



COMMUNITY BENEFIT & Health Improvement Plan

Sharing the S.P.I.R.I.T.

FY 2019-2021

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Section 1 — Introduction

Mission, Vision & Values

MISSION

Our communities expect and deserve superior medical treatment, compassionate care and expert guidance in maintaining their health and well-being. At Carroll Hospital, our mission is to offer an uncompromising commitment to the highest quality health care experience for people in all stages of life. We are the heart of health care in our communities.

VISION

Carroll Hospital is a portal of health and wellness. We take responsibility for improving the health of our populations through care management and delivering high quality, low cost services in the most appropriate settings. We engage our community at all points of care and promise to provide a seamless health care experience.

Carroll Hospital and The Partnership for a Healthier Carroll County (The Partnership) share the same values, which are clearly defined and integrated in our signage, employment applications, community materials and more. Our values characterize all our actions and experience inspired by personal relationships and genuine compassion.

Our S.P.I.R.I.T. Values include:

Service: *Exceed customer expectations*

Performance: *Demonstrate accountability and achieve excellence in all that we do*

Innovation: *Take the initiative to make it better*

Respect: *Honor the dignity and worth of all with compassion*

Integrity: *Uphold the highest standards of ethics and honesty*

Teamwork: *Work together, win together*

Community Benefit Service Area

Carroll Hospital primarily defines its community benefit service area as Carroll County. The hospital further defines primary and secondary service areas in our Financial Assistance Policy. These communities and zip codes include:

Primary

Finksburg (21048)	Keymar (21757)
Hampstead (21074)	Manchester (21102)
Mount Airy (21771)	New Windsor (21776)
Sykesville (21784)	Taneytown (21787)
Union Bridge (21791)	Upperco (21155)
Westminster (21157 & 21158)	Woodbine (21797)

Secondary

Reisterstown (21136)

The Health Services Cost Review Commission (HSCRC) defines a hospital's primary service area as follows for the mandated community benefit report: "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." (Source: HSCRC FY 2017 Community Benefit Narrative Reporting Instructions).

By that definition, Carroll Hospital's primary service areas include community members living in the following postal zip code areas:

Westminster (21157)	Eldersburg/Sykesville (21784)
Westminster (21158)	Hampstead (21074)
Manchester (21102)	

For the Community Benefit & Health Improvement Plan, we will align the community benefit primary service area definition with the hospital's Financial Assistance Policy definition.

Carroll Hospital Community Benefit Policy

In 2005, the Governing Board of Carroll Hospital established a board-level Community Benefit Policy to clarify and standardize the importance of this element of our mission as a community hospital and as a non-profit organization. Copy is attached in the Appendix.

Section I — Introduction

Community Benefit Planning & Evaluation Committee Membership & Responsibilities

Membership on the Community Benefit Planning and Evaluation Committee is by appointment by the president of Carroll Hospital and includes a diverse group of clinical, financial, compliance, educational and community outreach leaders from the hospital. It also includes representatives from The Partnership, Access Carroll and the Carroll County Health Department.

The committee's charge includes:

1. Developing the Carroll Hospital Community Benefit & Health Improvement Plan for review and approval by the hospital's executive team, the Carroll Hospital Board of Directors and The Partnership's Board of Directors.
 - The plan must be based on information from our recent Community Health Needs Assessment (CHNA) and address verified community needs.
 - The plan must comply with all relevant aspects of the 2010 Affordable Care Act, the HSCRC Community Benefit Guidelines and the IRS 990 guidelines.
 - The Community Benefit & Health Improvement Plan will become an integrated component of the hospital's overall strategic plan and The Partnership's strategic plan.
 - Annual budget projection will include efforts to support Community Benefit & Health Improvement Plan objectives and strategies to address prioritized needs.
2. Reviewing and updating the Carroll Hospital board-approved policy (attached) regarding community benefit fulfillment by our hospital.
3. Providing guidance and assistance regarding the communication of our Community Benefit & Health Improvement Plan either via web, hard copy or other medium.
4. Rolling out and informing the Carroll Hospital Management Forum about the plan.
5. Annually monitoring our organizational compliance with the plan to include the impact we are having on the identified needs and to support required narrative reports to the HSCRC and IRS.
6. Reporting our annual evaluation of our Community Benefit & Health Improvement Plan performance and recommendations to the executive team and board of directors of both Carroll Hospital and The Partnership.

Maryland State Health Services Cost Review Commission

Each year, Carroll Hospital submits a comprehensive community benefit report to the HSCRC, which includes an accounting of community benefit activities conducted by the hospital and a narrative which supplements the financial report. The major categories covered in the report include: community health services, health professionals education, mission-driven health services, research, cash and in-kind contributions, community building activities, community benefit operations and charity care (financial assistance).

The detailed activities and financial data for the report are gathered throughout the year in Lyon Software's CBISA — an online community benefits data and reporting software.

In recognition of the importance of this work, a multi-step review and approval process is incorporated. The Community Benefit Planning & Evaluation Committee members review the preliminary expense report and narrative to consider expenditures in context with activities designed to impact the needs identified. The expense report is then reviewed internally by leaders, including the LifeBridge Health board's community mission committee, the hospital board and, ultimately, submitted to the HSCRC.

A community version of the report is published in the hospital's community newsletter, in its annual report, and on the web sites of the hospital and The Partnership. Progress toward the desired health improvement targets and outcomes of all health improvement efforts will be organized via the evaluation responsibilities of the Community Benefit Planning and Evaluation Committee, who will prepare an annual summary report to the board of directors of Carroll Hospital and The Partnership.

Carroll Hospital Former Community Benefit & Health Improvement Plans

A Community Benefit Planning and Evaluation Committee and formal written plan have been in place at Carroll Hospital and The Partnership for several years. The Community Benefit & Health Improvement Plans FY2014 to FY2016 and FY2017 to FY2018 were the previous plans by the hospital and The Partnership to address the 2012 and 2015 Community Health Needs Assessments, respectively.

See Appendix for a copy of the previous plans.

Section II — Community Health Needs Assessment

In the fall of 2011, the board of directors of The Partnership voted unanimously to undertake responsibility for a Community Health Needs Assessment (CHNA). The process would assure compliance with all requirements as defined by federal or state authorities and assure the hospital's ability to develop a hospital board-approved Community Benefit & Health Improvement Plan.

In previous years, The Partnership's Board of Directors assumed responsibility as the "Community Coalition" required in a separate but somewhat similar State Health Improvement Process (SHIP), and this year they built on this responsibility. In 2018, it was determined with the support of the Carroll Hospital, the Carroll County Health Department and the board of directors that The Partnership will now serve as the backbone organization for community health improvement in Carroll County under the Collective Impact Model. The Community Benefit & Health Improvement Plan as well as the Local Health Improvement Plan will both be components of the Common Agenda.

This coordination of efforts has proven to be an extremely successful process. The 2012 and 2015 Community Health Needs Assessments were used to create seamless plans reaching further than the anticipated Community Benefit and Local Health Improvement Plans. The outcomes were seen in

other organizations' strategic plans throughout the county. Community engagement in the plan has been strong, and measurable progress has been captured via our Healthy Carroll Vital Signs data monitoring system.

We continue this process as we moved forward gathering more information with each assessment, providing longer term trending reports and measurable results and connecting with additional key informants and target populations while we streamline the efforts.

The Partnership integrates bi-annual measurement processes into all of its health improvement work known as "Healthy Carroll Vital Signs (HCVS)." These measures build on national benchmarks and improvement targets and have been nationally recognized for use in community health improvement work. All of this experience enhances The Partnership's ability to lead a process of this importance and exceptional scope.

There continues to be a strong integrated approach by the leaders at the Carroll County Health Department (CCHD) with Carroll Hospital's Sharing the S.P.I.R.I.T. Plan and The Partnership's strategic plan. The creation of a Community Health Plan is underway, which will incorporate both of the previously mentioned Plans as well as a broader community plan that will include local businesses, nonprofits and governmental agencies.

Take the Community Health Survey

And Help Us Fast-Forward to a Healthier Carroll County

How can we build a healthier Carroll County now? You are the answer. Take the online Community Health Survey between July 1 and August 31, and tell us what you need to live healthier today and every day.

1. Go to HealthyCarroll.org/Survey
2. Complete the quick online survey.
3. Be honest. Your answers will help decide what health priorities need to be addressed by health care leaders in Carroll County.

Don't wait.
Rush to HealthyCarroll.org/Survey to help us build a healthier community now.

Conducted by:

Go to HealthyCarroll.org/Survey to accelerate change in Carroll County now.

Fast-forward to a healthier Carroll County.

FOCUS GROUPS

Conducted by:

Fast-forward to a healthier Carroll County.

KEY INFORMANT

Conducted by:

Advertising for online Community Health Survey

Section II — Community Health Needs Assessment

Assessment Overview

To assure compliance with all regulatory requirements, a multi-component process was determined necessary.

Components include:

Primary Data:

- An online **Community Health Needs Survey** was conducted with Carroll County residents between July 1 and August 31, 2017. The survey was designed to assess their health status, health risk behaviors, preventive health practices and health care access primarily related to chronic diseases and injury. A total of 1,254 resident surveys were completed. Additionally, this same survey was promoted to randomly selected residents at community events during this same timeframe, and an additional 46 surveys were completed.
- **Three Key Informant Survey sessions** were held with community leaders and partners. Key informants represented a variety of sectors, including public health and medical services, nonprofit and social organizations, children and youth agencies, and the business community. An additional and separate key informant session was held with mid-level, nonprofit direct service providers. The respondents were asked to complete the survey using their professional knowledge with the populations they serve. A total of 93 key informant surveys were completed.
- Five sessions of **Targeted Populations Research** were conducted using a survey tool that was aligned with the key informants. Focus groups included African American, Hispanic/Latino, LGBT, low income and older adult community members. We asked the respondents to complete the survey as it related to their identified population. A total of 92 surveys were completed.

Secondary data was collected and reviewed to reinforce and possibly identify any additional needs that may have been uncaptured in our primary data components. This extensive data includes:

- **County/Community Demographics:** This information was collected from the Carroll County Department of Economic Development. A good understanding of the ethnic diversity, age distribution, education and employment status, poverty status and more is the necessary context for considering all of this information.
- **Our Community Dashboard:** 100+ indicators were selected from a Maryland-specific list of core measures.
- **Healthy Carroll Vital Signs:** Data indicators are updated twice annually to report on the trending patterns of the plan's priority issues.

- **State of Maryland Health Improvement Process and Local Health Improvement Plan:** 38 high impact objectives were identified with a per-county profile serving as the baseline document.
- **Carroll Hospital Data:** Using the Horizon Performance Manager, readmission rates were tracked using nine recurring categories.
- **Maryland Rural Health Plan:** This Maryland Rural Health Association document gives life to the health care status of rural Marylanders.
- **Healthy Community Vision Project:** This project employed innovative methods to get community involvement in determining the key health issues facing Carroll County.
- **Other Data**
 - County Health Ranking, which is collected by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.
 - *ALICE Study of Financial Hardship*, which is a United Way project. Alice stands for Asset Limited, Income Constrained, Employed.
 - *Summary of the Self-Sufficiency for Maryland 2016*, which is published by the Maryland Action Partnership and calculates how much income a family must earn to meet basic needs.

Information Gaps

While every attempt was made to design a comprehensive assessment, it may not measure all aspects of health in the community, nor can it adequately represent all possible populations of interest. For example, undocumented residents and members of all minority groups might not be represented in sufficient numbers.

It is important to note that the number of completed surveys and limitations to the sampling method yield results that are directional in nature and may not necessarily represent the entire population within Carroll County.



Summary

Details and findings from each component were combined for a “Consolidated Report,” and an executive summary was created for a high level overview of the assessment results. A great deal of information is available for future reference and online at HealthyCarroll.org.

Then, working collaboratively, The Partnership’s board, Carroll Hospital’s board and executive team, local officials, representatives from the Needs Assessment Committee and the hospital’s Community Benefit Planning and Evaluation Committee took the next critical step of prioritizing our focus for action in the next three years. A joint strategies meeting was then convened on December 15, 2017, and was facilitated by Teresa Shattuck, of Shattuck and Associates, after a thorough review of the assessment process, documentation and results.

During the survey process, the key informants and the focus groups were asked questions regarding social determinants of health. This year’s process included nine social determinants of health in the presentation and discussion. Listed in alphabetical order:

1. Affordable housing
2. Early childhood education
3. Economic success
4. Educational attainment
5. Employment opportunities
6. Food security
7. Job skills
8. Quality health access
9. Social support

Social determinants listed below are in order of most identified:

1. Employment opportunities
2. Affordable housing
3. Quality health access
4. Job skills

The top 20 health issues identified through survey collection, County data, and moderated session were included in the prioritization process.

The 20 issues listed here in alphabetical order:

1. Alcohol abuse
2. Alzheimer’s disease/dementia
3. Asthma
4. Cancer
5. Chronic respiratory disease/COPD
6. Congestive heart failure
7. Dental health
8. Diabetes
9. E-cigarettes/vaping
10. Heart health
11. Immunization/vaccination
12. Injury
13. Illegal substance abuse
14. Mental health
15. Obesity
16. Prescription drug abuse
17. Physical inactivity
18. Sexually transmitted diseases and infection
19. Stroke
20. Tobacco use

Section II — Community Health Needs Assessment

To narrow the topic areas for that prioritization process, we requested active input from attendees into determining the priority needs for the focus of the Community Benefit & Health Improvement Plan from among the list of the 20 items on previous page.

We used interactive electronic technology to capture the confidential votes of all attendees. The criteria for prioritization was on a 6-point scale. We had two criteria:

Seriousness

- How significant is the consequence if we do not address this issue?
- How pervasive is the scope of this issue? Does it affect the majority of our population or only a small fraction?
- Is it getting worse? Negative trend?

Ability to Impact

- Can we make a meaningful difference with this issue?
- What is our ability to truly make an impact?
- Are there known proven interventions with this issue?

Using the natural breaks that occurred during the prioritization, we were able to rule in 13 of the health areas as we continued in the planning process. Identifying and bringing together our community leaders and stakeholders for each of the 13 health areas afforded us the opportunity to dig deeper into the concentration of efforts, gaps and needs relative to the area. We were then able to systemize and establish roles and responsibilities. The results are as follows:

- Substance abuse disorders: illegal drug use, prescription drug abuse, alcohol, tobacco
- Dental health
- Primary and secondary prevention of chronic conditions: Physical inactivity, obesity, diabetes, cancer, heart disease, stroke
- Mental health

Identified Needs Not Addressed

Immunization/ Vaccination

It was determined that Carroll County's primary immunization concern is the Influenza immunization, which currently is being managed through a collaborative and cooperative process. Additionally, Carroll Hospital offers flu resource information to everyone who uses services as the hospital, as well as in outpatient settings to encourage individuals to get their vaccine. The resources list locations throughout the county where flu vaccines are offered. This information is also listed on the hospital's website and promoted via social media. Flu clinics are held every fall at senior centers as a collaborative initiative led by The Partnership's Healthy Aging Leadership Team with senior centers and a private pharmacy.

Dental Health/ Oral Hygiene

Access Carroll expanded on its primary care medical services to add dental care in fiscal year 2014. In addition, oral health screenings are offered as part of the hospital's annual health fair each year and throughout the county at community events. Additionally, the Partnership's Healthy Aging Leadership Team will evaluate possible roles for improving oral health. The Carroll County Health Department has a dental clinic for children and pregnant women who have medical assistance.

Key Community Benefit Issues

FY 2019 – 2021

During fiscal years 2019 to 2021, the hospital and partners will focus internal and external strategies with anticipated primary outcomes in the following top key issues. These were determined in collaboration with our community and local public health experts via the Community Health Needs Assessment process described above.

In priority order they are:

1. Behavioral health
2. Diabetes
3. Cancer
4. Heart health

These same four areas will simultaneously be addressed collaboratively with other community partners under the leadership of The Partnership.

Section III — Key Community Benefit Issues

Implementation Strategies

Meeting the Need

The three-year plan will allow us to focus on the prevalent and high impact issues identified via our FY2018 Community Health Needs Assessment. We are interested in results, and this plan includes our proposed ideas on how to accomplish positive progress in the prioritized need areas.

To identify the priorities, several values were defined and applied via varied group efforts with key community involvement. Because improving community health requires varied intervention strategies, some identified needs will be met by collaborative strategies addressing not only the community external to Carroll Hospital, but also by focusing on hospital staff, volunteers and both patients and families (a.k.a. internal constituents). By addressing internal constituents alongside those external to the hospital, there is a consistency of message and an increased ability to positively impact the community.

As this is not Carroll Hospital's first Community Health Needs Assessment or our first Community Benefit & Health Improvement planning process, it was affirming to note the alignment of multiple strategic initiatives already underway by various departments in Carroll Hospital and also by our affiliates, The Partnership and Access Carroll.

Working closely with partners has been a hallmark of this community hospital that will continue. *Connecting people, inspiring action and strengthening community* are the distinguishing characteristics of The Partnership, which builds the engagement and active involvement of individuals and organizations toward measurable health improvement results. The Partnership's vision is to be a leader in implementing healthy community strategies.

The Partnership's Board of Directors has assumed the Collective Impact Model for Community Health Improvement. With this action, The Partnership will serve as the backbone organization for Carroll County, and a Common Agenda among our member organizations will be used. This is a very exciting endeavor for our community as we are able to move beyond collaboration and further the ability of the collective. The Partnership also will create a Community-level Health Plan that will not only include

the Community Benefit & Health Improvement Plan and the Local Health Improvement Plan, the Rural Health Plan but also our partner organizations' and municipalities' efforts in addressing the prioritized community health needs.

All initiatives identified will be advanced under the accountability of Carroll Hospital except those specifically identified as accountable to The Partnership, Access Carroll or the Carroll County Health Department. All actions identified are expected to require the full three years of implementation to accomplish the desired health improvement impact and the targeted results.

There are obvious cross-relationships among several of the priority needs identified. Behavioral health, diabetes, cancer, and heart health all emerged as prominent health problems and share many risk factors and contributing behaviors. We intend to integrate fitness, nutrition, blood pressure awareness, and cholesterol and glucose screenings into programming whenever possible.

Despite a still relatively homogeneous population, we recognize the importance of ethnic and cultural awareness as well as linguistic sensitivity in all outreach activities.

The following outline arranges the needs, in the priority order determined with our community, and describes the need/key finding, objectives, strategies and anticipated outcomes associated with each priority.

We have also included indicators relative to each need area for use in measuring impact and results. The indicators will be tracked by The Partnership and Carroll Hospital. All will be reported publicly on The Partnership's website, HealthyCarroll.org.

Note: The Partnership will address health and wellness with complementary programming specifically for the growing older adult population. Initiatives will be in place to address the needs of this population. Access to health care will be addressed in continuity with The Partnership's Access Leadership Team, which also serves as the Local Health Improvement Coalition. In addition, the Coalition oversees the Local Health Improvement Plan, a component of the Maryland State Health Improvement Plan.

Section III — Key Community Benefit Issues Implementation Strategies



Behavioral Health

Mental Health, Substance Abuse and Alcohol Abuse

The pattern of co-occurrence among behavioral health issues and substance abuse is well documented. Thus, our plan to improve health status in these areas requires acceptance of that relationship and a dual diagnosis approach.

Carroll County has a reported 3,140.8 per 100,000 population age-adjusted emergency room visit rate due to mental health. This number has been on a downward trend since 2011 when it was 3,812.2 (2014, MDH).

Objective:

People across the lifespan are free of addiction and abuse of illegal substances and their effects. Carroll residents have access to integrated, principle-driven mental health systems of care providing recovery/resiliency-oriented services.

Strategies:

1. Continue current programming:

- a) Partnership with Maryland Department of Health (MDH), Youth Services Bureau, the Carroll County Health Department (CCHD) and others to improve communication and improved resources for mental health.
- b) Mental health provider education and outreach—radio talks on WTRR regarding depression and other top mental health issues.

- c) Promote availability of The Partnership's Substance Abuse and Mental Health Resource Directory for the community.
- d) Annual *Risky Business* educational conference produced in coordination with other partners including CCHD, The Partnership and others. The goal is to increase awareness of specific local issues related to substance abuse and/or mental health; to build collaborative opportunities for action, and to bring best practices or new ideas to the forefront. Target audience is school teachers, guidance counselors and mental health professionals, family members of persons receiving services related to substance abuse or mental health.
- e) Collaborate with the CCHD to expand variety and availability of best-practice tobacco-quit assistance programs; expand participation in those programs.
- f) Access Carroll in partnership with the CCHD will continue to be a site for tobacco cessation classes, services and supplies.

- g) Continue to offer complementary health treatments such as acupuncture to use as an adjunct in managing behavioral health issues.
- h) In collaboration with the CCHD, continue Peer Support Specialist program within many areas of the hospital, including the emergency department (ED), as well as Access Carroll. Hospital social work staff and Access Carroll staff have oversight of the program.
- i) 22/7 coverage for case management in the ED.
- j) Continue relationship with and access to Shoemaker Center and other local providers.
- k) Participation in community fairs related to substance abuse issues and resources.
- l) Active participation with the Criminal Justice Diversion program.
- m) Continue with guidelines/hospital policy regarding controlled dangerous substances availability from Carroll Hospital's emergency department.
- n) Continue active participation with the Opioid Overdose Prevention Coalition and Local Overdose Fatality Review Team and other related community groups.
- o) Work with the CCHD-funded mobile crisis services for mental health and addiction.
- p) Collaborate with the CCHD and The Partnership to use consistent messaging, including MDH messaging, to promote an anti-stigma campaign for mental health and substance use.
- q) Continue naloxone education program and distribution of naloxone from ED in collaboration with the CCHD.
- r) Hospital employs full-time behavioral health navigator who focuses on the outpatient population and sees individual patients in person, telephonically and also runs the outpatient adult and adolescent addiction education groups for psychiatric day programs.
- s) Offer Accountable Care Organization (ACO) provider training on how prescriptions can lead to opiate addiction and the connection to heroin abuse. An ACO-wide pain contract will be offered for their use in their offices.
- t) Access Carroll and the CCHD continue to offer behavioral health services for low-income and at-risk Medicare recipients, directly addressing the provider shortage in the community.
- u) Continue working with the CCHD and local law enforcement in a collaborative effort between the behavioral health system, behavioral health consumers, family advocates and community services to provide Crisis Intervention Training (CIT).

2. Potential future programming:

- a) Explore adding tele-psychiatry for behavioral health services within the LifeBridge Health system.
- b) Evaluate implementing depression screening into Carroll Health Group primary care offices with the use of the PHQ9 and implanting social work into those offices.
- c) Recruit behavioral health providers to staff outpatient services for patients.
- d) Explore pilot to utilize Battlefield Acupuncture in the emergency department to manage pain while reducing the use of opioids.
- e) Explore future training and distribution of naloxone to Carroll Health Group provider offices to be administered in the case of an overdose emergency within their offices.

Anticipated Outcome:

Reduction of avoidable readmissions for patients having high utilization (greater than three annually) of behavioral health unit services related to substance abuse and/or co-occurring mental health diagnoses.

Reduction of avoidable emergency department visits for patient having high utilization (greater than three annually) related to behavioral health diagnoses.

Indicators:

- Number of patients re-admitted to Carroll Hospital inpatient unit 3+ times/year for behavioral health diagnosis (Carroll Hospital)
- Suicide mortality—rate per 100,000 (MD Vital Statistics) — SHIP (MD Vital Statistics)
- ED visits related to mental health conditions—SHIP (Maryland Health Services Cost Review Commission)
- Drug-induced mortality rate (deaths caused by prescription or illicit drugs—rate per 100,000 SHIP (Maryland Vital Statistics)
- ED visits for addictions-related conditions—SHIP (Maryland Health Services Cost Review Commission)

Section III — Key Community Benefit Issues

Implementation Strategies

Diabetes

9.7% of Carroll County adults have been diagnosed with diabetes (2016, MD BRFSS) and 28.5% of Carroll County Medicare beneficiaries were treated for diabetes in 2015, according to the Centers for Medicare & Medicaid Services.

Objective:

Through increased participation in diabetes education and screening opportunities, community residents with diabetes or prediabetes will achieve increased disease awareness, compliance and self-management education to prevent associated complications. Thus, there will be an improved health status for residents of Carroll County.

Strategies:

1. Continue current programming:

- a) Diabetes self-management education
- b) Diabetes and prediabetes education programs in outreach markets, including Mt. Airy
- c) Diabetes workshop annually
- d) Total Health Expo annually
- e) Senior expo annually
- f) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus on health and wellness. Responding to the identified needs, this team will propose, develop and carry out the team-determined and agreed upon initiatives. These efforts will include a focus on physical activities and education addressing diabetes and prediabetes. Existing programming, such as Walk Carroll and Stay Strong, can be expanded or modified to best address issues of exercise and nutrition in this population.
- g) The Partnership will offer support to municipalities for increased physical activities with a focus on park development and work with the county to support the planning and implementation of the county-wide bicycle-pedestrian master plan.
- h) The Partnership and hospital collaborative Carroll's Cooking for Wellness™ classes including sessions directed at a variety of population and potentially held at sites throughout the community.
- i) Offer a free Diabetes Basics Class 6x/year for patients referred to the Diabetes Program that cannot meet their cost obligation.

- j) Continue to offer staff support to the Diabetes Prevention Program recognized through the CCHD.
- k) Offer no-cost diabetes and prediabetes screening to the community at scheduled dates and times throughout the year.

2. Potential future programming:

- a) Develop automatic referral process from Carroll Health Group practices to Diabetes Program for anyone with diabetes.
- b) Explore possibility of offering supplemental diabetes education and support in physician offices.
- c) Explore additional opportunities for diabetes education outreach and screening with the faith community.
- d) Assess current diabetes program and explore updates
- e) Collaborate with the CCHD to offer and refer patients and staff to the evidence-based, CDC-supported National Diabetes Prevention Program for people with prediabetes.
- f) Collaborate with the Bureau of Aging and Disabilities to promote the evidence-based *Living Healthy, Living Well with Diabetes* program for people with diabetes and prediabetes.

Anticipated Outcome:

Compliance with best practice standards for self-management of diabetes will be increased through education. Progression rate from pre-diabetes to diabetes will slow.

Indicators:

- Percentage of adults with diabetes (MD BRFSS)
- Age-adjusted death rate due to diabetes/rate per 100,000 (MD Vital Statistics/OCD)
- Emergency department visit rate due to diabetes—SHIP (Maryland Health Services Cost Review Commission)

Heart Health

Heart disease is the leading cause of death in our community. Carroll County is reporting 176.4 deaths per 100,000 population due to heart disease (Maryland Vital Statistics (MVA), 2016) and 46.3 deaths per 100,000 population due to cerebrovascular disease and stroke (MVA, 2016). The Healthy People 2020 national health target is to reduce the stroke deaths to 33.8 deaths per 100,000. Additionally, 32.8% of Carroll County adults have high cholesterol and 9.9% of Medicare beneficiaries in Carroll County have atrial fibrillation (2015, MD BRFSS; 2014, CMS).

Objective:

Increase focus on improving and maintaining cardiovascular health with an emphasis on addressing stroke and heart disease risk factors, recognition, early intervention and prevention.

Strategies:

1. Continue current programming:

- a) Offer monthly blood pressure screenings at multiple locations throughout Carroll County, reaching all outreach markets, providing education and referrals as appropriate.
- b) Provide education and blood pressure screening as requested to local businesses and organizations.
- c) Promotion of Heart Month in February with education and awareness programs.
- d) Increase risk awareness via promotion of Stroke Month in May to include educational programs and marketing.
- e) Offer monthly stroke survivors support group.
- f) Outpatient health navigators are made aware of every patient who is discharged from the hospital with a diagnosis of congestive heart failure and follow them as appropriate.
- g) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus of health and wellness. Responding to the identified needs, this team will propose, develop and carry out the team-determined and agreed upon initiatives. These efforts will include a focus on physical activities and education addressing cardiovascular health. Existing programming, such as stroke awareness, can be expanded or modified, while new initiatives can be implemented in response to community need.
- h) *Lose to Win* – nutrition and weight loss program.
- i) The Partnership and hospital collaborative *Carroll's Cooking for Wellness™* classes including sessions directed at a variety of population and potentially held at sites throughout the community.

- j) Telemonitoring services at home are offered to patients with heart failure after hospital discharge or referral from physician or staff.

2. Potential future programming:

- a) Explore opportunities for heart and stroke education outreach with the faith community.
- b) Explore development of web linked videos on heart healthy eating.
- c) The Partnership is currently exploring community gardens.

Anticipated Outcomes:

The community will maintain a continued downward trend in the death rate per 100,000 populations in Carroll County due to cardiovascular disease and stroke.

Indicators:

- Percentage of adults with high blood pressure (MD BRFSS)
- Percentage of adults with high cholesterol (MD BRFSS)
- Age-adjusted death rate due to CVA (stroke)—rate per 100,000 (MD Vital Statistics)
- Age-adjusted death rate due to heart disease—rate per 100,000 (MD Vital Statistics)
- Emergency department visit rate due to hypertension—SHIP (Maryland Health Services Cost Review Commission)
- Percentage of adults who engage in regular physical activity (150 min. moderate or 75 min. vigorous) (MD BRFSS)

Section III — Key Community Benefit Issues Implementation Strategies



Cancer

Cancer continues to be a leading cause of death in our community. The incidence of breast cancer and melanoma are greater in Carroll County than the Maryland State averages; early detection screening compliance rates for breast and colon are below the American Cancer Society recommended targets. A total of 71.3% of adults aged 50 and older have ever had a sigmoidoscopy or colonoscopy exam, and 78.1% of women aged 50 and older have had a mammogram in the past two years (2014, MD BRFSS).

Objective:

Decrease the burden of cancer in Carroll County by providing cancer education and screening opportunities with a focus on risk factors, prevention, early detection, and access to appropriate treatment and support.

Strategies:

1. Continue current programming:

- a) Promote cancer awareness months: write articles on cancer awareness and screenings in various media. Awareness marketed on hospital's social media channels, marquee and digital signage.
- b) Provide cancer education at health fairs, businesses and organizations, local events and Relay For Life.

- c) Provide sun safety programs to elementary schools, Head Start, community pools, summer camps, 4-H Fair, The Boys & Girls Club, vacation bible schools, area colleges and health fairs. The Partnership will support skin cancer awareness and prevention programming with an emphasis on children and youth. Current programs include tree plantings to increase awareness of needed shade areas (*Safer in the Shade*) and use of protective measures for sun exposure (*Fun in the Sun*). Collaborative efforts with local child serving agencies and community pools.

The Partnership will support skin cancer awareness as it affects the Healthy Aging Population. Skin cancer prevention, education and identification are the focus.

- d) Offer free, one-on-one informational consultation and clinical breast exam screenings with Carroll Hospital's Center for Breast Health physicians to targeted areas of the community.
- e) Offer skin cancer screenings onsite and at outreach locations.
- f) Offer *Embrace to Win Weight Management Survivorship* program to cancer survivors (all cancer types) to improve health and decrease obesity, which could impact recurrence rates.
- g) Offer cancer support group and breast cancer support group monthly. Offer prostate cancer support group every other month in partnership with local urology practice.
- h) *Pink Fling* – a breast cancer awareness, education and fundraising event. Provides a fun afternoon with educational and inspirational speakers, breast cancer survivors and a silent auction.
- i) Hold multidisciplinary breast conference every week.
- j) Studio YOU, a special area in the Wellness Boutique on hospital campus, offering wigs, hats, breast prostheses, mastectomy bras custom order for a fee.
- k) Center for Breast Health, a collaborative, team-based approach to breast care.

- l) Referrals to Patient Assistance Funds.
- m) Offer monthly "After Cancer" Survivorship e-newsletter.
- n) Offer genetic counseling referrals.
- o) Collaborate with Carroll County Health Department's Breast and Cervical Cancer Program (BCCP) and colorectal cancer program to increase awareness of cancer screening and services for low-income county residents.
- p) Collaborate with Carroll County Health Department's Cigarette Restitution Fund to raise awareness of and offer a range of services to help people quit using tobacco.

2. Potential future programming:

- a) Increase awareness and provide education on HPV and the HPV vaccination to the school systems in collaboration with the CCHD.
- b) Coordinate with a provider practice to identify and refer patients who meet the criteria for lung cancer screening.

Anticipated Outcome:

Increase awareness and education of screening guidelines and recommendations as well as prevention for skin, breast, cervical and colon cancers.

Indicators:

- Age-adjusted mortality rate from cancer per 100,000—SHIP (MD Vital Statistics)
- Melanoma incidence—rate per 100,000 (MD Cancer Registry)
- Percentage of adults who smoke tobacco (MD BRFSS)
- Adolescents who use tobacco products – SHIP (Maryland Youth Risk Behavior Survey)

Section IV — Financial Assistance



Carroll Hospital is committed to ensuring that financial resources are not a barrier to anyone seeking health care in our community. Every effort is made to find a payment method that is fair and equitable to the patient. Flexible and individualized approaches are used to obtain services that are provided without discrimination on the grounds of race, color, sex, national origin or creed.

Through education and financial counseling, the underinsured and uninsured, and those who have declared a medical hardship, are directed to the most appropriate place to receive a reduced cost for medically necessary care.

This is accomplished by providing the following services:

- Screening for all federal/state programs as well as local funding and charitable programs. Payment options are communicated by signage, the patient information sheet, uniformed summary bill and the hospital website.
- Assistance with the application process for Medicaid, Medicare and Social Security Disability Insurance; every patient is assigned an advocate to ensure all necessary requirements are met in a timely manner, removing any barriers to the process such as documentation procurement. All associated fees are paid by the hospital.
- Our financial counselors are Maryland State Certified and recognized as advocates to many programs such as Qualified Medicare Beneficiary (QMB), and the SOAR (SSI/SSDI Outreach, Access and Recovery for people who are homeless) Program, which has an immediate impact and relief for homelessness. As advocates, we are able to complete the application process without the patient having to travel for interviews.
- Provide necessary interpreter services to eliminate any language barrier at no cost to our patients.
- Provide outpatient services through our affiliation with Access Carroll such as unlimited labs, a limited number of high-cost diagnostic studies and many other outpatient services (See Appendix for the matrix in Financial Assistance Policy for additional information).
- Education is provided on pharmacy assistance programs for either drastically reduced or free drug enrollment and provide assistance with completing the application.
- Assist patients with the COBRA insurance process and when appropriate, provide initial payment for COBRA coverage.
- Financial assistance is provided for either a total reduction of the bill or a sliding scale percentage based on yearly poverty guidelines. Carroll Hospital exceeds the Maryland State requirement of providing a reduction up to 150% of the Federal Poverty Guidelines by offering a reduction up to 375%. Once financial assistance is granted, the patient is covered for reduced-cost care for a 12-month period. The financial assistance policy (see Appendix) is reviewed and updated annually.
- Financial assistance is offered to a patient within the service area who qualifies for any means tested Federal or State program, waiving the application process.
- In conjunction with our local health department, community needs are identified and, through a collaborative effort, programs are developed to address the need. As an example, the *Best Beginnings* program addresses the large population of uninsured and ineligible for insurance community members in need of prenatal care. A sliding scale fee is offered based on income and used for all services necessary, including physician visits, to ensure a healthy pregnancy and ultimately a healthy baby.
- Our financial counselors are trained and updated on the many agencies within our community that potentially provide access to care for services such as drug addictions programs, shelters, etc. As part of a multi-agency collaboration, a yearly educational session is mandatory to ensure an understanding of the many options available to patients.
- The financial counselors work with many different entities on the patient's behalf in an effort to not only take care of the immediate need for services, but also to establish a plan for a continuation of care and remove the barriers that obstruct access.

Section V — Evaluation

Carroll Hospital’s mission is to be the heart of health care in the community by committing to offer the highest quality health care experience for people in all stages of life. The hospital’s board of directors recognizes the hospital’s charitable mission to the community and governs the organization in a manner that assures that the hospital fulfills that commitment.

Management has sought input from key community stakeholders and the community by conducting a comprehensive health survey. Taking into account the findings of that survey, management has defined key health priorities, objectives and measures of success to advance the health of the community. The board of directors has ratified those priorities.

The president and executive council will assure that the identified priorities are incorporated into the yearly tactical/operational plan and long-range strategic plan of the organization. The board of directors will assume oversight to assure that the hospital carries out the overall strategies identified in the Community Benefit & Health Improvement Plan.

An annual evaluation of the Community Benefit & Health Improvement Plan will be conducted. This evaluation will assess:

- Resources: The sufficiency and allocation of resources available to operate the planned programs
- Activities: Progress toward completion of the proposed strategies
- Outcomes: To the extent an outcome has been established, benchmark progress toward achievement of the desired outcome

Using a standard format for evaluation, the Community Benefit Planning and Evaluation Committee (Committee) will conduct

the detailed evaluation by reviewing both qualitative and quantitative information provided by the hospital, The Partnership and other applicable external resources/agencies. Based on the review of progress toward the achievement of Community Benefit & Health Improvement Plan objectives and outcomes, the Committee will make recommendations to continue, discontinue, modify or expand the program.

Additionally, The Partnership conducts a semi-annual review of the indicator measurements, which are then presented to The Partnership board twice a year.

Annually, the Committee will review the report of community benefit expenditures and accompanying narratives related to the Community Benefit & Health Improvement Plan. This report will be submitted to the HSCRC subsequent to that review. The results will also be the basis for information reported on the hospital’s annual form 990 tax filing.

The LifeBridge Health board’s community mission committee will evaluate the adequacy of the processes in place to validate the accuracy of the community benefit-related expenses and reporting of those results to external parties.

The board has the responsibility for monitoring the hospital’s achievement of the individual objectives adopted in the Community Benefit & Health Improvement Plan. As such, the board will receive the results of the annual evaluation performed by the Community Benefit & Health Improvement Plan development team. This report will summarize the hospital’s progress toward achievements of proposed strategies and desired outcomes, as well as any recommendations related to future programs.

Review Process Timeline

October/November	Community Benefit Planning and Evaluation Committee conducts evaluation of plan—Outcomes, Expenditures, and Narrative Support.
November	Community mission committee of the board reviews report of expenses and narrative submitted to the HSCRC.
December	The LifeBridge Health and Carroll Hospital boards approve final report. Plan expenditures and narrative reported to the HSCRC in conjunction with annual reporting requirements.
March-May	990 form filing is approved by the risk, audit and compliance committee. Annual budget process/ goal development.
June	Annual evaluation of Community Benefit & Health Improvement Plan for fiscal year submitted to the Carroll Hospital board.

Section VI — Committed Resources

Hospital-Based Physicians

Inpatient

A shortage of primary or specialty providers has perhaps posed the most significant challenge in inpatient care delivery. Substantial physician subsidies have become necessary to ensure that all patients requiring anesthesia, pediatric, obstetric, psychiatric, critical care and general medical care have the access they need once admitted to the hospital, including 24/7 coverage. Carroll Hospital has hospitalist programs in each of these areas and allocates a significant amount of resources to sustain the programs. In FY17, more than \$8.6 million was spent to ensure care for all patients and recruiting and retaining physicians.

Outpatient

Equally important is access to physicians on an outpatient basis, not just for the uninsured, but for all patients, especially our growing Baby Boomer population. To ensure our community has access to quality physicians, Carroll Hospital continually monitors statistically calculated need in our medical service area by developing a comprehensive medical staff development plan. The report includes both an analysis of the hospital's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties.

The physician needs assessment methodology used is based on a qualitative standard established by the Internal Revenue Service (IRS). The report guides the hospital's recruiting strategy, helps us to prioritize recruiting efforts and allows the hospital to place contingencies on recruited physicians to ensure they see medically underserved, uninsured, Medicare and Medicaid patients. Recruitment priorities for FY17 included primary care, cardiology, gastroenterology, obstetrics/gynecology, psychiatry, surgery and neurology.

Coverage in the Emergency Department

While Carroll Hospital cares for patients with no means to pay their medical expenses throughout the hospital, it is seen most acutely in the ED, where many underserved or uninsured patients often come for primary and emergent care.

Since all patients presenting to the ED are treated for any medical condition regardless of their ability to pay for care, the uninsured population poses a significant challenge, not only to the hospital but also to physicians providing care in the hospital and in the ED. Due in part to a lack of or minimal reimbursement, it has become increasingly difficult to find specialists to provide around-the-clock, on-call services for the ED. The more serious issue is that this trend affects not only our uninsured/underinsured patients, but all patients seeking treatment in our ED.

The likelihood that patients present more acutely in the low-income population and the accompanying increased potential for malpractice claims also has contributed to specialists choosing not to cover non-paying patients in the ED. That gap is most significant in surgical specialties, including orthopaedics, otolaryngology (ENT), general surgery and plastic surgery. There also has been increasing reluctance from other specialties with significant ED volumes, including vascular surgery, neurosurgery and neurology.

To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Carroll Hospital has continued two major costly initiatives to address the gap proactively. First, the hospital contracts with 10 medical specialties to ensure 24/7 coverage in the ED. Implemented in 2006, those specialties include neurosurgery; general, plastic, vascular and oral surgery; orthopaedics; urology; podiatry; ophthalmology and ENT. While payment for ED call may help with the gaps in coverage for the uninsured, it bears a significant financial toll on the hospital. The expense to pay physicians for ED call totaled \$854,602 in FY2015.

Access to Care—The At-Risk Population: Access Carroll

Another ongoing significant undertaking in the hospital's mission to continue to provide for the uninsured is our partnership with the Carroll County Health Department to fund Access Carroll, a private, nonprofit health care provider that cares for low-income and uninsured people in the area. Many Carroll Hospital affiliated physicians and specialists donate their time to and accept referrals from Access Carroll. In FY17, Access Carroll had 6,237 medical encounters (464 new patients), 4,231 dental encounters (513 new patients) and 4,800 behavioral health encounters (140 new patients) for a total of 15,268 encounters. This practice hopefully will continue to ease the use of the ED as a source of primary care for the uninsured and ensure they have access to general health care when they need it, so that health conditions do not worsen due to their inability to pay for services.

Since 2005, Access Carroll has been helping its patients manage chronic diseases, including diabetes, hypertension, respiratory conditions, chronic pain and mental health issues. The practice features seven medical exam rooms, four dental suites, a centralized pharmacy and 4,200 square feet of space dedicated to behavioral health and recovery services.

**Accountable Care Organization (ACO)
Physician-Hospital Organization (PHO)**

The Carroll ACO and Carroll PHO are collaborations among physicians and Carroll Hospital that focus on care coordination and health information sharing and solutions. Led by physicians, the organizations are designed to solve large and complex challenges that frustrate physicians and their offices. ACOs have been found uniquely effective in delivering better care at lower costs in a manner that also improves the economic health of participating physician practices.

Two of the most significant benefits anticipated are better patient care and better outcomes. By providing physicians with evidence-based care plans developed by the physicians of the ACO/PHO and by connecting patients to clinical, educational and support resources, both patients and physicians will have the tools they need to improve the care process.

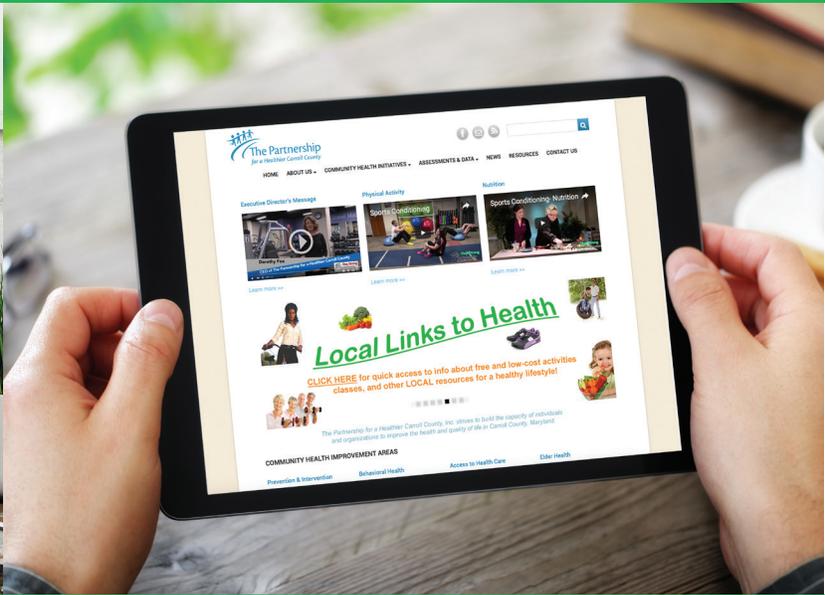
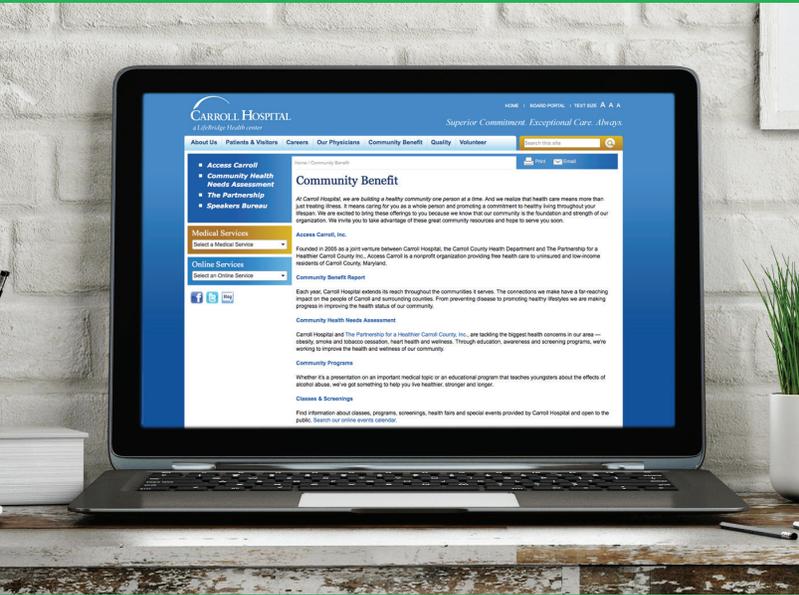
In addition, helping physicians understand and implement the connectivity they need to exchange health care information at a state and national level is crucial. Through its members, the ACO/PHO will have the expertise physicians can draw upon to implement systems that will qualify for Meaningful Use and allow for participation in CRISP, Maryland’s Health Information Exchange.

We know that the key to success in the future will be collaboration, efficiency, cost reduction and quality. And, while we can never be certain what challenges health care will face in the future, what we do know is that it’s changing rapidly. We also know that the Maryland Health Care Commission and Centers for Medicare and Medical Services will continue to pressure providers across the state and throughout the country to find ways to provide more coordinated care and reduce costs.

Carroll Hospital is making significant progress through its ACO/PHO and will continue to develop the organizations to integrate and improve patient care.



Section VII — Communication



Internal Communication

The Community Benefit & Health Improvement Plan will be shared with the boards of Carroll Hospital and The Partnership. The Community Benefit Report is shared with hospital leadership and the board of directors each year before it is submitted to the HSCRC.

An overview of the final report and progress on community benefit outcomes will be presented to management forum regularly and communicated to hospital staff through internal newsletters.

External Communication

The Community Benefit & Health Improvement Plan implementation strategy will be communicated at The Partnership's annual *We're On Our Way* community event, and will be posted on the hospital's and The Partnership's websites by June 30, 2018.

Carroll Hospital publishes the Community Benefit Report in its annual report to donors, distributed January/February each year, as well as the winter/spring issue of *A Healthy Dose*, the hospital's community magazine mailed to more than 50,000 households.

The report also is made available on the hospital's website (CarrollHospitalCenter.org) after February. The Community Benefit tab on the hospital's home page (CarrollHospitalCenter.org/Community-Benefit) links to a comprehensive overview of our various community benefit initiatives and programs. A link to this community benefit strategic plan also will be included on that page.

The HSCRC Community Benefit Report is submitted to the HSCRC in December and published as part of the state's community benefit report. It also is available on the HSCRC's website (hscrc.state.md.us).

Section VIII — Conclusion

This plan is a result of the collaborative work by the Community Benefit Planning and Evaluation Team. Each member's contributions are greatly appreciated.

Needs not addressed in our plan and what else we will do

- Four of 20 identified needs were selected as the priorities of this Community Benefit & Health Improvement Plan based on:
 - 1) Seriousness
 - 2) Ability to impact
- Information about the other needs, including full copies of all CHNA component results, is included in the Appendix of this plan, posted on the website and communicated to our diverse community partners for their use.
- While impact efforts will target the priorities for results, all of The Partnership's teams and Carroll Hospital will remain aware of the other needs, monitor any changing trends annually and remain open to plan modifications if assessments warrant that action.
- Any opportunity for collateral impact on a need other than the prioritized needs will be explored, measured and celebrated.

Ongoing Commitment to Community Benefit

- Inclusion in Carroll Hospital's and The Partnership's annual goal review and/or strategic planning processes.
- Introduction of Community Benefit & Health Improvement Plan to Carroll Hospital management forum and integration with annual performance review systems for accountability.
- Hardwired system and timeframe for impact expectations, results measurement and accountability.
- Hardwired system for results reporting and accountability to community mission committee of the LifeBridge Health Board, LifeBridge Health and Carroll Hospital boards as well as The Partnership Board.
- Delivery system transformations within Carroll Hospital and its subsidiaries, to address population health including a focus on prevention; continuous improvements in care quality and safety and efforts to advance care quality across the health care continuum have potential ability to impact results outside of the top four priority areas.



Section IX — Appendices

FY2017 – FY2018 Community Benefit Plan

FY2014 – FY2016 Community Benefit Plan

Carroll Hospital Financial Assistance Policy

Carroll Hospital Community Benefit Policy

FY2018 Community Health Needs Assessment