	**351% - 400%**

UPMC WESTERN MARYLAND CORPORATION
Employed Providers
March 2020

UPMC Western Maryland Health Corporation
TIN# 52-0591531
NPI# 1609831247
12500 Willowbrook Road
Cumberland, MD 21502-6393
• ***(Denotes each practice location within each group)***

UPMC WMHS Behavioral Health Services IP NPI# 1285779884
***UPMC WMHS Behavioral Health Services (Clinic)*OP NPI# 1306092531**

Office:
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
Tiffany Bennett CRNP	1922556612
Edward M. Ehlers, M.D.	1104883883
Kevin H. Peterson, EdD	1053527895
Debra N. Schaaf, PhD	1790737195
Rebecca Sokal, M.D.	1366860611
Gratiela Zbarcea M.D.	1497860399

LOCUMS *(BH Coverage)*

Logan Foltz M.D.	1730490640
Kawish Garg M.D.	1013164342
Harish Goyal M.D.	1558517391
Jessica Merkell-Keller M.D.	1437448107
Angela Onwuanibe M.D.	1083637441
Melanie Rowson M.D.	1679777130

UPMC WMHS Specialty Services NPI# 1184769952

Cardiothoracic Services

Office
12502 Willowbrook RD, 3rd Floor
Ste. #470
Cumberland, MD 21502-6593
Telephone: (240) 964-8724
Fax: (240) 964-8735

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

Rabih Chaer M.D.	1881648343
Lana E Grubb, P.A.	1467918741
Eric Hager M.D.	1083814933
Tina Long, PA-	841747722

Samantha Marino, P.A.C.	1477118149
Mark G. Nelson, M.D.	1134111743
Leah (Bucci) Rearrick, P.A.	1033469317
Richard Redlinger M.D.	1376704619

LOCUMS *(Cardiothoracic Surgery Coverage)*

Christopher Clancy M.D.	1427214790
Peter Horneffer M.D.	1437145356

Cardiology Services

Office
12502 Willowbrook RD
Ste. #420
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
Ning Jiang M. D	1841430188
Kenneth Judson, D.O.	1770525891
Linda Krause CRNP	1275737009
Francis M McCaffrey (Pediatric Cardiology)	1851365795
Pratikkumar J Patel, D.O.	1356789200
Allison (Amann) Rexrode, CRNP	1275845406
Mark F. Wilt, PA-C	1003975400
Heidi N. Race, P.A.	1154512556

LOCUMS *(Cardiology Coverage)*

Martin Albornoz, M.D.	1780687178
Samer Azouz, M.D.	1275532129
Susan Bennett, M.D.	1144237090
Shawn Howell, M.D.	1447392659

Wound Care& Hyperbaric Center

Office
12502 Willowbrook RD
Ste. #360
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
Anna Reineke, CRNP	1306303227

UPMC WMHS Specialty Services **NPI# 1184769952**
Continued

Gastroenterology

Office
12502 Willowbrook RD
Ste. #640
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.	689659997
Beverly Moser, CRNP	1023411683
Basil Njei, M.D.	1336435965
Vamshidhar Vootla M.D.	1144485467

LOCUMS *(Gastroenterology Coverage)*

Chintamaneni Choudari M.D.	1538148283

Medical Oncology/Int. Med

Office
12502 Willowbrook RD
Ste. #440
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

LOCUMS *(Oncology Coverage)*

Shaad E Abdullah, M.D.	1669676250
Jameel Audeh, M.D.	1104817063
John Downs, M.D.	1093780496
Ronald Ruskowski, M.D.	1245237296
William Waterfield, M.D.	1871552760
Quamar Zaman, M.D.	1093893331

Infectious Diseases

Office
12502 Willowbrook RD
Ste. #400
Cumberland, MD 21502-3775
Telephone: (240) 964-8913
Fax: (240) 964-8911

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

Rameet Thapa, M.D.	1346553534

LOCUMS *(Infectious Diseases Coverage)*

Aman Dalal, M.D.	1750595575

Pulmonary Diseases/Critical Care Medicine

Office
12502 Willowbrook RD
Ste. #280
Cumberland, MD 21502-6494
Telephone: (240) 964 -8750 (Dr. Sagin)
(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

Ailia W. Ali, MD.	1649400201
Ayham Bataineh, M.D.	1972904365
Mark A. Sagin, M.D.	1750343505
Richard G. Schmitt, M.D.	1336271667
Dawn M. Snyder, CRNP	1932343456
Krystal Abucevicz-Swick CRNP	1750867362

LOCUMS *Pulmonary Diseases (PULM) / Critical Care (ICU) Coverage*

Vanessa Alvarez, M.D. *(PULM/ICU)*	1023034196
Brian Cuneo, M.D. *(PULM/ICU)*	1821193483
Sean N Doodley, M.D. *(PULM/ICU)*	1871575027
Stuart Jacobs, M.D *(PULM)*	1467418111
Manu Kaushal, M.D. *(PULM/ICU)*	1902035918
Maria Mayorga, M, D *(PULM)*	1558457127
John Morrissey, M.D. *(PULM/ICU)*	1740293984
Abbas Omais, M.D *(PULM)*	1699748046
Natvarlal Rajpara, M.D. *(PULM/ICU)*	1629065305
Nimesh Shah, M.D. *(ICU)*	1740227990

Occupational Health

Office
1050 Industrial BLVD
Ste. #15
Cumberland, MD 21502-4331
Telephone: (240) 964-9355
Fax: (240) 964 -9356

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

James B. Deren, M.D.	1053310078
Misty Lingenfelter, CRNP	1295240695

UPMC WMHS Specialty Services **NPI# 1184769952**
Continued

Nephrology

Office
12502 Willowbrook RD
Ste. #400
Cumberland, MD 21502
Telephone: (240) 964 -8910
Fax: (240) 964 -8911

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

Umair Syed Ahmed M.D.	1053310078
Hassaan Rasheed, M.D.	1679724801

LOCUMS (*Nephrology Coverage*)

Erin M. Bohen, M.D.	1538263082

Obstetrics & Gynecology (OB/GYN)

Office
12502 Willowbrook RD
Ste. #660
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
Fax: (240) 964 -8336

Jorge Andrade, M.D.	1619973914
Kathryn Collette (Huber), CRNP	1235652306
Sherilyn Crist, RN, CNM	1174962849
Sharon Eaton, CNM	1972005783
Tom Hartsuch, M.D.	1306830252
Beth H. Jelinek, M.D.	1689700023
Leah (Bennett)Kozlowski, PA	1336557370
Andrea Velandia PAC	1467478925

LOCUMS (*OB/GYN Coverage)*

Adegboyega Adejana, M.D.	1316149909
Jean Talbert, M.D.	1407918741

Plastic Surgery

Office
12502 Willowbrook RD
Ste. #450
Cumberland, MD 21502-6593
Telephone: (240) 964 -8931
Fax: (240) 964 -8932

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

Emme Chapman-Jackson, M.D.	1740487727

UPMC WMHS Specialty Services **NPI# 1184769952**
Continued

Pain and Palliative Care

Office
12502 Willowbrook RD
Ste. #300
Cumberland, MD 21502-6579
Telephone: (240) 964 -8939
Fax: (240) 964 -8949 (240) 964 -8687

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

Benjamin Goldstein, M.D.	1578978383

Endocrinology

Office
12502 Willowbrook RD
Ste. #330
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

LOCUMS (*Endocrinology Coverage)*

Sheeba Asghar, M.D.	1780865758

Center for Clinical Resources (CCR)

Office
12502 Willowbrook RD
Ste. #300
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

Heart Failure Clinic (CCR)

Brandi L. Clark, CRNP	1558790485
Kristen Kessel CRNP	1932744869

Pulmonary (CCR)

Krystal Abucevicz-Swick CRNP	1750867362

Diabetes Program (CCR)

Joni Brode, R.D.	1427310101
Allison Lutz, R.D.	1205122421
Lynn Metcalf CRNP	1538444369
Jennifer Perrin, R.D.	1073834685
Kristin Wilkins, R. D	1376911719

UPMC WMHS Specialty Services NPI# 1184769952
Continued

Outpatient Nutritional Counseling

Office
12501 Willowbrook RD. 2nd Floor
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

Allison Lutz, R.D.	1205122421
Melody Lindner R.D.	205232824
Vicky Vrabel, RD	1265791925

Neurological Surgery

Office
12502 Willowbrook RD
Ste. #420
Cumberland, MD 21502-6567
Telephone: (240) 964 -8944
Fax: (240) 964 -8942

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

Or Cohen-Inbar, M.D.	1578971594
Keeley M Cook PA	1750940789

Neuro Hospitalist

Office
12502 Willowbrook RD
Ste. #280
Cumberland, MD 21502-6494
Telephone: (240) 964 -8750
Fax: (240) 964 -8699

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

Iakov Rudenko, M.D.	1932595527

Rehabilitation Unit (Inpatient- Rehab)

Office
12500 Willowbrook RD. 6th Floor
Cumberland, MD 21502
Unit number: (240) 964 -6000
Unix Fax Number: (240) 964 -6005

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

Telephone: (301) 777 -1930 Fax (301) 777 -8470 (Dr. Amir & Dr Janjua)
Telephone: (240) 522 -0098 Fax (240) 522 -0099 (Dr. Dey)
Telephone: (301) 724 -7027 Fax (240) 964 -4872 (Dr. Figueroa)

UPMC WMHS Specialty Services NPI# 1184769952
Continued

Rehabilitation Unit (Inpatient- Rehab) continued

Murtaza Amir, M.D.	1508971920
Dennis Dey, M.D.	1972546364
Augusto F. Figueroa, M.D.	1740268945
Riaz Janjua, M.D.	1508865908
Heidi N. Race, P.A.	1154512556

Emergency Room (Trauma)

Office
12500 Willowbrook RD
Cumberland, MD 21501-1671
Trauma/Emergency: (240) 964 -1200

Remit:
P. O. Box 1671
Cumberland, MD 21502
Telephone: (240) 964-8515

Telephone: (301) 777 -1930 Fax (301) 777 -8470 (Dr. Amir & Dr Janjua)
Telephone: (240) 522 -0098 Fax (240) 522 -0099 (Dr. Dey)
Telephone: (301) 724 -7027 Fax (240) 964 -4872 (Dr. Figueroa, Dr. Kheder)
Telephone: (301) 724 -8847 Fax (301) 724 -7016 (Dr. Chisholm)
Telephone: (301) 777 -5358 Fax (301) 777 -8031 (Dr. Arrisueno)

LOCUMS *(Trauma Coverage)*

Murtaza Amir, M.D. *(Neurology)*	1508971920
Kheder Ashker, M.D. *(Neurosurgery)*	1770561979
Juan A. Arrisueno, M.D. *(General Surgery)*	1851393565
Roy D. Chisholm, M.D. *(General Surgery)*	1275550279
Dennis Dey M.D *(Neurology)*	1972546364
Augusto F. Figueroa, M.D. *(Neurosurgery)*	1740268945
Riaz Janjua M.D *(Neurology)*	1508865908

UPMC WMHS Primary Care Services NPI# 1902926686

Internal Medicine (Dr. Naeem)

Office
625 Kent Avenue
Ste. #204
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

Jessica Grove, CRNP	1093212094
Muhammad Naeem, M.D.	1710186291

UPMC WMHS Primary Care Services NPI# 1902926686
Continued

Internal Medicine (Dr. Gupta)

Office
625 Kent Avenue
Ste. #101
Cumberland, MD 21502-3799
Telephone: (301) 724 -7117
Fax: (240) 964 -4297

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

Sunil K Gupta, M.D.	1093886657

Family Practice (La Vale Primary Care)

Office
1313 National Highway
La Vale, MD 21502-7618
Telephone: (240) 362 -0288
Fax: (240) 362 -0052

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

Jennifer Barlow, CRNP	1811957202
Barbara Pyle, CRNP	1861498412
Nancy White, CRNP	1336545466

MAC Primary Care

Office
12502 Willowbrook RD
Ste. #680
Cumberland, MD 21502
Telephone: (240) 964 -8921
Fax: (240) 964 -8922

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

Ayesha Abid, M. D	1437565868
Anupama Khandare, M.D.	1255610580
Mary Ann Riley, D.O.	174736441
Katie Ritchey C.R.N.P	

UPMC WMHS Urgent Care Services NPI# 1952495079

Frostburg Health Center

Office
1070 New Georges Creek RD
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

Nicole Bonner, CRNP	1770733248
Paul Burke, PA	1053388132
Michael Cetta, M.D.	160983345
Bonnie Cox, PA-C	1376536912
Tammy Crayton, CRNP	1386192250
Kathleen Glibbons, PA	1669876678
Robert Hallock, M.D.	1043265804
Jeremy Hunt, CRNP	1144465600
Amit Kalaria, M.D.	1578510897
Thomas Kidd, PA	1053321075
Ronald Kinsey, M.D.	1477580660
Jason Layman, CRNP	1811942147
Wendell Lewis, PA	1265428569
Misty Lingengelter, CRNP	1295240695
Lynn Metcalf, CRNP	1538444369
Diana Pepe, CRNP	1770819518
Rory Price, PA-C	1942201991
Ashley G Reese, PA-C	1588919591
Rebekah Reyes, CRNP	1942672704
Natalie Sesto, PA	1275078578
Wendi Shillingburg, PA	1033207238
Aaron Snyder, M.D.	1730104043
Jeremy Steward, CRNP	1346769742
Heidi J Stout, PA-C	1518071950
Crystal Walls, CRNP	1396222998
Eric Williams, PA	1801331186
Derek Wolfe, PA	1457347783
Rondal Zapf, CRNP	1659709558

Urgent Care South Cumberland

Office
1050 Industrial Boulevard. Ste 17
Cumberland, MD 21502
Telephone: (240) 964 -9300
Fax: (240) 964 -9310

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

Nicole Bonner, CRNP	1770733248
Paul Burke, PA	1053388132
Michael Cetta, M.D.	160983345
Bonnie Cox, PA-C	1376536912
Tammy Crayton, CRNP	1386192250
Kathleen Glibbons, PA	1669876678

UPMC WMHS Urgent Care Services NPI# 1952495079
Continued

Robert Hallock, M.D.	1043265804
Jeremy Hunt, CRNP	1144465600
Amit Kalaria, M.D.	1578510897
Thomas Kidd, PA	1053321075
Ronald Kinsey, M.D.	1477580660
Jason Layman, CRNP	1811942147
Wendell Lewis, PA	1265428569
Misty Lingengelter, CRNP	1295240695
Lynn Metcalf, CRNP	1538444369
Diana Pepe, CRNP	1770819518
Rory Price, PA-C	1942201991
Ashley G Reese, PA-C	1588919591
Rebekah Reyes, CRNP	1942672704
Natalie Sesto, PA	1275078578
Wendi Shillingburg, PA	1033207238
Aaron Snyder, M.D.	1730104043
Jeremy Steward, CRNP	1346769742
Heidi J Stout, PA-C	1518071950
Crystal Walls, CRNP	1396222998
Eric Williams, PA	1801331186
Derek Wolfe, PA	1457347783
Rondal Zapf, CRNP	1659709558

Advanced Lakeside Urgent Care

Office
23789 Garret Highway
McHenry, MD 21541
Telephone: (240) 488 -4139
Fax: (240) 488 -4956

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

Nicole Bonner, CRNP	1770733248
Paul Burke, PA	1053388132
Michael Cetta, M.D.	160983345
Bonnie Cox, PA-C	1376536912
Tammy Crayton, CRNP	1386192250
Kathleen Glibbons, PA	1669876678
Robert Hallock, M.D.	1043265804
Jeremy Hunt, CRNP	1144465600
Amit Kalaria, M.D.	1578510897
Thomas Kidd, PA	1053321075
Ronald Kinsey, M.D.	1477580660
Jason Layman, CRNP	1811942147
Wendell Lewis, PA	1265428569
Misty Lingengelter, CRNP	1295240695
Lynn Metcalf, CRNP	1538444369
Diana Pepe, CRNP	1770819518
Rory Price, PA-C	1942201991
Ashley G Reese, PA-C	1588919591

UPMC WMHS Urgent Care Services NPI# 1952495079
Continued

Rebekah Reyes, CRNP	1942672704
Natalie Sesto, PA	1275078578
Wendi Shillingburg, PA	1033207238
Aaron Snyder, M.D.	1730104043
Jeremy Steward, CRNP	1346769742
Heidi J Stout, PA-C	1518071950
Crystal Walls, CRNP	1396222998
Eric Williams, PA	1801331186
Derek Wolfe, PA	1457347783
Rondal Zapf, CRNP	1659709558

Hunt Club Medical Clinic

Office
45 Hunt Club Dr
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

Nicole Bonner, CRNP	1770733248
Michael Cetta, M.D.	160983345
Bonnie Cox, PA-C	1376536912
Robert Hallock, M.D.	1043265804
Jeremy Hunt, CRNP	1144465600
Amit Kalaria, M.D.	1578510897
Thomas Kidd, PA	1053321075
Ronald Kinsey, M.D.	1477580660
Wendell Lewis, PA	1265428569
Lynn Metcalf, CRNP	1538444369
Rory Price, PA-C	1942201991
Ashley G Reese, PA-C	1588919591
Rebekah Reyes, CRNP	1942672704
Natalie Sesto, PA	1275078578
Wendi Shillingburg, PA	1033207238
Aaron Snyder, M.D.	1730104043
Jeremy Steward, CRNP	1346769742
Heidi J Stout, PA-C	1518071950
Crystal Walls, CRNP	1396222998
Eric Williams, PA	1801331186
Rondal Zapf, CRNP	1659709558

Revised 3/13/20 MS

From: Thomas, Jennifer
To: Hilltop HCB Help Account
Subject: Re: Clarification Required - UPMC Western Maryland FY 21 Community Benefit Narrative
Date: Sunday, May 22, 2022 11:48:24 AM

Report This Email

Hello!
Please see my responses below:

- For Question 44, on page 5 of the attached, your hospital's facility-level Board of Directors or Board Committee is listed as "N/A – not involved" but is also listed as helping in the following way: "Other (explain): Provide oversight and facilitate integration with the strategic plan." Please clarify – was "N/A – Person or Organization was not involved" selected by mistake? **That was a mistake, my apologies.**

- In your response to Question 244 on page 19, one sentence reads, "Our Center for Clinical Resources addresses chronic disease management and financial assistance for patients whose income is 300% above the poverty level." Please confirm that the Center works with those *above* 300% FPL rather than *below* 300% FPL. **This should be BELOW 300% FPL.**

I will complete the survey separate from this email as requested.

Thank you,
Jen

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 9:19 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Thomas, Jennifer <thomasj39@upmc.edu>
Subject: Clarification Required - UPMC Western Maryland FY 21 Community Benefit Narrative

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for UPMC Western Maryland. In reviewing the narrative, we encountered a few items that require clarification:

- For Question 44, on page 5 of the attached, your hospital's facility-level Board of Directors or Board Committee is listed as "N/A – not involved" but is also listed as helping in the following way: "Other (explain): Provide oversight and facilitate integration with the strategic plan." Please clarify – was "N/A – Person or Organization was not involved" selected by mistake?
- In your response to Question 244 on page 19, one sentence reads, "Our Center for Clinical Resources addresses chronic disease management and financial assistance for patients whose income is 300% above the poverty level." Please confirm that the Center works with those *above* 300% FPL rather than *below* 300% FPL.
- Please respond to Questions 218 and 219, as well as Question 139 if applicable, using the following supplemental survey: https://umbc.co1.qualtrics.com/jfe/form/SV_3mbHIOxpPLyp4i2?Q_CHL=gl&Q_DL=80sWkmJkLoWmf1y_3mbHIOxpPLyp4i2_MLRP_3dtAvJIlbgV2gFE

Please complete the supplementary survey linked above and provide all other clarifying answers as a response to this message.

Q135. Section IV - Physician Gaps & Subsidies

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	○	◉	
Cardiology	◉	○	Physician recruitment to meet community need
Dermatology	○	◉	
Emergency Medicine	○	◉	
Endocrinology, Diabetes & Metabolism	◉	○	Physician recruitment to meet community need
Family Practice/General Practice	◉	○	Physician recruitment to meet community need
Geriatrics	○	◉	
Internal Medicine	◉	○	Non-resident house staff and hospitalists
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	◉	○	Physician recruitment to meet community need
Oncology-Cancer	○	◉	
Ophthamology	○	◉	
Orthopedics	◉	○	Coverage of emergency department call
Ololaryngology	◉	○	Coverage of emergency department call
Pathology	○	◉	
Pediatrics	◉	○	Coverage of emergency department call
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	◉	○	Physician recruitment to meet community need
Psychiatry	◉	○	Physician recruitment to meet community need
Radiology	○	◉	
Surgery	○	◉	
Urology	○	◉	
Other. (Describe) Urgent Care, Nephrology, Infectious Disease, Pulmonary, GI, Wound Care	◉	○	Physician recruitment to meet community need

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

See attachment

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

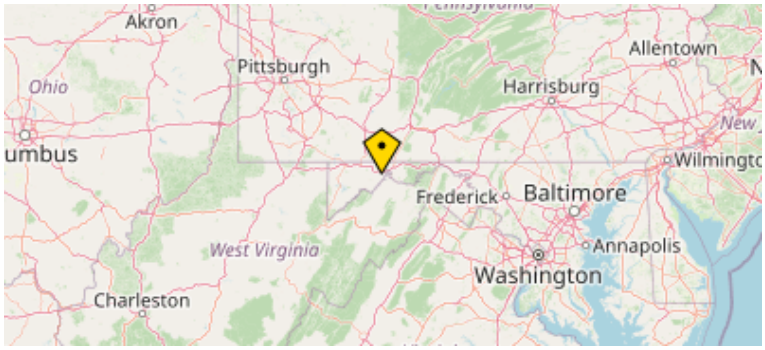
physician subsidies explanation.xlsx
11.9KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q1. Thank you. To edit your answers, please use the "back" button below. To submit your answers, please use the "forward" button below.

Location Data

Location: (39.5995, -78.8461)

Source: GeoIP Estimation



C00 **MISSION DRIVEN HEALTH SERVICES (please list)**

C10 PHYSICIAN SUBSIDIES - TOTAL

C20 Organizationally Owned Urgent Care Centers - Frostburg, Lakeside, Hunt Club, & South Cumberland

C40 Hospitalists

C50 Psychiatric Physician Practice

C51 Obstetric Physician Practice

C52 Nephrology practice

C53 Infectious Disease Practice

C54 Endocrinology practice

C55 Pulmonary Physicians

C56 Cardiology Physicians

C57 GI Physicians

C58 Wound Care physicians

C59 Orthopedic and other Locums needed for specialty coverage

C60 Primary Care Physician Practices

Justification

There are only two other urgent care facilities in Allegany County, one is 7 miles from the hospital and one is 8 miles away. They are both very busy , established urgent care centers, but they can't come close to meeting the community need. Urgent Care is needed to keep patients from seeking emergency room care for non-emergent needs. However, due to our poor payer mix, even our urgent cares find it difficult to break even.

Due to the fact that UPMC Western Maryland's payer mix is over 70% governmental payors, it is necessary for us to subsidize the income of the hospitalist group that we employ. No community providers will round on their patients when they are admitted, making the hospitalist program a necessary service to run our hospital. Without the subsidy, no hospitalist group would contract with us.

There are no community based, non-employed psychiatric physicians in our service area. These physicians are necessary to offer our inpatient and outpatient behavioral health services. Again, due to the poor payor mix, this practice has to be subsidized.

There is only one community based, non-employed OB/GYN physician in our service area along with one FQHC that provides some OB/GYN services to our community. These providers do not come close to meeting the need as our OB/GYN practice is extremely busy, seeing 18,100 patient encounters annually. These physicians are necessary to offer our hospital labor and delivery and obstetric services as well. Again, due to the poor payor mix, this practice has to be subsidized.

UPMC Western Maryland runs the only outpatient dialysis facility in Allegany County, with a consistent caseload of over 100 patients. The next closest facility is 40 minutes away and in a different stae and only has 7 stations. We of course also must offer dialysis services to our inpatients. There is only one community nephrologist, who is close to retirement and is cutting back his patient load. Our nephrology practice sees 7,500 patient encounters annually and requires subisdy due to the fact that most dialysis patients are Medicare.

There is no other infectious disease physician in the service area. He sees 2,600 patient encounters annually that would otherwise need to travel out of town. Again, the poor payer mix makes it difficult to break even.

With our focus on chronic disease management to reduce total cost of care, endocrinologists are necessary specialists to help manage the diabetic population. There are no community based endocrinologists. This practice sees 4,400 patient encounters annually. These patients would either have to drive out of town for care or would not get the specialist care that they need. Poor payer mix necessitates a subsidy.

With our focus on chronic disease management to reduce total cost of care, pulmonologists are necessary specialists to help manage the COPD population. There are no community based pulmonologists. This practice sees 9,700 patient encounters annually. These patients would either have to drive out of town for care or would not get the specialist care that they need. Poor payer mix necessitates a subsidy.

With our focus on chronic disease management to reduce total cost of care, cardioologists are necessary specialists to help manage the CHF population. There are no community based cardioologists. This practice sees 33,100 patient encounters annually. These patients would either have to drive out of town for care or would not get the specialist care that they need. Poor payer mix necessitates a subsidy.

There are no community based gastroenterologists. This practice sees 11,300 patient encounters annually. These patients would either have to drive out of town for care or would not get the specialist care that they need. Poor payer mix necessitates a subsidy.

UPMC Westrern Maryland Wound Clinic is the only one within 45 minutes. Most of these patients are seen for weeks and can't afford their copays. Again, the poor payer mix necessitates a subsidy.

This is the cost of covering services for the hospital, especially for trauma and ED coverage

We continue to see the community primary care physicians with large patient panels retiring. We continue to recruit and employ more primary care physicians and APPs. Again, our high governmental payer mix makes it difficult to be profitable. Our primary care providers see 35,000 patient encounters annually.