Western Maryland Regional Medical Center
(210027)

FY2014

Community Benefit Report Narrative

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I: WMRMC FY 14

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
213 Beds 20 Bassinets	Adults: 11,805 Nursery: 1,018 Total: 12,823	21502 21532 21562 21539 21536	Garrett Memorial Hospital	12%	27%

For purposes of reporting on your community benefit activities, please provide the following information: Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

The Western Maryland Regional Medical Center provides primary and secondary acute care services for a six county region covering: Upper Potomac region of Maryland, Eastern West Virginia, and Southwestern Pennsylvania. However, with the majority of patients residing in Allegany County (72%) it is considered the community benefit service area and focus of the community health needs assessment.

Allegany County is located in rural Western Maryland and had a population of 75,087 when the needs assessment was completed, yet is estimated to have declined to 73,962. The county is part of the Appalachian region and has low education levels, limited racial diversity, a large elderly population, and low household incomes. Allegany County and its service providers are impacted by being in a tri-state region which includes Pennsylvania and West Virginia.

Allegany County is 51.9% male and 48.1% female. A smaller percent of the population is under 5 years old (4.7%) than in Maryland (6.2%). A larger percent of the population is 65 years and older (18.3%) than in Maryland (13.4%). There is less racial diversity in Allegany County than in the U.S.; 88.8% of the population is white, 8% is black, and 1.6% is Hispanic or Latino.

The average household size is 2.25 and single parent households declined slightly from 35 to 34 percent. The median household income in Allegany County increased slightly but is well below the U.S. median ($39,846 vs. $72,483). The percentage of individuals living below the poverty

line increased since last year's report from 15.2 to 16.1 percent. The percentage of Allegany County children living in poverty has also risen from 25 to 26 percent and is higher than the Maryland rate (14%).

In Allegany County and the surrounding areas: 29% of employees work in management, business, science, and arts; 22% work in service; 24% work in sales or office jobs; and 15% work in production, transportation, and material moving. 16% of Allegany County residents travel outside of the county to work. The latest report from the Bureau of Labor Statistics lists the unemployment rate in Allegany County at 8%.

While 88% of Allegany County adults have a high school diploma, the county has only 16.1% of adults with a bachelor's degree or higher compared to 35.6% in Maryland. In addition, 11.3% of Allegany County residents age 16 and over are illiterate.

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

In Allegany County, the areas of highest need are 21532 (Frostburg) at 4.0 and 21502 (Cumberland) with a CNI of 3.8. Other high need areas include 21562 (Westernport) and 21521 (Barton) at 3.6. The area with the lowest need is 21557 (Rawlings) with a CNI of 2.2.

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

b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II - WMRMC FY 14

Target Population -Allegany County, MD Total- 73,962 (estimate) By sex 51.9% Male 48.1% Female Average age -41.6 years 4.7% under age 5 18.3% 65 years and over	By race & ethnicity 88.8% White 8% Black/African Am. 0.2% Native American 0.9% Asian 1.6% Hispanic or Latino
Source: U.S. Census Bureau, 2011-2013 3-Year American Community Survey	
Median Household Income	Allegany County: $39,846 Source: U.S. Census Bureau, 2011-2013 3-Year American Community Survey
Percentage of all people with incomes below the federal poverty level	Allegany County: 16.1% Source: U.S. Census Bureau, 2008-2012 American Community Survey
Percentage of uninsured people (under age 65)	Allegany County: 12% Source: County Health Rankings –Univ. of Wisconsin 2014
Percentage of Medicaid recipients by County	Allegany County: 27% Source: Maryland Medicaid eHealth Statistics
Life Expectancy by County.	Allegany County: 78.0 White 80.0 Black (SHIP) Source: Maryland DHMH Vital Statistics Administration 2012
Mortality Rates by County	Allegany County: 7,375 per 100,000 age adjusted Source: County Health Rankings –Univ. of Wisconsin 2014
Limited Access to healthy food.	Allegany County: 16% Source: County Health Rankings 2014 Report
Transportation-Percentage of occupied housing units without access to vehicles	Allegany County: 9.6% (22.4% of renter occupied units) Source: U.S. Census Bureau, 2008-2012 American Community Survey
Illiteracy	Allegany County: 11.3% Source: County Health Rankings 2012 Report
Pop. 25+ With Bachelor's Degree or Above %	Allegany County: 16.1% Source: U.S. Census Bureau, 2008-2012 American Comm. Survey
Children living in Single Parent Households %	Allegany County: 34% Source: County Health Rankings 2014 Report
Language Other Than English spoken at home %	Allegany County: 4.1% Source: U.S. Census Bureau, 2008-2012 American Comm. Survey
Population to Primary Care Provider Ratio	Allegany County: 1698:1 Source: County Health Rankings 2014 Report
Adults who currently smoke %	Allegany County: 23% Source: County Health Rankings 2014 Report
Inadequate Social Support %	Allegany County: 19% Source: County Health Rankings 2014 Report

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__x__Yes
____No

Provide date here. 01/26 /12 (mm/dd/yy)

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

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

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

__x_Yes Enter date approved by governing body here: 01/26 /12 (mm/dd/yy)
___No

If you answered yes to this question, provide the link to the document here.
http://alleganyhealthplanningcoalition.com/lhap_pdf/ProgressReportFY11-14FINALRankings.pdf

http://alleganyhealthplanningcoalition.com/pdf/dashboardupdate%20apr%202014.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

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

a. Is Community Benefits planning part of your hospital's strategic plan?

_x__Yes
___No

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

i. Senior Leadership

1. _x__CEO

2. __x_CFO
3. _x__Other (System Management Team)

ii. Clinical Leadership

1. _x__Physician
2. _x__Nurse
3. _x__Social Worker
4. _x__Other (Allied Health, Dentist)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. _X_ Committee (Scott Lutton, Nancy Forlifer, Kathy Rogers, and Kim Repac)
3. ___Other (please describe)

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

Spreadsheet	__x___yes	_____no
Narrative	__x__yes	_____no

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

Spreadsheet	__x___yes	_____no
Narrative	__x___yes	_____no

If you answered no to this question, please explain why.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES
This Information should come from the implementation strategy developed through the CHNA process.

1. *Please use Table III (see attachment)or, as an alternative, use Table IIIA, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting.*

Since this report only includes initiatives occurring in FY14, not all identified community needs are addressed in these tables. Some needs were addressed at other times during the multi-year cycle. A final report of the multi-year cycle with process measures for actions (not

just hospital initiatives) can be found at the link below:
http://alleganyhealthplanningcoalition.com/lhap_pdf/ProgressReportFY11-14FINALRankings.pdf

TABLE IIIA

Initiative 1

Identified Need-Obesity	• Only 28.4% of Adults are at a healthy weight (BRFSS) • 20% of elementary age children were in the BMI 95th percentile or higher (School Health Nurses)
Hospital Initiatives: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Mile Movers-walking program with incentives to move more and use the trails Project Fit/Family Fit-fitness curriculum for targeted elementary schools, with special challenge to promote activity, healthy eating choices and adult involvement Change to Win-10 week program also intended to increase the percentage of healthy weight adults by aiding participants in making healthy lifestyle choices that lead to permanent weight loss. Worksite Wellness-focused on promotion of physical activity and healthier nutrition choices using e-mail blasts, newsletter, mini-grants, presentations and challenges. Smart Moves- 12 week non-diet, family approach to weight management includes behavior modification, nutrition education, and exercise. Breastfeeding Support-outreach, education and system change to increase breastfeeding, including site visit by National Breastfeeding Center

Primary Objective	• Activate policy and environmental changes to increase physical activities.
	  ○ Increase use and ease of access to trails and sidewalks
	  ○ Increase the amount of physical activity in a school setting and behavioral intervention to reduce screen time
	  ○ Increase worksite assessment of employee health and adoption of policies to promote physical activity
	• Promote increased choice of and access to healthful food and beverage choices
	  ○ Promote healthier food and beverage choices in community & schools and implement product placement of nutritious products for improving healthier selections
	  ○ Implement campaigns to provide nutrition information about healthy choices and link to physical activity;
	  ○ Educate and promote safe breastfeeding

Single or Multi-Year Initiative Time Period	Multi-year- since 2011
Key Partners in Development and/or Implementation	WMHS, Make Healthy Choices Easy (partnership that includes YMCA, ACHD, fitness centers, Board of Education, UM Extension, Family Junction, Western MD AHEC, Maryland Physicians Care, and several others), Allegany County Chamber of Commerce, National Breastfeeding Center, Project Fit America, and Allegany County Health Planning Coalition.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. #efforts to increase use of local trails # new physical activity opportunities offered in schools # worksites, Policies and strategies implemented # healthy choice efforts % of breastfed babies and duration of breastfeeding

<table>
<tr><td></td><td>Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA.
Various participant feedback and assessment tools are used to determine the success of hospital initiatives. Some biometric measures are obtained.</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td>Outcome:
Increased to 32.4% of Adults at a healthy weight
Decreased to 17% of elementary age children were in the BMI 95th percentile or higher
The process and impact measures of the hospital initiatives are as follows:
Mile Movers: 5 efforts to increase trail use including challenges, walks, trail count, promotion of trail with 572 encounters.
Project Fit/Family Fit: All 3 elementary schools showed aggregate improvement in fitness skill testing at the end of year two. 235 children made 17,131 physical activity and healthy eating choices, and adults were also involved in 48% of those actions.
Change to Win-
<table><tr><td>Dates /# sessions</td><td># employee</td><td># community</td><td>Total lbs. lost</td><td>% goal</td></tr><tr><td>Sept-Dec</td><td>5</td><td>17</td><td>172</td><td>68%</td></tr><tr><td>Jan-Mar</td><td>1</td><td>24</td><td>143</td><td>64%</td></tr><tr><td>Apr-June</td><td>4</td><td>17</td><td>140</td><td>62%</td></tr></table>Worksite Wellness-49 of the 65 worksites (75%) receiving resource modules promoting healthy choices were actively engaged, and monthly Wellness tips sent to 6500 employees
Smart Moves-8 families completed program: 7 youth lowered their BMI and 4 youth had a lower BMI percentile, 6 youth showed improved self-esteem, 7 youth reduced the amount of screen time, 8 youth increased the amount of physical activity & increased their intake of fruits and vegetables, and 3 youth reduced consumption of sugary drinks and 5 youth stayed the same at one or none per day
Breastfeeding Support- 63% of babies being breastfed at discharge. Recommendations from NBFC used to make improvements and policy changes to improve breastfeeding. Outreach education done with all pediatrician and OB/GYN offices.</td></tr>
<tr><td>Continuation of Initiative
This is the final year of the Local Health Action Plan so the continuation of the strategies has been incorporated into the next community health needs assessment process. Healthy weights and physical activity will continue to be a priority.</td><td>The continuing status of hospital initiatives are described below.

Mile Movers-the program structure is changing to increase numbers but promotion of walking and use of local trails and facilities will continue.
Project Fit/Family Fit-current contract with Project Fit America ends this year, but based on success and support, we plan to continue enhancement activities with the schools and teacher training. Expansion to other locations will be investigated. Challenge will be offered to all elementary schools in area.
Change to Win- Plan to continue program based on results.
Worksite Wellness- Plan to increase outreach and engagement of worksites in healthy choices, seeking to improve tracking of results.
Smart Moves- Plan to continue and increase parent involvement. Will use same assessment tools pre and post program.
Breastfeeding Support-There will be increased efforts to promote and support breastfeeding based on the consultant feedback and recent measures.</td></tr>
</table>

A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Mile Movers- $1,557 Project Fit/Family Fit- $2,940 Change to Win- $4,159 Smart Moves - $1,586 Breastfeeding Support-$7,328 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants Mile Movers-$0 Project Fit-$0 Change to Win- $3,480 Smart Moves-$0 Breastfeeding Support-$0

Initiative 2

Identified Need-Access to Care	• 85.8% Persons (under 65)with health insurance- (13.2% uninsured)(SHIP-Network of Care) • 25% Individuals report missing medical appointments due to transportation (local survey)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Community Health Access Program (CHAP)-safety net program for uninsured and underinsured individuals Transportation –taxi and bus vouchers and partnership in a Mobility Management Program Addressing Social Determinants-Direct support and collaboration with community partners to assist individuals with prescription medication, food, and other social determinants Workgroup on Access to Care –facilitate community collaborative to address access issues in the community and to work with a regional effort to improve access to oral health care for adults. Workforce Development- recruitment of physicians in identified areas of need
Primary Objective	• Increase access to health care services by maintaining or increasing enrollment in public & safety net programs, increasing provider availability and addressing the transportation barrier. o Promote enrollment in programs offered by State and safety net alternatives when an individual is not eligible o Recruit PCP and MH providers to meet the identified community need o Collaborate to identify mechanism for addressing transportation barrier • Provide dental care for under/uninsured adults o Link under/uninsured adults with cost effective dental care versus the emergency dept.
Single or Multi-Year Initiative Time Period	CHAP and Workgroup on Access to Care-Multi-year, Since 2001 Transportation and Addressing Social Determinants- Multi-year, Since 2011 Workforce Development- needs assessed every three years, 2011, 2014
Key Partners in Development and/or Implementation	CHAP is joint venture of WMHS and Allegany Health Right, with support from area physician offices, Tri-State Community Health Center. Coordinated under Workgroup on Access to Care including Associated Charities, Dept. Social Services, AHEC, ACHD, UM Extension, Carver Community Center, and Managed Care Organizations, ACCU, and Healthy Howard. Transportation has involved the Allegany County Health Planning Coalition including WMHS, Allegany County Health Dept., Human Resource Development Commission, human service providers, and transportation vendors. Mountain Health Alliance and the Dental Society.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. # served via safety net # providers (PCP & MH)

	% reporting transportation as reason for missing medical appointment # adults using ED for dental care # provided dental care with expanded services Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA. Various participant feedback and assessment tools are used to determine the success of hospital initiatives.	
Outcomes (Include process and impact measures)	Outcome • Increased to 88.1% Persons (under 65) with health insurance- (12% uninsured) • 25% Individuals report missing medical appointments due to transportation- Local survey not repeated until July 2014- but showed decrease to 23%. The process and impact measures of the hospital initiatives are as follows: Community Health Access Program (CHAP/PAC-FAP)-873 individuals were assisted via the CHAP program and 84% supported in the transition to either Medical Assistance or another coverage via the Health Exchange. Transportation –1664 encounters for taxi or bus vouchers. Facilitated work group to evaluate and plan strategies to address transportation needs in community. With grant and partner support, helped with establishment of a Mobility Management program at HRDC. Addressing Social Determinants-Increased access to food, prescriptions, emergency assistance and transportation through collaboration and donations to community partners. Workgroup on Access to Care –In collaboration with partners, reduced inappropriate use of the emergency department for dental care by 12% Workforce Development-Added capacity for primary care, obstetrics and behavioral health to address identified needs.	
Continuation of Initiative - This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Access to care will continue to be a priority.	The continuing status of hospital initiatives are described below. Community Health Access Program (CHAP) - Program ended on 12-31-2013 with start of Health Benefit Exchange. Transportation –Based on success of Mobility Management Program would like to seek support for expansion of program and engagement of more community partners. Addressing Social Determinants- Based on identified community needs and the impact of social determinants on health status when basic needs are not addressed, these efforts will continue in a more coordinated manner and with additional focus on helping individuals gain resources to become self-sufficient. Workgroup on Access to Care –Will build upon success in addressing access issues in the community and collaborate with partners so that individuals receive care in the most appropriate setting. Workforce Development-Will continue to identify and recruit for providers based on community needs.	
A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Community Health Access Program (CHAP)- $23,646 Transportation – $34,644 Addressing Social Determinants- $331,158 Workforce Development-$523,176 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants Community Health Access Program (CHAP)-$0 Transportation –$0 Addressing Social Determinants-$0 Workforce Development-$0

Initiative 3

Identified Need- Emotional and Mental Health	• 7517.9- Rate of behavioral health related ED visits per 100,000 population (SHIP-Network of Care) • Poor Mental Health Days-reported average of 4.2 days in past 30 days age adjusted (SHIP-Network of Care)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Parish Nursing provides information, support and resources to volunteers in Faith-based communities promoting health and wellness for mind, body and spirit. Community Support Grants to promote development of positive, non-abusive relationships and to enhance social connectedness. Coaching individualized support to identify goals and steps for making healthy lifestyle choices. Poverty Initiative- education and advocacy effort to increase understanding of poverty and to develop a comprehensive response. Community Health Workers- trained non-clinical outreach workers to help clients access needed resources, provide social support, make healthier lifestyle choices, and self-manage chronic health conditions.
Primary Objective	• To integrate mental health and physical health including more depression screening • Facilitate opportunities for social connectedness o Promote development of positive, non-abusive relationships for improved health o Community education about depression, bipolar disorder, abuse and neglect and available resources to help o Promote support of families with faith-based groups through outreach, visitation and other social events o Promote integrative wellness in the community through educational opportunities
Single or Multi-Year Initiative Time Period	Multi-year programs. Parish Nursing since 1997, Community Support Grants as of 2013, and Coaching since 2012 Poverty Initiative- multiyear, starting 2014 Community Health Workers- multiyear, since December 2013
Key Partners in Development and/or Implementation	WMHS, Allegany County Health Planning Coalition, Allegany County Health Dept.-Mental Health Systems Office, Faith Based Communities, Cumberland Ministerial Assn., Community Wellness Coalition, Family Junction, CASA of Allegany County, Human Resource Development Commission, Allegany Health Right, Western Maryland Area Health Education Center, and Westmar Middle School.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. # depression screenings documented in ECW # Coalition sponsored programs offered # participants in program, increasing over time # trained, # resources identified and #events Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA. Various participant feedback and assessment tools are used to determine the success of hospital initiatives. Grant recipients report the results of their project to the hospital. Uniform data collection form used by Community Health Workers at WMHS and in the community.

Outcomes (Include process and impact measures)	Outcome: • Reduced rate of behavioral health related ED visits to 6846.8 per 100,000 population • Decreased Poor Mental Health Days-reported to an average of 3.8 days in past 30 days (age adjusted) The process and impact measures of the hospital initiatives are as follows: Parish Nursing- 94% of the parishes were engaged with 4,431 volunteer hours and 39,644 encounters. 5 programs from faith-based communities were added to the community resource list. Community Support Grants –Support and social connection provided for 313 people reached through grant projects and 55 trained through expansion of Mental Health First Aid. Coaching-25 community members either one-on-one, over the phone, or via email. 22 of the participants (89%) have met an established goal or are successfully progressing. The goal areas have included: healthy eating, exercise, stress management, organizing, tobacco cessation, career, and finances. Poverty Initiative- 100 completed training and at least 50% committed to take action using the information. Additional trainings were scheduled and a community initiative is being considered. Community Health Worker- 9 individuals were trained as Community Health Workers. 76 unduplicated individuals were served by the CHWs at WMHS with 998 visits being made. Assisted with referrals to: 67-Transportation, 49-Prescription (4 Med. Mgmt. and 45 Rx Assistance), 20-Insurance, 4-Tobacco Cessation, 29-Food, 55-Housing/Utilities, and and184-Other –not specified. With the CHW support, there were 50 reports of reduced tobacco use, 109 reports of increased activity level, and 57 reported goals were met. 36 individuals had reduced disease state red flags.	
Continuation of Initiative- This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Behavioral health will continue to be a priority**.**	The continuing status of hospital initiatives are described below. Parish Nursing-based on the broad outreach and positive community feedback, we will continue to support the Parish Nurse program. Community Support Grants-Efforts will continue to establish partnerships that provide social connectedness and reduce poor mental health days. Coaching- interest in and impact of coaching continues to grow and will be continued. Poverty Initiative- Based on community interest and engagement this initiative will continue with trainings and community wide planning. Community Health Worker- Based on initial data, the plan is to continue and possibly expand this service.	
A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Parish Nursing- $62,549 Community Support Grants-$4,691 Coaching-$8,375 Poverty Initiative-$3,810 Community Health Worker- $97,054 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants Parish Nursing-$72 Community Support Grants-$0 Coaching-$0 Poverty Initiative-$0 Community Health Worker-$0

Initiative 4

Identified Need-Substance Abuse	• 13.4 Drug-induced Deaths per 100,000 population (SHIP-Network of Care) • 6.4% Alcohol-related crashes (MCTSA-SHA)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Just Bring It-community outreach and education tools for medication safety and patient engagement
Primary Objective	• Provide education on controlled substance prescriptions including screening, treatment, and monitoring as well as misuse, storage, and disposal. ○ Develop a public educational campaign in tandem with the prescriber training to address safe use, storage and disposal of prescription drugs and identification of abuse and available treatment resources • Enforce laws and promote programs to prevent excessive alcohol consumption
Single or Multi-Year Initiative Time Period	Multi-year starting in 2012
Key Partners in Development and/or Implementation	WMHS, Western Maryland Insurance Company, LLC, Allegany County Health Dept. Associated Charities, Pharmacies, Drug and Alcohol Council, various community organizations, Physician offices, law enforcement and the Allegany County Health Planning Coalition.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. # participants in education program Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA. Various participant feedback and assessment tools are used to determine the success of hospital initiatives. Health department and law enforcement report the medication collections.
Outcomes (Include process and impact measures)	Outcome • Increased Drug-induced Deaths to 15.5 per 100,000 population • Reduced Alcohol-related crashes to 6.2% The process and impact measures of the hospital initiatives are as follows: 10,210 individuals received information about prescription use, storage and disposal. 1610 Just Bring It bags were distributed and providers report use of bags by patients to bring medications to appointments. 5,432 prescription medication containers were collected in FY14.
Continuation of Initiative-This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Substance abuse will not be a priority in the new plan, but an Overdose Prevention Task Force has been established and the Coalition will collaborate when needed.	The continuing status of hospital initiatives are described below. Though there will continue to be education about alcohol and substance abuse, it will not be a priority. Use of the Just Bring It bags/magnets will be integrated into discharge sessions with pharmacists and in the Center for Clinical Resources.

A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Just Bring It-$584 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants $0

Initiative 5

Identified Need-Screening	• 225.1 ED visits for hypertension per 100,000 population (MD residents only) (SHIP-Network of Care) • 379.6 ED visits for diabetes per 100,000 population (MD residents only) (SHIP-Network of Care)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Outreach Education and Screening-promotion of USPSTF recommended screenings. Center for Clinical Resources-clinic with disease management services for diabetes, CHF, COPD, mediation management and anticoagulation. Except for the anticoagulation lab test, there are no fees charged for the CCR. Diabetic Medical Home-clinic providing disease management education and support for diabetics.
Primary Objective	• Improve delivery of clinical prevention services consistent with USPSTF recommendations o Implement an education campaign for both providers and consumers regarding consistent screening recommendations • Support self-management programs for diabetes and other chronic diseases as needed o Promote and expand diabetes self-management program at WMHS o Identify other self-management programs that are feasible in the area
Single or Multi-Year Initiative Time Period	Outreach Education and Screening-multi year, with regular review of recommendations Center for Clinical Resources-multiyear, opened November 2013 Diabetic Medical Home- single year transitioning into CCR
Key Partners in Development and/or Implementation	Medical staff and area providers, AC Health Department, WMHS, American Cancer Society, Tristate CHC, Western Maryland AHEC, Parish Nurses, and Allegany County Health Planning Coalition.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. #providers willing to share recommended screenings # consumers educated on recommended screening # participants in program, increasing over time # initiated programs Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA. Various participant feedback and assessment tools are used to determine the success of hospital initiatives. The Finance and Quality Improvement staff compile visit data and cost savings for patients in the disease management programs and CCR.
Outcomes (Include process and impact measures)	Outcome: Increased rates to… • 231.6 ED visits for hypertension per 100,000 population (MD residents only) • 385.6 ED visits for diabetes per 100,000 population (MD residents only) The process and impact measures of the hospital initiatives are as follows: Outreach Education and Screening-6 practices distributed 1000 rack cards

	promoting recommended screening. Know your Numbers campaign resulted in 11,286 encounters and 202 participants with all their numbers. Center for Clinical Resources- reduction in admissions by 27% and ED visits by 16%. Diabetic Medical Home- More than 813 unduplicated people were served. Demand for the service and initial findings were used to support development of the Center for Clinical Resources, addressing diabetes, CHF, COPD and more in a coordinated manner.	
Continuation of Initiative – This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Screening will not continue to be a priority but disease management will be an ongoing priority**.**	The continuing status of hospital initiatives are described below. Outreach Education and Screening- Screenings will continue to be promoted by WMHS, but it will no longer be a priority area of the local health action plan. Center for Clinical Resources- Reduction of preventable admissions and ED visits, associated cost savings, along with increasing demand and patient satisfaction, justify the continuation and expansion of services at the CCR. Diabetic Medical Home- this service was merged with the CCR.	
A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Outreach Education and Screening-$240 Center for Clinical Resources-$465,659 Diabetic Medical Home-$362,071 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants Outreach Education and Screening-$0 Center for Clinical Resources-$0 Diabetic Medical Home-$24,416

Initiative 6

Identified Need-Heart Disease and Stroke	• 256.8 age adjusted death rate per 100,000 population from heart disease (SHIP-Network of Care)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	CHF Clinic- disease management program that educates and monitors individuals with congestive heart failure Blood Pressure Checks-at various locations.
Primary Objective	• Support evidence based practices that will impact the rate of heart disease deaths o Maintain & develop primary, secondary and tertiary prevention strategies for heart disease
Single or Multi-Year Initiative Time Period	CHF Clinic, since 2011 Blood Pressure Checks, multi year starting before 2000
Key Partners in Development and/or Implementation	WMHS, EMS, media, Parish Nurses, Western Maryland AHEC, TriState CHC, ACHD and Allegany County Health Planning Coalition, Country Club Mall.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. # participants completing the various prevention strategies Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA.

	Various participant feedback and assessment tools are used to determine the success of hospital initiatives. Cardiology department tracked the use of the CHF clinic, until it merged with CCR.	
Outcomes (Include process and impact measures)	Outcome: • Reduced age adjusted death rate to 245.4 per 100,000 population from heart disease The process and impact measures of the hospital initiatives are as follows: CHF Clinic-There were 191 unduplicated participants with 1482 visits. The admissions per patient were reduced for those seen in the clinic. Blood Pressure Checks-721 blood pressure checks were completed via program at the mall and 52.8% of the readings were in the normal range. Education and reminders to check with their provider were given when the reading was high.	
Continuation of Initiative - This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Heart disease will continue to be a priority.	The continuing status of hospital initiatives are described below. CHF Clinic- this service was merged with the CCR. Blood Pressure Checks- service will continue to be offered and tracked at the mall location. Integration of blood pressure checks with other services will continue to increase.	
A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative CHF Clinic-$94,665 Blood Pressure Checks-$897 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants CHF Clinic-$74,345 Blood Pressure Checks-$0

Initiative 7

Identified Need-Chronic Respiratory Disease	• 68.9 ED visits for asthma per 100,000 population (Md residents only) (SHIP-Network of Care)
Hospital Initiative: The initiatives listed are designed to address and/or support the primary objectives of the Local Health Action Plan listed in the next row.	Outreach Education- COPD and Asthma-presentations, displays and risk assessments at various community locations about COPD and Asthma. Better Breathers Club- education and support for individuals dealing with chronic respiratory diseases.
Primary Objective	• Implement an educational campaign regarding chronic respiratory diseases o Implement COPD Awareness campaign o Educate and support individuals in identifying triggers and controls for asthma
Single or Multi-Year Initiative Time Period	Outreach Education- COPD and Asthma-multiyear, increase in 2012 Better Breathers Club- multiyear, since 2013
Key Partners in Development and/or Implementation	WMHS, Better Breathers Club, Pulmonary Rehab, Pediatricians and Primary Care Providers, School Health Nurses, Western Md AHEC, Human Resource Development Commission, ATK and Hunter Douglas.
How were the outcomes evaluated?	Outcomes are evaluated through an annual update and comparison to the baseline measure for the identified needs. Metrics are identified and used to assess short term progress toward outcomes. # reached # educational opportunities # individuals educated about triggers & controls

	Data shared every 6 months with Allegany County Health Planning Coalition to evaluate progress. Also reported to System Management and Board via the Strategic Plan. Hospital initiatives are also tracked in CBISA. Various participant feedback and assessment tools are used to determine the success of hospital initiatives. Some data reported by Pulmonary staff.	
Outcomes (Include process and impact measures)	Outcome: • Reduced ED visits for asthma to 61.6 per 100,000 population (Md residents only) The process and impact measures of the hospital initiatives are as follows: Outreach Education- COPD and Asthma- 4 programs were reported with 300 participants reached. 19 individuals assisted with addressing their triggers for asthma. Better Breathers Club- 53 participants received information and support from the sessions.	
Continuation of Initiative - This is the final year of the Local Health Action Plan so the continuation of all the strategies has been incorporated into the next community health needs assessment process. Asthma will continue to be a priority.	The continuing status of hospital initiatives are described below. Outreach Education- COPD and Asthma- COPD and Asthma education will increase by being added to the Center for Clinical Resources. Community outreach and education will also continue to address the preventive aspects. Better Breathers Club- The plan is to continue this service.	
A. Total Cost of Initiative for Current Fiscal Year **B. What amount is Restricted Grants/Direct offsetting revenue**	A. Total Cost of Initiative Outreach Education- COPD and Asthma-$293 Better Breathers Club-$797 Overall Coordination- $9,520	B. Direct offsetting revenue from Restricted Grants Outreach Education- COPD and Asthma-$0 Better Breathers Club-$0

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

After thorough analysis of the community's needs and assets, thirteen priorities were identified. All of the community health priorities identified through the CHNA were addressed by the local health action plan (implementation strategy). Due to the extent of the identified needs, implementation was spread over multiple years and partnerships with various sectors of the community. Tobacco use, health literacy, healthy start, cancer and immunizations are priorities identified in the CHNA, with complete implementation plans and outcomes. However, they are not included in this report as the hospital's role was secondary or outside the parameters of community benefits (such as tobacco cessation for employees). Details for these priorities can be found at: http://alleganyhealthplanningcoalition.com/lhap_pdf/ProgressReportFY11-14FINALRankings.pdf

The Local Health Action Plan incorporates social issues and the hospital continues to be engaged in addressing overarching issues which directly impact community health.

V. PHYSICIANS

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

The CBSA area for Western Maryland Regional Medical Center is designated a health professional shortage area (HPSA) for low income populations needing primary care, and a HPSA in mental health and dental care for Medical Assistance eligible residents. According to the County Health Rankings (University of Wisconsin), the US Benchmark is to have 1 PCP for every 1,051 persons; Allegany County has 1 primary care provider for every 1,698 individuals. WMHS is also below the US benchmark in dental and mental health providers.

The Physician Needs Analysis done in June 2011 found the top need for WMHS to be primary care, and to a lesser extent, specialists in the areas of Vascular Surgery and Urology. Based on the specialty referrals for uninsured clients in the safety net program, the greatest unmet needs are in Neurology and Nephrology. Dental care for adults has also been identified as a significant need resulting in inappropriate use of the emergency department. However, through partnerships this need has been declining.

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

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

Based on the community health needs assessment and Medical Staff Development Plan, Western Maryland Regional Medical Center has included physician subsidies in the following categories: hospitalists, psychiatric physician practice, obstetric physician practice, and primary care physician practice. With a growing number of area physicians electing to concentrate on their office practice and not admit their patients to the hospital, WMHS needed to expand the Hospitalist program to respond to community need. During the Community Health Needs Assessment, physician shortages were identified in primary care, psychiatry and obstetrics and WMHS responded by recruiting and maintaining practices in these areas. These needs were not being met by other agencies in the community and were much needed services. As a WMHS practice these physicians align with the WMHS Financial Assistance Policy and help ensure that more patients are provided with care in the most appropriate setting.

VI. APPENDICES

I. Description of Financial Assistance Policy (FAP)
II. WMHS Financial Assistance Policy (FAP)
III. Patient Information Sheet
IV. WMHS Mission, Vision, and Values

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

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

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

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

Appendix II

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

FINANCIAL ASSISTANCE POLICY

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

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

In addition, WMHS is designated as charitable (i.e., tax-exempt) organizations under Internal Revenue Code (IRC) Section 501(c)(3). Pursuant to IRC Section 501(r), in order to remain tax-exempt, each tax-exempt hospital is required to adopt and widely publicize its financial assistance policy. WMHS will post notices of its Financial Assistance Policy at patient registration sites, Admissions, Patient Accounting Department and at the Emergency Department. Notices of its Financial Assistance Policy will also be sent to patients on patient bill statements. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients as part of the Admission Handbook given to every admitted patient prior to discharge and upon request.

This policy covers Western Maryland Regional Medical Center and Physician Clinics and Practices owned by WMHS.

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

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

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

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

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

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

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

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

PROCEDURE:

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

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

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

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

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

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

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

7. When calculating total income for purposes of assessing eligibility for financial assistance, the following will be considered in the calculation of total income:
   a. Earned Income
   b. Social Security
   c. Pension Income
   e. Unemployment Compensation
   f. Business or Farm Income less Business or Farm Expenses
   g. Any other income such as rents, royalties, etc.

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

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

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

9. The application, with supporting documents, should be completed by the applicant and returned to the Financial Counseling Department within 10 business days. If partial information is returned, WMHS will provide the applicant with written notice of that describing the missing information and the applicant will be given additional time to provide the required information and supporting documents. If the applicant does not respond, the applicant's request for Financial Assistance will be considered incomplete and WMHS will provide the applicant with written notice of

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

11. Once the Financial Assistance application is complete, decisions on eligibility will be made within 15 business days by the financial counselor and Director, Patient Accounting. Financial Assistance grants over $2,500 will also require the approval of Vice President, Revenue Cycle. The Director and Vice President have the ability to make exceptions as circumstances deem necessary. In the event a patient has medical services scheduled within this 15 day review period, all reasonable measures will be taken to expedite review of the application. The applicant will be notified in writing by the WMHS financial counselor of the determination.

12. If the patient's application for Financial Assistance is approved, it will be made effective for medical services furnished within the 12-month period prior to the approval date and remain effective for 12 months after approval date.

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

14. If a patient account has been assigned to a collection agency, and patient or guarantor requests Financial Assistance, the collection agency will be notified and the account will be placed on hold pending the completion of the application for Financial Assistance within ten business days. WMHS will also provide patients with the Accounts Receivable Collection policy upon request. In the event the application is not completed by the patient within a reasonable amount of time, the application will be denied and the account will be returned to the collection agency.

15. If the application for Financial Assistance is denied, the patient has the right to request the application be reconsidered, in which case the application will be reviewed by the Director, Patient Accounting for final evaluation and decision.

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

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

APPROVAL

Director, Patient Accounting	Date
Vice President, Revenue Cycle/Physician Enterprise	Date

2014 SLIDING SCALE ADJUSTMENTS (Based on FPL)

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

PATIENT RESPONSIBILITY PERCENTAGES

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%	30%	40%
1	0 ($11,670) - $23,340	$23,457-$26,141	$26,258-$29,058	$29,175-$31,976	$32,093-$35,010
2	0 ($15,730) - $31,460	$31,617-$35,235	$35,393-$39,168	$39,325-$43,100	$43,258-$47,190
3	0 ($19,790) - $39,580	$39,778-$44,330	$44,528-$49,277	$49,475-$54,225	$54,423-$59,370
4	0 ($23,850) - $47,700	$47,939-$53,424	$53,663-$59,387	$59,625-$65,349	$65,587-$71,550
5	0 ($27,910) - $55,820	$56,099-$62,518	$62,798-$69,496	$69,775-$76,473	$76,753-$83,730
6	0 ($31,970) - $63,940	$64,260-$71,613	$71,933-$78,605	$79,925-$87,598	$87,918-$95,910
7	0 ($36,030) - $72,060	$72,420-$80,707	$81,067-$89,715	$90,075-$98,722	$99,083-$108,090
8	0 ($40,090) - $80,180	$80,581-$89,802	$90,203-$99,824	$100,225-$109,847	$110,248-$120,270
FPL range	**Thru 200%**	**201% -224%**	**225% - 249%***	**250% - 274%**	**275%-300%**

Each additional person, add $4,060 to base FPL.

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

MEDICAL HARDSHIP FINANCIAL GRID

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

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

Hospital Financial Assistance

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

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

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

Patients' Rights and Obligations

Patients' Rights:

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

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

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

Patients' Obligations:

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

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

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

discuss this matter. (See contact information below).

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

Contacts:

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

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

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

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

Important Billing Information

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

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

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

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

Mission, Vision & Values

Mission Statement

Superior care for all we serve

Vision Statement

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

Core Values – i2care

Integrity – Demonstrate honesty and straightforwardness in all relationships

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

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

Accountability – Ensure effective stewardship of the community's trust

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

Excellence – Strive for superior performance in all that we do