Community Benefit
& Health Improvement Plan

The Picture of Health FY 2022-2024

CARROLL HOSPITAL
A LifeBridge Health Center
CARE BRAVELY

The Partnership
for a Healthier Carroll County

Table of Contents

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 healthcare experience for people in all stages of life. We are the heart of healthcare 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 healthcare 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)
Hampstead (21074)
Mount Airy (21771)
Sykesville (21784)
Union Bridge (21791)
Westminster (21157 & 21158)
Keymar (21757)
Manchester (21102)
New Windsor (21776)
Taneytown (21787)
Upperco (21155)
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)
Westminster (21158)
Manchester (21102)
Eldersburg/Sykesville (21784)
Hampstead (21074)

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. A 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 websites 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, which 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 and FY2019 to FY2021, were the previous plans by the hospital and The Partnership to address the 2012, 2015 and 2018 Community Health Needs Assessments, respectively.

See Appendix for a copy of the previous plans.

Section II — Community Health Needs Assessment

In fall 2019, 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.

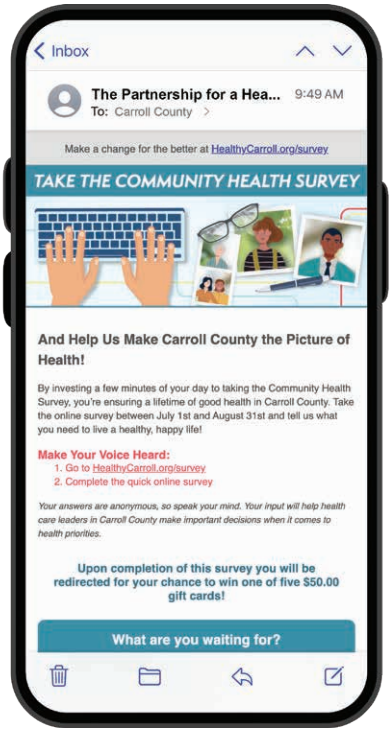
In previous years, The Partnership's Board of Directors assumed responsibility as the "Community Coalition" required in a separate but somewhat similar State Health Improvement Process (SHIP) and continues to build on this responsibility. In 2018, it was determined with the support of Carroll Hospital, the Carroll County Health Department and the board of directors that The Partnership would 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.

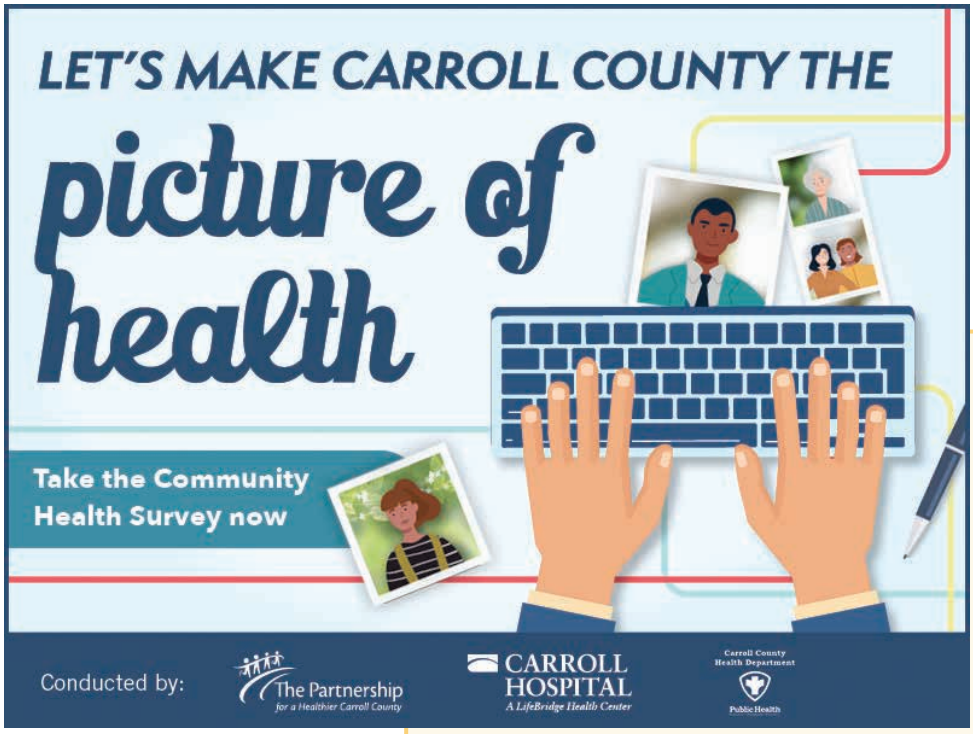
This coordination of efforts has proven to be an extremely successful process. The 2012, 2015 and 2018 Community Health Needs Assessments were used to create seamless plans reaching further than the anticipated Community Benefit and Local Health Improvement Plans. The outcomes were seen in other organizations' 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 move 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 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 previously mentioned Plans as well as a broader community plan that will include local businesses, nonprofits and government agencies.





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 and September 2020. The survey was designed to assess their health status, health risk behaviors, preventive health practices and healthcare access primarily related to chronic diseases and injury. A total of 744 resident surveys were started with 728 completed throughout the county to promote geographical and ethnic diversity among respondents.
- **Three Key Informant Survey sessions** were held between July and September 2020. 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. Two sessions included community leaders and stakeholders with expert knowledge, and one 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 56 key informant surveys were completed during the moderated sessions. All sessions were conducted by video conference due to the advisories related to the COVID-19 pandemic.
- Ten sessions of **Targeted Populations Research** were conducted in focus groups with different community groups including African American (x2), Behavioral Health Consumers (x2), Hispanic/Latino, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer), Transitional Aged Youth, Older Adult (x2), and a lower income population group. All sessions were scheduled between July and September 2020. Research participants were invited to complete a survey to identify the specific needs of their community. In addition, The Partnership led a moderated discussion with each group after completion of the online survey except for the LGBTQ group which was completed by online survey only. Three of the groups were moderated virtually. More than 50 individuals completed the survey and/or participated in a focus group.

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:

From Executive Summary:

- **Our Community Dashboard**
- **Healthy Carroll Vital Signs**
- **State of Maryland Health Improvement Process and Local Health Improvement Plan**
- **Other Data**
    - **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 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.
- County Health Ranking, which is collected by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.
- Carroll Hospital Data: Using the Horizon Performance Manager, readmission rates were tracked using nine recurring categories.
- *ALICE* Study of Financial Hardship, which is a United Way project. Alice stands for Asset Limited, Income Constrained, Employed.

Section II — Community Health Needs Assessment

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.

Prioritization

Working collaboratively, The Partnership's board, Carroll Hospital's board and executive leaders, 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 and prioritization meeting was convened on February 9, 2021 and was facilitated by Edward Gerardo, consultant, 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 development
3. Economic success
4. Educational attainment
5. Employment opportunities
6. Food security
7. Job skills
8. Quality health access
9. Social support

The three social determinants of health believed to be the most important to address are listed below in alphabetical order:

1. Affordable housing
2. Employment opportunities
3. Social support

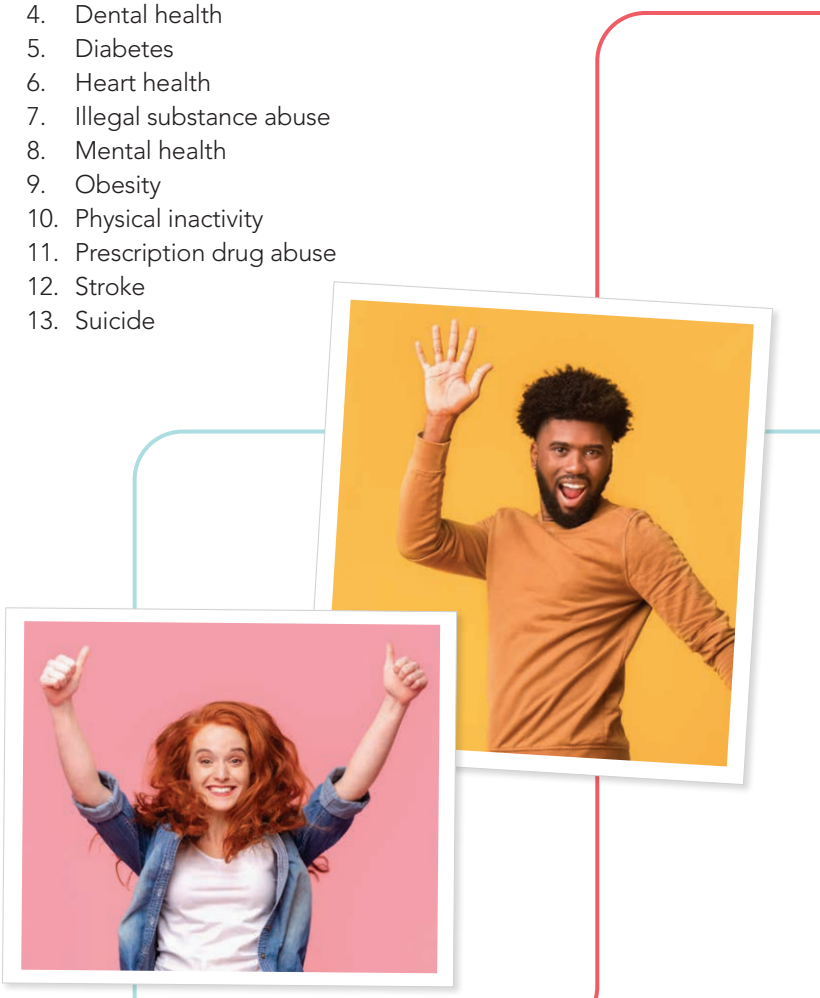
The three social determinants of health identified as having the greatest impact if addressed are as follows:

1. Quality health access
2. Early childhood development
3. Affordable housing

The top 13 health issues identified through survey collection, county data and moderated sessions were included in the prioritization process.

The 13 issues are listed here in alphabetical order:

1. Alcohol abuse
2. Alzheimer's disease/dementia
3. Cancer
4. Dental health
5. Diabetes
6. Heart health
7. Illegal substance abuse
8. Mental health
9. Obesity
10. Physical inactivity
11. Prescription drug abuse
12. Stroke
13. Suicide



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 13 items on the previous page.

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

Significance/pervasiveness

- 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 highly articulated and repeated themes that occurred during the assessment, we were able to rule in 13 of the health areas as we continued in the prioritization 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.

Key Community Benefit Issues

FY 2022 – 2024

During fiscal years 2022 - 2024, the hospital, The Partnership, health department and other 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 Prioritization process described above.

In priority order they are:

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

Obesity efforts that are interrelated with the key issues of diabetes, cancer and heart health will be a main concentration.

These same four key issues 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 FY2020 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 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, the Local Health Improvement 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. Mental 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, behavioral health, 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 healthcare 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

#1 Mental Health BEHAVIORAL HEALTH

Carroll County has a reported 4,554 per 100,000 population emergency department visits due to mental health conditions (2020, Carroll Hospital). This number has been on an upward trend since 2015 when it was 2,949.5. This represents a 54.4% increase from 2015 to 2020 on an average annual growth rate of 10.8%.

The COVID-19 pandemic has presented challenges related to the mental health of community members, such as lack of in-person counseling and physician visits, lack of access to support groups, significant changes in routine, fear, social isolation, anxiety and depression.

Strategies:

a) Partnership with Maryland Department of Health (MDH), The Partnership for a Healthier Carroll County, Youth Services Bureau, the Carroll County Health Department (CCHD), Suicide Coalition and others to improve communication and improve resources for mental health.

b) 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 Behavioral Health Resources and Services 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 schoolteachers, guidance counselors and mental health professionals and family members of persons receiving services related to substance abuse or mental health.

e) The Partnership will lead and sustain a leadership team composed of community and subject matter experts, with a focus on mental health and wellness. Responding to the identified needs, this team will coordinate, propose, develop and implement the team-determined and agreed upon initiatives. These efforts will include a focus on anti-stigma and education addressing mental health. Existing programming, such as the CARE campaign, can be expanded or modified to best address issues of mental health disorders. This team also serves as the LHIC.

f) Continue to offer complementary health treatments such as acupuncture to use as an adjunct in managing behavioral health issues.

Section III — Key Community Benefit Issues Implementation Strategies

g) 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's staff have oversight of the program. Direct referrals to mental health resources are provided by the peer support specialist as appropriate.

h) Continue relationship with and access to Shoemaker Center and other local providers.

i) Participation in community fairs to share information on substance abuse issues and resources.

j) Active participation with the Criminal Justice Diversion program.

k) Referrals to the CCHD-funded mobile crisis services for mental health and addiction when needed.

l) Collaboration among Carroll Hospital, CCHD and The Partnership to use consistent messaging, including MDH messaging, to promote an anti-stigma campaign for mental health and substance use.

m) Hospital will continue to employ full-time behavioral health navigator who focuses on the high risk population.

n) Access Carroll and the CCHD continue to offer behavioral health services for at-risk individuals, directly addressing the provider shortage in the community.

o) 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).

p) Offer outpatient psychiatry, including telepsychiatry, for behavioral health issues.

q) Continue depression screening in Carroll Health Group primary care offices with the use of the PHQ9 and increasing the availability of social work resources and referrals to outpatient mental health resources.

r) Actively participate in the Greater Baltimore Regional Integrated Crisis System (GBRICS) project through appropriate workgroups or providing data and information when needed to assist in the development of the project components to improve infrastructure and expand availability of behavioral health crisis services.

s) Multi-disciplinary Behavorial Health committee formed.

t) Explore ways to educate and promote screening for mental illness to emphasize importance of prevention (living mentally healthy) and early detection of mental illness.

u) Explore opportunities (including virtual) for mental health education outreach to faith community and workplaces for education, screenings and increasing awareness of community resources that are available.

u) Explore ways to promote National Acupuncture Detoxification Association (NADA) as an adjunct to mental health treatment.

Anticipated Outcome:

- Reduction of avoidable readmissions for patients having high utilization (greater than three annually) of behavioral health unit services related to mental health and or co-occurring diagnosis
- Reduction of avoidable emergency room visits for patients having high utilization (greater than three annually) related to mental health conditions

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) - (MD Vital Statistics)
- ED visits related to mental health conditions - (Carroll Hospital)
- ED visits for addictions-related conditions - (Carroll Hospital)





Section III — Key Community Benefit Issues Implementation Strategies

#2 Diabetes WITH A SUB FOCUS OF OBESITY

9.1% of Carroll County adults have been diagnosed with diabetes (2019, MD BRFSS) and 29.6% of Carroll County Medicare beneficiaries were treated for diabetes in 2018, according to the Centers for Medicare & Medicaid Services.

The COVID-19 pandemic has presented challenges for individuals with diabetes due to lack of preventative screenings, lack of primary care health visits, fear of seeking medical care, lack of access to fitness facilities and appropriate exercise, and increased stress.

Strategies:

a) Provide diabetes self-management education by physician order.

b) Offer a free Diabetes Basics Class for patients referred to the Diabetes Program that cannot meet their cost obligation.

c) Provide diabetes and prediabetes education programs & screenings in outreach markets, including virtual learning opportunities.

d) Provide free weekly diabetes education calls ("Diabetes Wednes-days") focused on behavior changes to reduce diabetes related complications.

e) Develop and implement a 12-week education and support program ("Balance Diabetes") designed to help people with diabetes achieve clinical indicators and establish behaviors that are known to reduce complications from Type 2 diabetes.

f) Enhance and support automatic, bidirectional referral processes from physician group practices to the Diabetes Program for anyone with diabetes or prediabetes.

g) Explore possibility of offering supplemental diabetes education and support to follow the Diabetes Standards of Care in physician offices.

h) Provide pharmacy support through the Care Transformation Organization Medication Management Pharmacist on diabetic patients to meet Diabetes Standards of Care in the physician offices.

i) 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 implement the team-determined and agreed upon initiatives. These efforts will include a focus on physical activities and education addressing diabetes and prediabetes with Prescription for

Nutrition as the umbrella program. Existing programming, such as Walk Carroll and Tryvent, can be expanded or modified to best address issues of exercise and nutrition in this population.

j) 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.

k) The Partnership and hospital collaborative Carroll's Cooking for Wellness™ classes including sessions directed at a variety of populations and classes potentially held at sites throughout the community.

l) Increase awareness of prediabetes and how to address this health issue with local resourcecs and programs, through communications directing the public to a resource page on healthycarroll.org.

m) Recruited an endocrinologist to join Carroll Health Group in order to provide additional access to care.

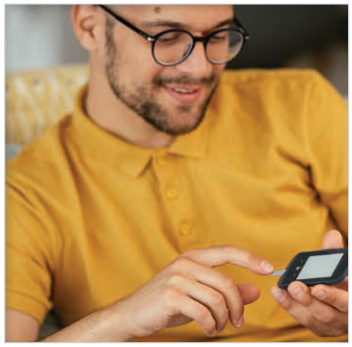
n) The Partnership will partner with community organizations to develop community gardens.

Anticipated Outcome:

- Decrease utilization of ED visit rate due to diabetes
- Adherence with best practice standards for self-management of diabetes will be increased through education

Indicators:

- Percentage of adults with diabetes over age 65 – (Carroll Hospital)
- Age-adjusted death rate due to diabetes/rate per 100,000 – (MD Vital Statistics/OCD)
- Emergency department visit rate due to diabetes – (Carroll Hospital)



#3 Cancer WITH A SUB FOCUS ON OBESITY

Cancer continues to be a leading cause of death in our community. The incidence of lung cancer and colon cancer are greater in Carroll County than the Maryland State averages; early detection screening compliance rates for breast and colon cancer are below the American Cancer Society recommended targets.

A total of 69.3% (2018, MD BRFSS) of adults aged 50 and older have ever had a sigmoidoscopy or colonoscopy exam, and 86.7% (2018, MD BRFSS) of women aged 50 and older have had a mammogram in the past two years.

The incidence and death rates of melanoma in Carroll County are higher than both the United States and Maryland rates. In the past year with the onset of the COVID-19 pandemic, cancer screenings were largely put on hold to prioritize urgent medical needs and to decrease the spread of the virus. As a result, preventative cancer screenings have decreased, which have impacted early diagnosis and delayed treatment. Estimates indicate more than one third of Americans missed routine cancer screenings due to COVID-19-related fears and service disruptions.

Strategies:

a) Provide colon and breast cancer prevention and screening education at health fairs, organizations, faith communities and/or local events.

b) Offer free, one-on-one informational consultation and clinical breast exam screenings with physicians from the Center for Breast Health at Carroll Hospital.

c) Offer skin cancer prevention education and screenings on-site and at outreach locations.

d) Offer Embrace to Win Survivorship program to cancer survivors (all cancer types) to improve health and decrease obesity, which could impact recurrence rates.

e) Provide genetic counseling and genetic testing services both on-site and virtually.

f) Provide nutritional education and counseling services to oncology patients either on-site in the William E. Kahlert Regional Cancer Center or by referral to outpatient nutrition counseling.

g) The Partnership will offer 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 including providing sun sails for local swimming venues (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.

h) Explore the development of cancer screening protocols within provider practices.

i) Educate on palliative care options to improve quality of life of patients diagnosed with cancer.

j) Educate and promote the use of complementary health therapies that may help with side effects of cancer treatments and improve physical and emotional well-being.

k) Reignite efforts to safely return to having cancer screenings and care in order to raise screening rates to pre-pandemic levels.

l) Collaborate with the cancer center for the Maryland Cancer Fund (to offer financial support to cover the costs of cancer care).

m) Recruit additional providers to join the William E. Kahlert Regional Cancer Center.

Anticipated Outcomes:

- 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 – (MD Vital Statistics)
- Melanoma incidence rate per 100,000 – (MD Cancer Registry)
- Breast Cancer screening rates (Advanced Radiology)

#4 Heart Health WITH A SUB FOCUS OF OBESITY

Heart disease is the leading cause of death in our community. Carroll County is reporting 172.9 deaths per 100,000 population due to heart disease (2016-2018, MDH) and 46.0 deaths per 100,000 population due to cerebrovascular disease and stroke (2016-2018, MDH), both higher than Maryland and national rates. The Healthy People 2030 national health target is to reduce the stroke deaths to 33.4 deaths per 100,000. Additionally, 30.2% of Carroll County adults have high blood pressure (2019, MD BRFSS) and 34.2% have high cholesterol (2019, MD BRFSS). The COVID-19 pandemic has presented challenges related to heart health in the community due to lack of preventative healthcare visits, lack of availability for elective procedures, lack of screenings for blood pressure, fear of seeking medical care for preventative or early identification of heart conditions, and closure or reduction of fitness facilities.

Strategies:

a) Offer monthly blood pressure screenings at multiple outreach locations, providing education and referrals as appropriate.

b) Offer Lose to Win (nutrition and weight loss program) annually and explore ways to either offer the program more frequently or to more participants to reach a larger audience.

c) Offer telemonitoring services at home to patients with heart failure after hospital discharge or referral from physician or staff.

d) Provide cooking classes both virtually and in-person to address identified needs, [i.e., cooking healthy on a budget, shopping basics, grocery store tours, cooking/ nutrition apps, cooking for specific chronic diseases].

e) Collaborate with the Carroll County Public Library to expand nutrition and cooking classes to the community and targeted populations.

f) The Partnership and hospital collaborative Carroll's Cooking for Wellness℠ classes including sessions directed at a variety of populations and classes potentially held at sites throughout the community.

g) 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 implement the team-determined and agreed upon initiatives. These efforts (Prescription for Nutrition) will include a focus on healthy eating, 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) Develop web-linked videos on heart healthy eating.

i) Offer heart health and stroke education at outreach locations including health fairs, organizations, faith communities and local events.

j) Recruited an additional cardiologist to join Carroll Health Group to increase access to cardiac care.

k) The Partnership is currently developing community gardens with partner organizations.

Anticipated Outcome:

- A continued downward trend in age-adjusted death rates for CVA (stroke) and hypertension
- Increased opportunities for physical activity to reduce obesity

Indicators:

- 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 diabetes – (Carroll Hospital)

Notes:

- Equity focus within programming
- Mental Health primary focus in Behavorial Health area (Sub focus–Substance Abuse)
- Emergency department visit rate due to diabetes – (Carroll Hospital)

Section IV — Financial Assistance

Carroll Hospital is committed to ensuring that financial resources are not a barrier to anyone seeking healthcare 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 assistance is provided 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 of up to 150% of the Federal Poverty Guidelines by offering a reduction of 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 healthcare in the community by committing to offer the highest quality healthcare 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 FY20, more than $10.2 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 FY20 included endocrinology, cardiology, oncology and hospice/palliative care. 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 orthopedics, 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; orthopedics; 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 $1.6 million in FY20.

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 healthcare 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 FY20, Access Carroll had 6,339 medical encounters (323 new patients), 2,914 dental encounters (403 new patients) and 9,317 behavioral health encounters (403 new patients) for a total of 18,570 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 healthcare 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 to promote better outcomes. 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.

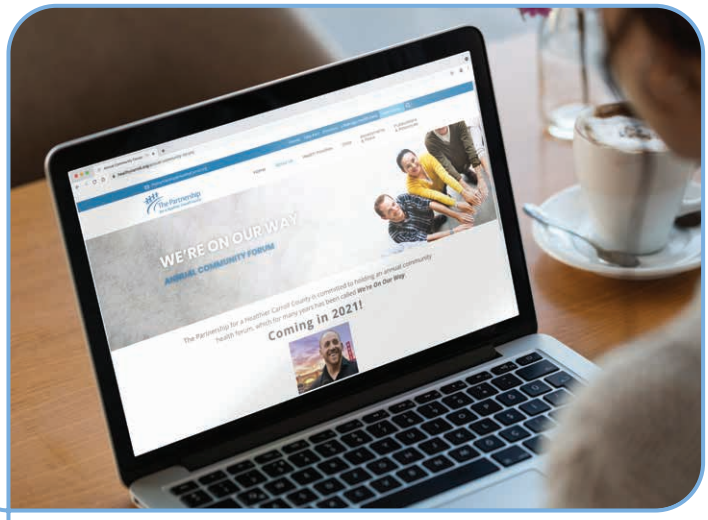
Two of the most significant benefits anticipated are better patient care and better outcomes. By providing care teams with the tool they need to develop evidence-based care plans and by connecting patients to clinical, educational and support resources, both patients and physicians will have the tools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

In addition, helping physicians understand and implement the connectivity they need to exchange healthcare 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 satisfy the Merit-based Incentive Payment System (MIPS) reporting requirements and promote 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 healthcare will face in the future, what we do know is that it's changing rapidly. We also know that the Maryland Healthcare 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. One of the programs the state has developed to support these goals is the Maryland Primary Care Program (MDPCP). This program provides funding and support for the delivery of advanced primary care. The Carroll PHO is participating in this program as a Care Transformation Organization (CTO) to support community practices in this effort.

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, 2021.

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/Significance/Pervasiveness
  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 healthcare continuum have potential ability to impact results outside of the top four priority areas.

Section IX — Appendices

FY2019 – FY2021 Community Benefit Plan

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

Notes:












CARROLL HOSPITAL
A LifeBridge Health Center
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The Partnership
for a Healthier Carroll County