Community Benefit & Health Improvement Plan

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

FY 2014-2016

The Partnership for a Healthier Carroll County

CARROLL HOSPITAL CENTER

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About our Community Benefit

***Sharing the S.P.I.R.I.T.**, the title of this Community Benefit plan, intends to describe the purposeful, values-based health care system efforts we have created to address needs in our community. Our S.P.I.R.I.T. (Service, Performance, Innovation, Respect, Integrity and Teamwork) values guide our journey to excellence and thus appropriately introduce this important plan.*

Carroll Hospital Center, centrally located in the county seat of Westminster, Maryland, is a 193-bed private, nonprofit medical campus providing preventative and acute health care for people in every stage of life.

Whether one is in need of a physician or specialist, emergency treatment, surgery, specialized care or wellness education, Carroll Hospital Center is dedicated to being the definitive resource for health care in the community.

With nearly 400 physicians on the medical staff representing more than 38 medical specialties, each year the hospital experiences more 432,000 patient encounters for inpatient and outpatient medical care and community programs.

Featuring the latest in medical treatment and technology, Carroll Hospital Center provides cancer care, including the Carroll Regional Cancer Center; cardiovascular care, including emergency angioplasty; comprehensive women's services, including The Family Birthplace, The Women's Place and the Center for Breast Health; home care services; a nationally ranked emergency department; outpatient services, featuring cardiac rehabilitation, wound care and a diabetes center; medical laboratories; a certified sleep center; and minimally invasive surgical options, including the da Vinci® robotic surgical system and direct anterior hip replacement.

The Partnership

Building on our long tradition of collaboration with our local residents in 1999, the hospital, in partnership with the Carroll County Health Department (CCHD), established *The Partnership for a Healthier Carroll County, Inc.* (The Partnership) to link the hospital's strengths with those of other well-established community partners, to achieve an improved health status.

The Partnership is the entity established to:

- Assess unmet health needs in our community
- Expand the capacity for health and quality of life improvement in our community
- Serve as our collaborative vehicle for interaction with the community
- Drive the effort to create a healthier Carroll County community.

This strategy has allowed Carroll Hospital Center to remain well connected with the community, to leverage resources in action alongside those of other key organizations and agencies and to assure measurable results. Monitoring the health status of the community is an ongoing and interactive process managed by The Partnership, which pursues improvement in the Core Health Improvement Areas (CHIAs) via leadership teams comprised of diverse individuals and organizations who share expertise and interest in the CHIA. With support and guidance from The Partnership, those leaders develop and implement action plans specifically intended to accomplish targeted results. "Healthy Carroll Vital Signs" specific to each CHIA Leadership Team are then affirmed and serve as one of the primary tools for results reporting.

Access Carroll

Together with The Partnership and the CCHD, Carroll Hospital Center took another big step forward in 2005 with the establishment of Access Carroll, Inc. This primary care practice model seeks to better understand and meet the complex and pressing health care needs of some of the most vulnerable members of the community while also helping to address the adjacent socio-economic and other challenges so often accompanying these health disparities. Seeking health improvement with the targeted population of the low income and uninsured is intrinsic to our mission, consistent with population health accountability models and is vital to accomplishing our *healthier community* vision.

Physician-Hospital Organization

Because the hospital leadership understands its responsibilities to reduce costs while improving the health status of our community, Carroll Hospital Center incorporates several best practices intended to align our organization with nationwide efforts to improve the experience of care, the health of our population and the per capita cost of care. We have established a local Physician-Hospital Organization (PHO) with a continually growing number of physician partners all of whom have agreed to share data, work toward common health-status goals and pursue a common electronic medical record exchange system.

Carroll Hospital Center is accredited with commendation by The Joint Commission.

Mission, Vision, Values

Our communities expect and deserve superior medical treatment, compassionate care and expert guidance in maintaining their health and well-being. At Carroll Hospital Center, 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.

Founded by and for our communities, our **vision** is that Carroll Hospital Center will help people maintain the highest attainable level of good health throughout their lives. We strive to be the best place to work, practice medicine and receive care. Our commitment is to be the hospital of choice.

We are continually focused on our **values** which are clearly defined and integrated in our signage, our employment applications, our community materials and more. Our values characterize all our actions and interactions within our multicultural environment. Working together, we provide an exceptional patient experience inspired by personal relationships and genuine compassion.

Our S.P.I.R.I.T. Values include:
Service: *Exceed customer expectations*

Performance: *Deliver efficient, high quality services and achieve excellence in all that we do*

Innovation: *Take the initiative to make it better*

Respect: *Honor the dignity and worth of all*

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

Teamwork: *Work together, win together*

Community Benefit Service Area

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

Primary

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

Secondary

Reisterstown (21136)	Littlestown (17334)
Gettysburg (17325)	Hanover (17331)

The Health Services Cost Review Commission (HSCRC) defines a hospital's primary service area as follows for the state-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 2012 Community Benefit Narrative Reporting Instructions, August 20, 2012)

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

Westminster (21157 & 21158)	Eldersburg (21784)
Hampstead (21074)	Taneytown (21787)

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 Center Community Benefit Policy

In 2005 the Governing Board of Carroll Hospital Center 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. A broad awareness of this organizational commitment is bolstered by an annual review of the document by all Associates. Copy is attached in the Appendix.

Community Benefit Planning & Evaluation Committee Membership & Responsibilities

Membership on the Community Benefit Planning and Evaluation Committee is via appointment by the President and CEO of Carroll Hospital Center and includes a diverse group of clinical, financial, compliance, business development, educational and community outreach leaders.

The committee's charge includes:

1. Developing the Carroll Hospital Center Community Benefit (CB) Plan, for review and approval by the hospital's Executive Team and by the Carroll Hospital Center 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 2012 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 plan objectives and strategies to address prioritized needs.

2. Reviewing and updating the Carroll Hospital Center Board-approved policy (attached) regarding community benefit fulfillment by our hospital.
3. Providing guidance and assistance regarding the communication of our Community Benefit plan either via web, hard copy or other medium.
4. Rolling out and informing the Carroll Hospital Center 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 plan performance and recommendations to the Executive Team and Board of Directors of both Carroll Hospital Center and The Partnership.

Maryland State Health Services Cost Review Commission

Each year Carroll Hospital Center submits a comprehensive community benefit report to the Health Services Cost Review Commission (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 professions 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 and 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 hospital board's Risk, Audit and Compliance Committee and ultimately submitted to the HSCRC. A community version of the report is published in the hospital's community newsletter and also on the hospital's website.

Progress toward the desired health improvement targets and outcomes of all health improvement efforts will be organized via the evaluations responsibilities of the Community Benefit Planning and Evaluation Committee who will prepare an annual summary report to the board of directors of Carroll Hospital Center and The Partnership.

Carroll Hospital Center Former Community Benefit Plans

A Community Benefit Committee and formal written plan have been in place at Carroll Hospital Center and The Partnership for several years. That early work is a strong indication of the organizational commitment to community benefit.

SECTION II — COMMUNITY HEALTH NEEDS ASSESSMENT

In the fall of 2011, the board of directors of The Partnership for a Healthier Carroll County, Inc. (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 Plan.

The Partnership's board of directors also assumed responsibility as the "Community Coalition" required in a separate but somewhat similar State Health Improvement Process (SHIP), which was organized to produce a Local Health Improvement Plan (LHIP).

Timelines for the CHNA and the SHIP/LHIP were concurrent.

The Partnership had conducted multiple previous needs assessments and integrated 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.

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

- **A statistically valid household survey with a confidence level of 95% and a +/- error rate of 3%**. A nationally recognized vendor was chosen to conduct this component and analyze the results. It has been identified as our *Community Health Survey*.
- **Secondary data.** 100+ indicators were selected from a Maryland-specific list of core measures. It was determined that the markers would include capacity for both statewide and nationwide comparability. Another nationally recognized vendor was chosen for this component known as Our Community Dashboard and can be accessed at any time by anyone via The Partnership's website at www.HealthyCarroll.org.
- **Key Informant Surveys.** 54 community leaders from a broad range of academic, business, government, non-profit, public health and health care fields participated in this online process.
- **Focus Groups.** Based on demographic data and best practices, four population groups were targeted for this component including our Hispanic community, our lower income community, our older adult community and our African-American community. Focus groups were conducted by steering committee members in partnership with local organizations who are actively involved with these populations.
- **Demographics.** 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.
- **Carroll Hospital Center Data.** Tracking vital statistics to ensure high quality services with efficient and effective service provision is already hardwired. In the CHNA, this information provides additional context for prioritization of needs identified.
- **State Health Improvement Process (SHIP).** The Department of Health and Mental Hygiene (DHMH) identified 39 High Impact Objectives with a per-county profile serving as the baseline document. After a thorough analysis, a Local Health Improvement Plan emerged with five priority improvement areas and is quite consistent with the priorities identified in the CHNA. There continues to be a strong integrated approach by the leaders at Carroll County Health Department (CCHD), with Carroll Hospital Center's *Sharing the S.P.I.R.I.T.* Plan and The Partnership's strategic plan. The Partnership continues to serve as the community coalition required in the SHIP/LHIP work. Copies of the SHIP and LHIP are included in the Appendix.
- **Other.** Additional timely and valid information was also collected. This includes the Robert Wood Johnson 2012 Health Rankings report for Carroll County and the 2012 Carroll County Transit Development Plan.

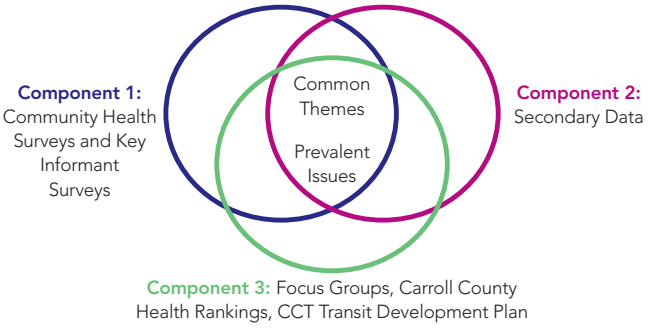
SUMMARY

Details and findings from each component were assembled into a large binder identified as the "Consolidated Report". A great deal of information is in there for future reference.

Then working collaboratively, The Partnership's board, the hospital's executive team, and the hospital's Community Benefit Planning Committee took the next critical step of prioritizing our focus for action in the next three years.

To narrow the topic areas for that prioritization process, key findings of all components were listed, as per the graph on page 5. Those topics identified in more than one of the circles were then counted as "Common Themes, Prevalent Issues or High Impact Areas" and are represented as the concentric circle on the graph on the next page.

Integration of the Components of the Community Health Needs Assessment 2012



The "Common Themes, Prevalent Issues or High Impact Issues" in alphabetical order are:

1. Age discrimination
2. Alcohol in excess
3. Arthritis
4. Asthma
5. Cancer (breast, colon, skin)
6. Diabetes
7. Flu
8. Health care transportation
9. Heart disease (cholesterol & high blood pressure)
10. Help to keep doctor's appointments
11. Help understanding doctors
12. Lack of exercise
13. Medical doctors who accept larger numbers of medical assistance patients
14. Mental health (suicide emergency department visits, anxiety disorders, depression)
15. Motor vehicle deaths
16. Obesity
17. Oral health care access, including availability of dentists who accept Maternal and Child Health Integrated Program (MCHIP)
18. Prescription assistance (stopped medication)
19. Substance abuse (especially prescription drug misuse)
20. Tobacco use

A joint strategies meeting was then convened on September 24, 2012 in two distinct segments.

The first segment featured an interactive presentation on the results of the Community Health Survey (household survey) and Key Informant Survey. It also included an overview from the Department of Health and Mental Hygiene (DHMH) regarding emerging changes anticipated within that agency as a result of health care reform and/or other state/federal efforts. That presentation and a written Executive Summary were thought to best prepare the group for the action phase.

The second segment required active input into determining the priority needs for the focus of the Carroll Hospital Center Community Benefit Plan and for The Partnership's Strategic Plan for FY 2014-2016 from among the list of the 20 items above.

We used interactive technology (clickers) to capture the confidential votes of all attendees. This technology was provided by McDaniel College and facilitated by Jim Kunz, Ph.D., assistant professor of social work at the college. Possible prioritization criteria had been gathered based on several widely respected national sources (a copy and source information is included in the Appendix) and final criteria selection was determined by The Partnership board's CHNA Committee and the Executive Council members of Carroll Hospital Center.

KEY COMMUNITY BENEFIT ISSUES – FY 2014-2016

During fiscal years 2014 – 2016 the hospital will focus internal and external strategies with anticipated primary outcomes in the following seven focus areas. 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. Obesity
2. Diabetes
3. Heart disease
4. Mental health*
5. Cancer
6. Lack of exercise
7. Substance abuse*

*Mental health disorders and substance abuse behaviors are often co-occurring conditions. The professional approach currently employed refers to them in a combined phraseology as behavioral health. Our health improvement activities associated with these conditions will be organized as behavioral health.

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

Also, it should be noted that two additional community health improvement areas—Access to Health Care and Elder Health—are still incorporated into The Partnership's strategic plan for FY 2014 – 2016. This strategic decision was made because of strong community requests that we maintain our successful drive to address access to care; and in regards to elder health, because we have improvement needs identified from a 2009 Elder Health Needs Assessment which that leadership team is actively pursuing.

SECTION III — KEY COMMUNITY BENEFIT ISSUES – IMPLEMENTATION STRATEGIES

The three-year plan will allow us to focus on the Prevalent & High Impact issues identified in our 2012 Community Health Needs Assessment. We are interested in impact, 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. Those values included:

- Community impact
- Urgency
- Size
- Severity
- Alignment with Carroll Hospital Center's and The Partnership's capabilities
- Return on investment

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 Center, but also by focusing on hospital staff, volunteers and both patients and families (aka 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 Center's first Community Health Needs Assessment or our first Community Benefit planning process, it is affirming to note the alignment of multiple strategic initiatives already underway by various departments in Carroll Hospital Center and also by our affiliate, The Partnership.

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. They build the engagement and active involvement of individuals and organizations toward measurable health improvement results and our vision of a healthier community. Be assured that those collaborative efforts will continue.

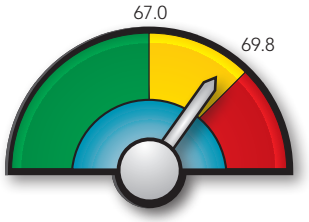
All initiatives identified will be advanced under the accountability of Carroll Hospital Center except those specifically identified as accountable to The Partnership. All actions identified are expected to require the full three years of implementation to accomplish the desired health improvement impact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

Obvious cross-relationships exist among several of the priority needs identified. For instance, obesity, heart disease, lack of exercise and diabetes 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 relatively homogenous population, we recognize the importance of ethnic and cultural awareness, as well as linguistic sensitivity in all outreach activities.

We also have included indicators relative to each need area for use in measuring impact and results. Some of the indicators will require data collection by either Carroll Hospital Center or Access Carroll with periodic results reporting to The Partnership. Others are individually sourced. All will be reported publicly on The Partnership's website www.HealthyCarroll.org.

OBESITY



A total of 68.9% of adults in the county are overweight or obese, and the trend is increasing. (Significant concern was expressed by African-American population members.) Specific data on local child/youth obesity is not available, but national data trends are alarming.

Objective:

Reduce the prevalence of overweight and obese adults in Carroll County; decrease the associated chronic and/or acute disease risks. Improve nutritional behaviors of children and families; inspire and empower individuals, including low income and minorities, to healthier eating behaviors

Strategies:

1. Continue current programming:

a) Lose to Win Wellness Challenge – offer this 12-week program in partnership with **Martin's Food Market** and area fitness centers. This comprehensive program promotes weight loss through nutrition, exercise and healthy lifestyles.

b) Nutritional screenings – offer screening sessions with a registered dietitian to assist people in improving nutritional health and well-being.

c) Cooking with the Doc – offer this nutrition program with a focus on the development of healthy lifestyles, a nutritious diet and exercising to reduce the risk of developing health-related problems related to weight.

d) The Partnership's L.E.A.N. Carroll Campaign – a framework focusing on lifestyle, education, activity and nutrition with multiple associated activities is well established and considered a "best practice" model. The 2012 Healthy Carroll Resource Guide and the 2012 Healthy Dining Guide are two important elements of the L.E.A.N. Carroll frame work. These guides required multiple contributions from community partners to be identified, assembled and then published. Targeted distribution of these publications will be completed by The Partnership.

e) The Partnership's Weight of the Nation programming, another L.E.A.N. Carroll framework element, was offered by The Partnership in collaboration with wellness programming to at least one continuing care retirement community and one educational facility.

f) Nutrition in elementary schools – promoting healthy eating in elementary schools is a primary prevention of obesity in the L.E.A.N. Carroll framework. The Partnership's It's Crunch Time and Farm to School programs with **Carroll County Public Schools** (CCPS), various private schools and other youth-serving programs have had strong participation with measurable results. Similarly, policy change efforts with CCPS and other agencies to address availability of low sugar drink/snack alternatives will continue as funding sources becomes available.

2. Potential future programming

Under the newly constructed Tevis Center for Wellness:

a) Add at least one additional location of the Lose to Win Wellness Challenge to increase central, northern and western community participation.

b) Explore offering hospital wellness program to local businesses.

c) Explore the mechanisms to offer the Lose to Win program on a regular basis with a concurrent weight-loss support group, to include a full-time nutritionist community educator.

d) Explore funding opportunities to offer the Lose to Win program either free or at a reduced cost for those who are unable to pay.

e) Explore other modalities for delivering education that addresses nutrition in newborns, healthy eating in toddlers and preschoolers as well as nutrition during pregnancy. Evaluate addressing these topics in current programming.

f) The Partnership will establish a leadership team with community experts to address both primary prevention and early intervention in obesity trends among Carroll County families.

g) The Partnership will annually provide all family practice, pediatric and internal medicine providers in Carroll Health Group and the PHO with the most current, free and helpful information for them to distribute to their patients regarding healthy weight maintenance.

h) The Partnership will launch at least one, sustainable, long-term primary prevention activity with local leaders and multiple Carroll County residents' involvement.

i) The Partnership will work directly with at least two local organizations to establish new policies addressing sugary drink product placement and availability.

j) The Partnership will explore ways to promote online access of these resources from www.HealthyCarroll.org through L.E.A.N. the designated leadership team.

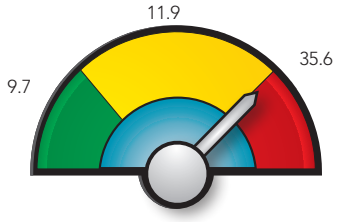
Anticipated Outcome:

Turn the curve (trend line) of overweight and/or obese adults in Carroll County and low income obese preschool children. Increase the percentage of adults who eat fruits and vegetables five or more times per day.

Indicators:

1. Adults who are overweight or obese.
2. Low income preschool children who are obese.
3. Adult fruit & vegetable consumption.

DIABETES



A total of 35.6% of Carroll County adults report having been told they have diabetes; another 14.1% have been told they are pre-diabetic; specific concern regarding diabetes was expressed by the African-American community.

Objective:

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

Anticipated Outcome:

Compliance with best practice standards for self-management of diabetes will be increased by education. Progression rate from pre-diabetes to diabetes will slow. Cultures and traditions of African Americans will be actively discussed with diabetic members of that ethnic group to identify respectful adjustments to traditional foods, etc.

Strategies:

1. Continue current programming:

a) Diabetes education in hospital or health care setting and out in the community

b) Diabetes support group

c) Baby Expo – gestational diabetes education

d) Total Health Expo annually

e) Senior Expo annually

2. Potential future programming:

a) Institute protocols in Carroll Health Group/PHO re: pre-diabetes action/management.

b) Develop and implement diabetes and pre-diabetes education for the African-American community, other outreach markets and for the uninsured population. The Partnership will research best practice options for addressing primary prevention and early intervention related to diabetes. The results of this research will be shared by The Partnership with our leadership team to determine any possible next steps.

c) Begin pre-diabetes outreach programs to specific targeted communities and outreach markets.

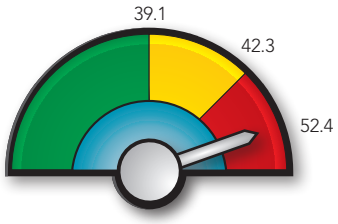
d) Carroll Hospital Center diabetes patients are assessed and evaluated by the Diabetes Center dietitians and/or nurses to determine the appropriateness of referral to the Lose to Win Wellness Challenge.

e) The Partnership will establish a leadership team with community experts to address both primary prevention and early intervention strategies that will address diabetes and pre-diabetes among Carroll County families.

Indicators:

1. Adults with diabetes.
2. Age adjusted death rate due to diabetes.
3. Reductions in acute care admissions and readmissions at Carroll Hospital Center for diabetes. (Data to be provided by Carroll Hospital Center to The Partnership).
4. Number of participants in African-American targeted outreach/screening and diabetes education programs developed and implemented by Carroll Hospital Center.

HEART DISEASE AND STROKE



Heart disease is the leading cause of death in our community. Carroll County is reporting 52.4 deaths per 100,000 population due to cerebrovascular disease and stroke in the 2008-2010 reporting cycle. This is 65% greater than the Healthy People 2020 national health target.

Additionally 33.8% of Carroll County adults have high cholesterol, 5.8% of adults in Carroll County have angina or coronary heart disease, 8.2% report already having had a myocardial infarction and almost 12% report never having their cholesterol checked.

Objective:

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

Strategies:

1. Continue current programming:

a) Work with high risk, chronically ill residents to improve access to care and follow-up through Carroll Hospital Center's Care Transitions Program.

b) Offer low cost cardiac assessments—includes height, weight, body fat analysis, resting EKG, blood glucose and cholesterol, blood pressure, pulse, customized individual report and individual education on risk factors, stroke and heart attack symptom recognition and an action plan.

c) Offer vascular screenings at least three times per year—includes Doppler studies and consultation with a vascular surgeon.

d) Promote Heart Health Awareness Month in February with educational programs to include, but not be limited to: Wear Red Day, Hands Only CPR training, stress reduction programs, and heart disease and stroke education.

e) Offer monthly blood pressure screenings at up to 10 locations throughout Carroll County, reaching all outreach markets.

f) Offer the "Heart of the Matter" educational and support program every other month.

g) Provide annual health risk assessments to all Carroll Hospital Center Associates and identify and counsel those at high risk for heart disease and stroke.

2. Potential future programming:

a) Achieve stroke center certification at Carroll Hospital Center within the next two years.

b) Offer heart, vascular and stroke educational programs to all five senior centers in Carroll County, with a focus on risk factors, early recognition and intervention.

c) Increase risk awareness via promotion of Stroke Awareness Month in May, to include educational programs, stroke risk assessments and marketing media.

d) Provide cholesterol education and screening to targeted populations including low income and African-American residents.

e) Track and trend findings from monthly blood pressure screenings throughout Carroll County reaching all outreach markets.

f) The Partnership will establish a leadership team with community experts to develop both primary prevention and early intervention strategies to address cardiovascular disease and stroke among people who live work or play in our community.

g) The Partnership's Elder Health Leadership Team will increase stroke risk factor awareness among older adults—over 65 years of age.

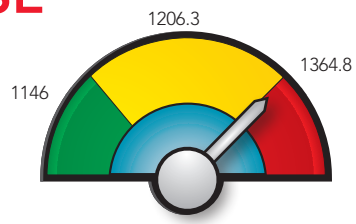
Anticipated Outcome:

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:

1. High blood pressure prevalence.
2. High cholesterol prevalence.
3. Age adjusted death rate due to cardiovascular accident.
4. Age adjusted death rate due to heart disease.

MENTAL HEALTH & SUBSTANCE ABUSE
(Behavioral Health)



The pattern of co-occurrence among mental 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.

The rate of visits to the Emergency Department for behavioral health conditions, including anxiety, depression, eating disorders, psychosis and post-traumatic stress disorder, is 1364.8 per 100,000 people, significantly higher than the SHIP target of 1146 per 100,000. Mental health/behavioral health problems are a major health concern. People in crisis should have access to services. Efforts to avoid mental health/behavioral health crisis situations require that patients and their families have the ability to manage chronic illness and access sources of integrated primary care.

Non-medical use of pain killers is defined as the use of prescription drugs which have not been prescribed by a physician, are used in a manner or dosage other than what was prescribed, or are used only for the experience or feeling they cause. Non-medical use does not include over-the-counter drugs. When prescription pain relievers are abused they can produce serious adverse health effects, including addiction. Drug dependency is a chronic, relapsing disorder which often results in self-destructive and criminal behavior. Among illicit drug use, the number of people abusing prescription pain relievers is second only to the number of people using marijuana.

Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. A total of 21.5% of Carroll County adults smoke. The 2020 improvement target is 12%.

Objective:

Ensure Carroll County residents have access to integrated, principle-driven mental health systems of care providing recovery/resiliency-oriented services. The availability of prescription drugs for potential misuse or illicit use will be reduced, the percentage of Carroll County adults who smoke will be reduced.

Strategies:

1. Continue current programming:

a. Partner with the **Maryland Department of Health and Mental Hygiene**, **Carroll County Youth Services Bureau** and others to improve communication and resources for mental health.

b. Promote mental health provider education and outreach —radio talks on WTTR 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. Conduct the annual Risky Business educational conference in coordination with the **Carroll County Health Department** (CCHD), The Partnership and others. The goal is to increase awareness of substance abuse and/or mental health; to build collaborative opportunities for action; and to bring best practices or new ideas to the forefront.

e. Expand variety, availability and participation in best-practice tobacco-quit assistance programs.

f. The Partnership will continue to expand the number of "Smoke-Free and Tobacco-Free Campuses" among Carroll County's large employers.

2. Potential future programming:

a. Expand adult outpatient behavioral health programs.

b. Develop new behavioral health programs focused on adolescents.

c. Implement a new service line program within Carroll Home Care, addressing mental health diagnosis.

d. Provide 24/7 coverage for case management in the Emergency Department.

e. Improve relationship with and access to **Shoemaker Center**.

f. Implementation of a **CCHD** peer support specialist program to be implemented in **Access Carroll** and Carroll Hospital Center Emergency Department, with Carroll Hospital Center social workers and Access Carroll staff overseeing the program.

g. Host and participate in community fairs related to substance abuse issues and resources.

h. Participate actively with the Criminal Justice Diversion program.

i. Implement new guidelines/Carroll Hospital Center policy regarding controlled dangerous substances availability from Carroll Hospital Center's Emergency Department.

j. The Partnership will establish a leadership team with community experts from both the public and private sector of behavioral health services, to develop strategies to address behavioral health issues.

k. The Partnership, via a Memorandum of Understanding (MOU) regarding funding from the **CCHD**, will recruit a part-time employee (0.5FTE). This person will become the CHIA specialist for The Partnership with responsibilities for forming the Behavioral Health Leadership Team; and overseeing the implementation of programs in the community that will advance the improvement targets with measurable results.

l. The Partnership will research and provide best practice information regarding tobacco risk awareness, assistance with quitting tobacco use and practitioner best practice protocols for Carroll Health Group and the **PHO**.

Anticipated Outcomes:

a. 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 behavioral health diagnoses.

b. Reduction of avoidable emergency department visits from high utilization patients (patients with more than three emergency department visits annually) related to behavioral health diagnoses.

c. Reduction of drug-related overdoses.

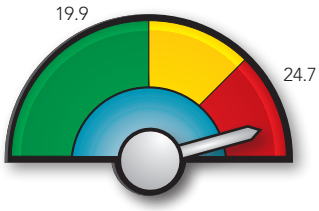
d. Reduction of drug-related suicides.

e. Carroll Health Group and the new **PHO** will increase provider documentation regarding tobacco cessation assistance and report results to the Community Benefit Development team.

Indicators:

- **Access Carroll** wait times for appointments.
- **Access Carroll**, number of patients in integrated primary care model.
- Carroll Hospital Center Emergency Department visits by **Access Carroll** patients related to behavioral health.
- Number of patients re-admitted to Carroll Hospital Center inpatient unit 3 or more times per year for behavioral health diagnosis.
- Self-reported good mental health.
- Percentage rate of nonmedical use of pain relievers.
- Percentage of Carroll County adults who smoke.

CANCER



Cancer continues to be a leading cause of death in our community. The incidence of breast cancer and melanoma are greater here than the Maryland state averages. Early detection screening compliance rates for breast and colon are below targets, and the death rate due to colorectal cancer is greater than the Maryland state average.

In order to meet the increasing need for local cancer care, Carroll Hospital Center is building state-of-the-art cancer and wellness centers that interweave medicine with preventative care. The William E. Kahlert Regional Cancer Center will offer expanded cancer services and coordinated care for patients with all types and stages of cancer. The Tevis Center for Wellness will feature educational programs, health screenings and resources as well as an expanded library and navigation services to help community members better prevent illnesses and promote wellness. This new comprehensive facility is due to open in the fall of 2014.

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, proper treatment and survivorship.

Strategies:

1. Continue current programming to address skin, colon and breast cancers.

a) Hold Multidisciplinary Breast Conference every week.

b) Track referrals to a breast health coordinator by Advanced Radiology of all patients who have an abnormal mammogram and are recommended for biopsy.

c) Offer skin cancer screenings to Associates and broader community at regular intervals throughout the year.

d) Track Carroll Hospital Center's participation in providing skin cancer awareness education to local beauty industry students.

e) Provide educational programs with incentives on tanning dangers/skin cancer to all area high schools during prom season.

f) Offer a cancer support group twice a month and breast cancer support group monthly.

g) Provide sun safety programs to elementary schools, **Head Start**, community pools, summer camps, 4-H fair, **Boys & Girls Club**, vacation bible schools, area colleges and health fairs/expos.

h) Provide cancer education at the **American Cancer Society**'s Relay For Life, health fairs, expos and local businesses, as requested.

i) Promote cancer awareness months by writing articles on cancer awareness and the importance of screenings in various media. Cancer awareness will be marketed on hospital's marquees, digital signage and/or on lobby displays.

j) Expand the Boutique – offering wigs, hats, breast prosthesis, mastectomy bras free-of-charge and also custom order wigs for a fee.

k) Hold the Pink Fling, a breast cancer awareness and Center for Breast Health fundraiser. Provides a fun afternoon with educational and inspirational speakers, breast cancer survivors, silent auction, lunch, etc.

l) Participate in Paint the TownMall Pink, annually in October. Provides breast cancer information and awareness material to the community.

m) The Partnership will continue its "Safer in the Shade" and "Safer at the Pool" skin cancer awareness and prevention programs with emphasis on children and youth.

2. Potential future programming:

a) Develop expanded programs with the newly constructed William E. Kahlert Regional Cancer Center.

b) Coordinate breast care in the new Center for Breast Health.

c) Extend skin cancer education and screening opportunities to outreach markets.

d) Provide colorectal educational programs on awareness and screening to all five senior centers in Carroll County.

e) Design breast cancer awareness programs to engage African-American and/or Hispanic participants.

f) Evaluate the mechanisms for establishing standard protocols for cancer screenings for all Carroll Health Group patients.

g) Carroll Hospital Center will offer a mammography incentive program to be done annually with local businesses to encourage compliance with the **American Cancer Society's** mammography screening guidelines for women age 40 and older.

d) Assess the feasibility of developing an ethnicity participation tracking system with regularly scheduled reports to the Community Benefit Development Team.

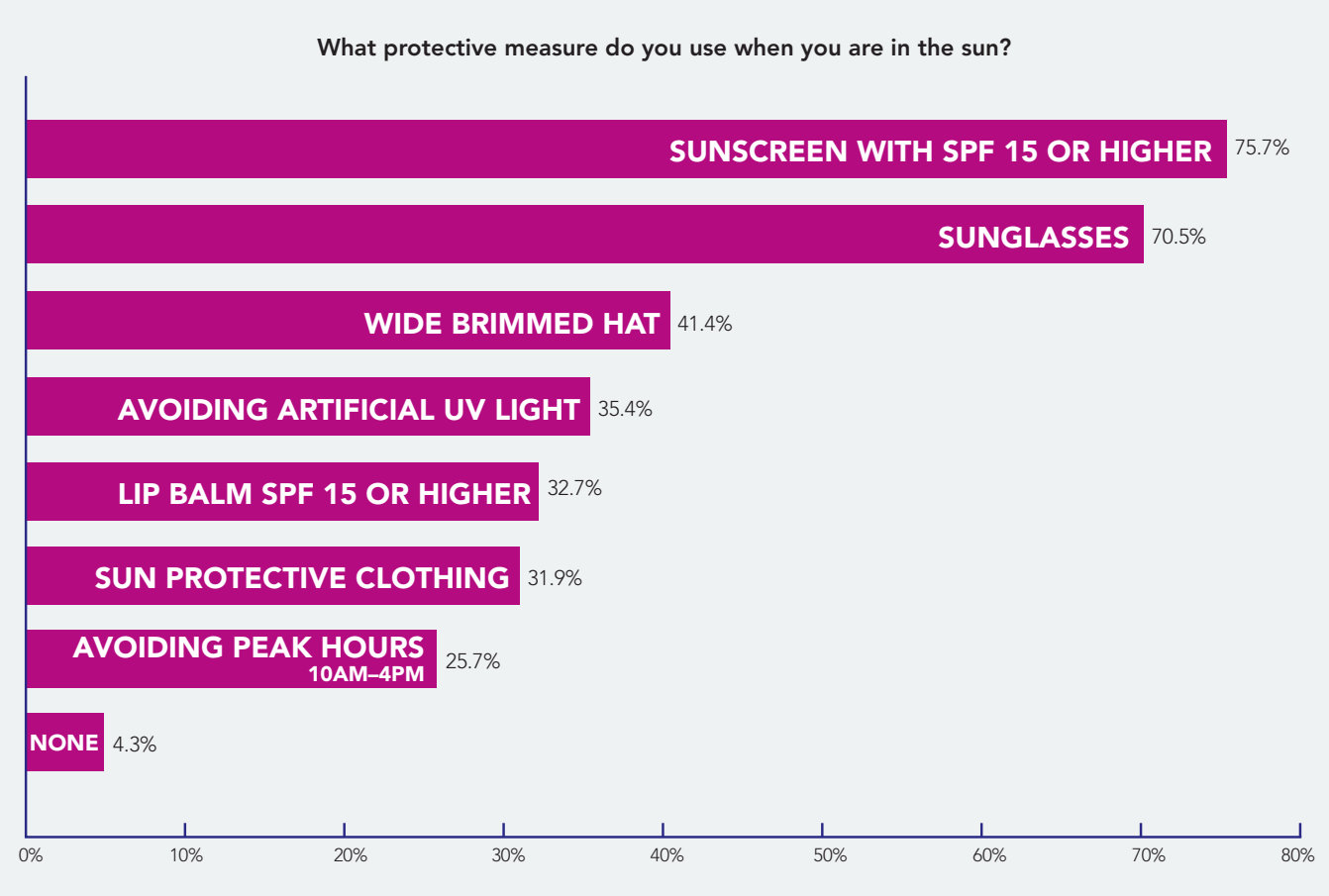
Anticipated Outcomes:

- Maintain a continued upward trend in early stage detection and screening compliance rates for breast and colon cancers.
- Increase education and screening opportunities for skin, breast and colon cancers.
- Increase participation patterns in programs from minority populations.

Indicators:

1. Compliance with the mammogram recommendations of the **American Cancer Society**.
2. Breast cancer early stage diagnosis trends.
3. Compliance with colon cancer screening recommendations (colonoscopy) of the American Cancer Society.
4. Colon cancer early stage diagnosis trends.
5. Skin cancer screening participation.
6. Numbers of people educated on importance of protective measures.
7. Melanoma occurrence rate*.

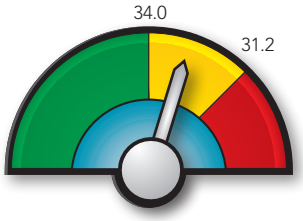
*Injury to skin occurs earlier in a person's life than when melanoma usually occurs.



Source: Holleran Community Survey 2012

LACK OF EXERCISE

Only 33.6% of Carroll County adults reported engaging in moderate physical activity at recommended levels. Active adults reduce their risk of many serious health conditions including obesity, heart disease, diabetes, colon cancer and high blood pressure. In addition, physical activity reduces the symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns.



Objective:

Inspire regular activity and exercise patterns among Carroll County adults and their families.

Strategies:

1. Continue current programming:

a. Carroll Hospital Center's Wellness Program – stress walking routes, walking programs.

b. Lose to Win Wellness Challenge – offer this 12-week wellness challenge in partnership with **Martin's Food Market** and area fitness centers. This comprehensive program promotes weight loss through nutrition, exercise and healthy lifestyles.

c. The Partnership's L.E.A.N. Carroll Campaign – a framework focusing on Lifestyle, Education, Activity and Nutrition with multiple associated activities is well established and considered a "best practice" model. Distribute and update the 2012 Healthy Carroll Resource Guide. It provides age-appropriate information on healthy living and comprehensive information on county parks and free or low-cost recreational opportunities that enhance exercise and fitness. This guide required multiple contributions from community partners to be identified, assembled and then published. Targeted distribution of these publications will be required by The Partnership.

2. Potential future programming:

a) Evaluate the possibility of a community walking program.

b) Evaluate the possibility of providing walking opportunities for Associates and community during lunchtime.

c) The Partnership will establish a leadership team with community experts to address both primary prevention and early intervention in obesity or overweight trends among Carroll County families. Exercise will be an important activity included in those plans.

d) The Partnership, in collaboration with the above leadership team, will research, design and implement local community–based walking challenges to include some aspects of the following ideas:

- Walking challenges happen simultaneously in many or all Carroll municipalities
- 12-month goals
- Mileage targets, participation targets
- Family friendly ideas
- High visibility of local leaders ie: mayors, CEOs, business leaders, etc.
- Scholarship-type prizes for student leaders who either research the problems and write great papers or design great ideas for solutions.

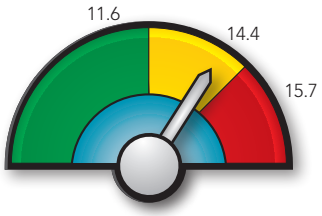
Anticipated Outcomes:

Continue to increase the trend of self-reported exercise.

Indicators:

1. Adults engaging in moderate physical activity.
2. Adults engaging in regular physical activity.

ACCESS TO HEALTH CARE*



Approximately 14,000 to 21,000 of 178,000 Carroll County residents have no health insurance, no medical home, and no prescription program, and are not eligible for Medical Assistance programs. High numbers of these people have multiple co-occurring chronic illnesses. And yet, these numbers do not reflect undocumented local persons. In addition, 14.4% of adults are unable to afford to see a doctor.

Objective:

Access to health care is important to eliminate health disparities and increase the quality and years of healthy life for all. Achieving measurable goals to advance access for all, with emphasis on health care for underserved and uninsured residents, is a cornerstone of this community hospital and of The Partnership.

Strategies:

1. Support establishment, infrastructure, leadership, direct patient care and operations of **Access Carroll, Inc**. with financial and in-kind services to assure a medical home availability to the low income, uninsured population.
2. Include **Access Carroll, Inc.** in the **PHO** to assure quality, outcomes measurement, shared databases and more.
3. Expand Carroll Health Group physician availability to underserved areas of Taneytown/Union Bridge.
4. Provide a matrix of hospital provided services associated with the hospital's financial assistance program.
5. Work collaboratively to resolve in-county and out-of-county transportation to health care services issues.
6. The Partnership and Carroll Hospital Center will each advocate for Federal Qualified Health Center (FQHC) status for **Access Carroll**.
7. The Partnership will encourage professional volunteerism at **Access Carroll**.
8. The Partnership will advocate for the health care transportation assistance efforts of partners at **Caring Carroll**.
9. Support the mobile health van program of **Mission of Mercy** which serves Taneytown and Reisterstown communities with diagnostic services.

**Access to Health Care and Elder Health are priorities The Partnership identified in prior needs assessment processes, and will continue to address in the low income, uninsured and older adult populations.*

Anticipated Outcome:

People living in Carroll County will have access to quality, affordable and available primary health care, dental care, behavioral health care, hospitalization and pharmaceuticals.

Indicators:

1. The number of patient encounters compared to budgeted encounters and the number of volunteer professional provider hours compared to budgeted hours at Access Carroll will increase from the 2012 baseline.
2. The value of free prescription assistance provided annually via Access Carroll will increase from the 2012 baseline.
3. Carroll Hospital Center Emergency Department (ED) visits by Access Carroll patients, related to behavioral health, will decrease.
4. Numbers of non-emergency ED visits by Access Carroll patients annually will decrease.
5. Number of new Carroll Health Group practices that will open in targeted communities.

ELDER HEALTH*

A focused Elder Health Needs Assessment was conducted by The Partnership in 2008. Conducted in collaboration with the Center for the Study of Aging at McDaniel College and with the prestigious Copper Ridge Institute, this focused study identified several key needs among our older population.

In 2010, priorities to be addressed were identified by members of The Partnership's Elder Health Leadership Team (EHLT). This diverse group of older adults and older adult service providers has identified and implemented several actions to achieve results in fall prevention, stroke risk awareness and prevention, flu prevention, seat belt compliance and other driver safety measures, and advanced directives awareness/utilization.

This work is ongoing and improvement targets have not yet been met in all areas. Some of the leadership team members may choose to continue that work but will, as a leadership team, turn the focus to the pursuit of results in the top three areas identified in the 2012 CHNA: obesity, diabetes and heart disease/stroke. The work will be specifically focused on the population who are 65 years of age and older. This leadership team will also seek improvement in the areas of flu prevention among those over age 65 and reductions in perceived age discrimination as well.

Objective:

Quality and years of healthy life are improved for adults over age 65.

Strategies:

The Elder Health Leadership Team will collaborate with the Primary Prevention and Early Intervention Leadership Team to implement age specific (over 65) strategies. Similar timing and most efficient implementation will be incorporated to assure full inclusion of this population and maximum impact.

**Access to Health Care and Elder Health are priorities The Partnership identified in prior needs assessment processes, and will continue to address in the low income, uninsured and older adult populations.*

Anticipated Outcomes:

Elder Health outcomes will be measured by the outcomes of the top three key community benefit issues (obesity, diabetes, and heart disease and stroke), for people ages 65 and older living in Carroll County.

Indicators:

1. Adults over 65 who received a flu shot.
2. Adults over 65 with diabetes.
3. Acute care admissions/readmissions to Carroll Hospital Center for diabetes among those over age 65.
4. Age adjusted death rate due to cardiovascular disease and heart diseases.
5. High blood pressure prevalence in those over age 65.
6. High cholesterol prevalence in those over age 65.

SECTION IV — FINANCIAL ASSISTANCE

Carroll Hospital Center 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 under-insured 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 Center 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, waving 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 "undocumented" community members in need of pre-natal 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. An interpreter is assigned to accompany the patient physician visits as needed.
- As part of our ongoing community education and assistance, a "Cover the Uninsured Day" is offered at our facility for community members to talk with a counselor to verify eligibility for any federal, state, or local programs. 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 not only to take care of the immediate need for services, but also to establish a plan for a continuation of care and removing the barriers that obstruct access.

SECTION V — EVALUATION

Carroll Hospital Center'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 CEO 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 Plan.

An annual evaluation of the Community Benefit 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 towards achievement of the desired outcome

Utilizing a standard format for evaluation (TBD), 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 Plan objectives and outcomes, the Committee will make recommendations to continue, discontinue, modify or expand the program.

Annually, the Committee will review the report of community benefit expenditures and accompanying narratives related to the Community Benefit 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 board's Risk, Audit and Compliance 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 Plan. As such, the board will receive the results of the annual evaluation performed by the Community Benefit Plan Development Team. This report will summarize the hospital's progress towards 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
December	Plan expenditures and narrative reported to the HSCRC in conjunction with annual reporting requirements.
January	Risk, Audit and Compliance Committee of the Board reviews report of expenses and narrative submitted to the HSCRC
February	Board reviews progress towards completion of strategic initiatives and evaluates outcomes
April	990 form filing is approved by the Risk, Audit and Compliance Committee
March-May	Annual budget process /Goal Development

Budget Process/Accounting

Each department is responsible for identifying and budgeting for its specific community benefit expenses. Where appropriate, Finance will set up individual line items for community benefit expenses. Any community benefit expenses should be submitted as part of the annual budgeting process.

Leaders also are expected to regularly record and submit in-kind resources for themselves and their departments to be included in the hospital's annual Community Benefit Report.

Strategic Planning

All community benefit priorities are tied directly to the hospital's strategic initiatives, specifically those focused on quality, service and growth. The community benefit plan is an integral component in the hospital's long-term planning process and also provides emphasis for the hospital's present priorities including:

1. Expanding our primary care and specialty presence in key geographic markets to better serve our patient population.
2. Managing utilization of the Emergency Department by helping patients manage chronic illness more proactively and by providing patients with more appropriate, less costly urgent care options.
3. Managing mental health patients more effectively by expanding Behavioral Health Services to provide more services on an outpatient basis.
4. Improving hospital performance in quality and patient safety.
5. Providing a comprehensive range of cardiovascular, cancer and diabetes services on an outpatient basis in key locations to better serve our patient population through development and construction of new cancer and wellness centers.

Carroll Health Group

Carroll Health Group, Carroll Hospital Center's network of primary and specialty physicians, is the foundation of the hospital's mission to "offer an uncompromising commitment to the highest quality health care experience for people in all stages of life."

Carroll Health Group physicians are located throughout the county for easy access for patients and many are also positioned near other important health care resources including lab, radiology, rehab services, pharmacy and medical equipment providers for enhanced patient convenience.

By building a group of some of the best board-certified, fellowship-trained physicians in their respective fields, the hospital is ensuring its patients have access to primary care (family practice, internal medicine, pediatrics and gerontology) and a broad range of specialties including cardiology, otolaryngology, endocrinology, general surgery, neurology, neurosurgery, OB/GYN, orthopaedics, plastic surgery and vascular surgery, where and when they are needed. Working from a common Electronic Health Record (EHR) system, those providers are able to collaborate as a team to create a more effective, more efficient and more holistic treatment plan for every patient.

In addition, many of our primary care offices serve as Patient-Centered Medical Homes (PCMH) which means that those practices serve as a "home base" for all of their patients' health care needs. It's a team-based model of care led by our primary care physicians who provide continuous and coordinated care. Patients are more involved in their own care, ensuring their health care plan is uniquely tailored to his or her needs.

As affiliates of Carroll Hospital Center, Carroll Health Group physicians meet the same high standards of quality to which every hospital program and service is held. By continuing to add skilled physicians who share the same care philosophy and values of Carroll Hospital Center and Carroll Health Group, the hospital will continue to develop its provider network to effectively meet the growing and changing needs and demographics of its primary service area.

Physician Recruitment

As described above, the hospital will continue to build upon its provider network, Carroll Health Group. Recruitment goals will be developed each year based on strategic priorities and in accordance to the Medial Staff Development Plan.

Hospital-Based Physicians

As the population continues to grow, demand for physicians continues to increase in virtually all specialties while the supply of physicians continues to decrease. The trend is leaving hospitals faced with significant challenges in recruiting and retaining the number of physicians required to continue to provide adequate health care access for all patients.

Inpatient

A shortage of primary or specialty providers has perhaps posed the most significant challenges in inpatient care delivery. Substantial physician subsidies have become necessary to ensure that all patients requiring anesthesia and pediatric, psychiatric and critical and general medical care have the access they need once admitted to the hospital. Carroll Hospital Center has hospitalist programs in each of these areas and allocates a significant amount of resources sustaining the programs.

Outpatient

Equally as important is access to physicians on an outpatient basis–not just for the uninsured, but for all patients in our growing community. To ensure our community has access to quality physicians, Carroll Hospital Center continually monitors statistically calculated need by developing a comprehensive medical staff development plan based on the health care needs of our medical service area. 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.

Coverage in the ED

While Carroll Hospital Center cares for patients with no means to pay their medical expenses throughout the hospital, it is seen most acutely in the Emergency Department (ED), where many 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 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 on-call services for the ED around-the-clock. This trend affects all patients seeking treatment in our ED.

The likelihood that patients present more acutely in the uninsured 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 has also been increasing reluctance from other specialties with significant ED volumes, including general surgery, 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 Center has continued two major, costly initiatives to address the gap proactively. First, the hospital contracts with ten 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. The expense to pay physicians for ED call has cost the hospital nearly $426,992.

Additionally, the growing volumes of uninsured patients has caused the hospital to recently institute an additional policy which allows physicians who see patients without a payment source in the ED to be reimbursed for physician services by the hospital at current Medicare rates. While payment for ED call may help with the gaps in coverage for the uninsured, it bears a significant financial toll on the hospital.

Physician-Hospital Organization (PHO)

The Carroll PHO is a collaboration among physicians and Carroll Hospital Center that focuses on care coordination and health information sharing and solutions. Led by physicians, the PHO is designed to solve large and complex challenges that frustrate physicians and their offices. PHOs 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 for the Carroll PHO are better patient care and better outcomes. By proving physicians with evidence-based care plans developed by the physicians of the 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 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 Center is making significant progress through its PHO and will continue to develop the organization to integrate and improve patient care.

Internal Communication

The Community Benefit & Health Improvement Plan will be shared with the Boards of Carroll Hospital Center and The Partnership. The Community Benefit Report is shared with hospital leadership before it is submitted to the HSCRC. The final report also is shared with the hospital's board of directors in February each year.

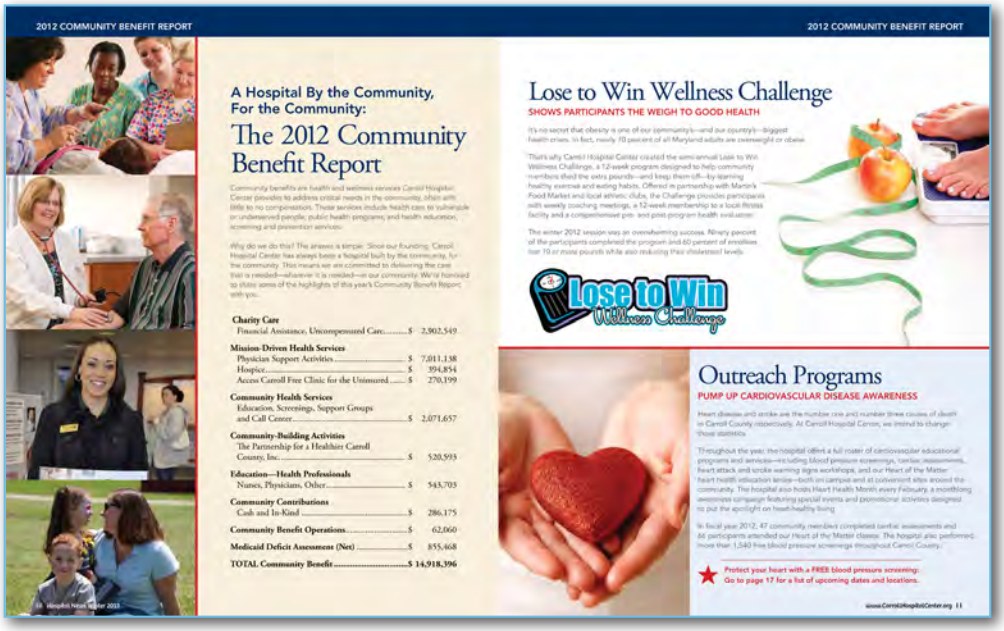
An overview of the final report and progress on community benefit outcomes will be presented to Management Forum each spring and communicated to hospital staff through internal newsletters.

External Communication

The Community Benefit & Health Improvement Plan implementation strategy has been 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, 2013. Carroll Hospital Center publishes the Community Benefit Report in its Annual Report to donors, distributed by January 31 each year, as well as the winter/spring issue of *Hospital News*, a community magazine mailed to more than 65,000 households.

The report also is made available on the hospital's website (CarrollHospitalCenter.org) by 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. This community benefit strategic plan also will be included on that page.

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



We employ the best and the brightest, which is reflected in the collaborative work of the Community Benefit Planning and Evaluation Team. Kudos to team members for their hard work, adherence to required timeline and setting high standards for the work. A well-deserved "thanks" and recognition is greatly deserved.

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

- 7 of 20 identified needs were selected as the priorities of this community benefit plan based on:
  1. Community impact
  2. Urgency
  3. Size (scope of need)
  4. Alignment with Carroll Hospital Center and/or The Partnership's capabilities
  5. Return on investment
- Information about the other 13 needs, including full copies of all CHNA component results, will be included in the Appendix of this plan, posted on the website and communicated to our diverse community partners for their utilization
- While impact efforts will target the seven priorities for results, all of The Partnership's teams and Carroll Hospital Center will remain aware of the other 13 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 seven prioritized will be explored, measured and celebrated (ie: Priority #7 Substance Abuse improvement efforts might result in improvement in "Alcohol in Excess").

Ongoing Commitment to Community Benefit

- Inclusion in Carroll Hospital Center's and The Partnership's annual goal review and/or strategic planning processes
- Re-branding of leadership team to Community Benefit Planning and Evaluation Team
- Establishment of new shared co-leadership of that team
- Introduction of community benefit plan to Carroll Hospital Center 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 Risk, Audit, Compliance Board Committee and full Carroll Hospital Center Board and the Partnership Board
- Delivery System transformations within Carroll Hospital Center 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 seven priority areas
- Carroll Hospital Center's and The Partnership's active membership in the Institute for Healthcare Improvement's Triple Aim framework to optimize health care system operating performance is expected to help produce impact in our community benefit performance as well.

SECTION IX — APPENDICES

Carroll Hospital Center Financial Assistance Policy

Carroll Hospital Center Community Benefit Policy

Holleran Key Informant Survey Results

Holleran Community Survey Results

Our Community Dashboard (Healthy Communities Institute results)

Focus Groups Results: African-American Focus Group; Hispanic Focus Group; Elder Health Focus Group; Low-Income Focus Group (2)

Robert Wood Johnson Foundation County Health Rankings 2012

Carroll County Demographics

Carroll Hospital Transit Development Study 2012 and proposed action plan

State Health Improvement Process (SHIP), Carroll County SHIP Profile and Carroll County Local Health Improvement Plan