Community Benefit and Health Improvement Plan

A Tapestry of Voices
FY 2025-2027

CARROLL HOSPITAL
A LifeBridge Health Center

CARE BRAVELY

The Partnership
for a Healthier Carroll County

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SECTION 1
Introduction

Representing the diversity and individuality of voices within Carroll County, this tapestry of a plan is created through the collective efforts of individuals who contribute their stories, experiences, and perspectives through the Community Health Needs Assessment. Each thread symbolizes a unique voice, coming together to form a cohesive and vibrant image. Celebrating the importance of listening to and valuing every voice, creating inclusivity, representation, and community engagement, reinforcing the message that every voice truly does matter.

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 application, community materials and more. Our values characterize all our actions and experiences 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: "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 the 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)
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.

COMMUNITY BENEFIT PLANNING & EVALUATION COMMITTEE MEMEBERSHIP & RESPONSIBILITIES

Membership on the Community Benefit Planning and Evaluation Committee is by appointment by the Executive Director of The Partnership for a Healthier Carroll County and includes a diverse group of clinical, financial, compliance, educational and community outreach leaders from the hospital and LifeBridge health system. 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.
    a. The plan must be based on information from our recent Community Health Needs Assessment (CHNA) and address verified community needs.
    b. The plan must comply with all relevant aspects of the 2010 Affordable Care Act, the HSCRC Community Benefit Guidelines and the IRS 990 guidelines.
    c. The Community Benefit & Health Improvement Plan will become an integrated component of the hospital's overall strategic plan and The Partnership's strategic plan.
    d. 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 Community Benefit data and 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 operational leaders, including LifeBridge Health's Finance Department and Population and Community Health Department, hospital presidents, the hospital board and, ultimately, submitted to the HSCRC.

A community version of the report is published in the hospital's 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, FY2019 to FY2021, and FY2022-FY2024 were the previous plans by the hospital and The Partnership to address the 2012, 2015, 2018 and 2021 Community Health Needs Assessments, respectively.

See Appendix for a copy of the previous plans.

SECTION 2

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, 2018 and 2021 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.

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 2023. 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 2,612 resident surveys were completed with 79 excluded due to living outside the geographical area.

- **Four Key Informant Survey sessions** were held between July and September 2023. 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, one session was held with mid-level, nonprofit direct service providers and one session was held with Young Business Leaders. The respondents were asked to complete the survey using their professional knowledge with the populations they serve. A total of 50 key informant surveys were completed during the moderated sessions. All sessions were conducted in person.

- Eleven 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 lower income population group (x2). All sessions were scheduled between July and September 2023. Research participants were invited to complete a survey to identify the specific needs of their community. In addition, The Partnership led and moderated discussion with each group after completion of the survey. All of the groups were held and moderated in person. More than 107 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 of this information.
  - **Our Community Dashboard:** 100+ indicators were selected from a Maryland-specific list of core measures.
  - **Healthy Carroll Vital Signs**: Data indicators are updated twice annually to report on the trending patterns of the plan's priority issues.
  - **State of Maryland Health Improvement Process and Local Health Improvement Plan:** 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.

- Carroll County Local Management Board Community Assessment, to identify the needs, gaps, and opportunities related to services for children, youth, and families.

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 online at HealthyCarroll.org.

Prioritization

Working collaboratively, The Partnership’s board, Carroll Hospital’s board and executive leaders, Carroll County Health Department Bureau Chiefs, 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 13, 2024 and was facilitated by Dorothy Fox, Executive Director and CEO of The Partnership for a Healthier Carroll County, 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 four social determinants of health believed to be the most important to address as ranked by the Key Informants are listed below in order of ranking: (three way tie for second)

1. Affordable housing
2. Economic success
2. Employment opportunities
2. Quality health access

The three social determinants of health believed to be the most important to address as ranked by the Focus Groups are listed below in order of ranking:

1. Affordable housing
2. Quality health access
3. Social support

The top 15 health issues identified through survey collection, county data and moderated sessions were included in the prioritization process.

The 15 issues are listed here in alphabetical order:

1. Alcohol abuse
2. Alzheimer’s disease/dementia
3. Cancer
4. Congestive Heart Failure
5. COPD
6. Dental health
7. Diabetes
8. Heart health
9. Illegal substance Use
10. Mental health
11. Obesity
12. Prescription drug abuse
13. Stroke
14. Suicide
15. Tobacco

To narrow the topic areas for that prioritization process, we requested active input from attendees in determining the priority needs for the focus of the Community Benefit & Health Improvement Plan from among the list of the 15 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 15 of the health areas as we continued in the prioritization process. Identifying and bringing together our community leaders and stakeholders for each of the 15 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 2025 – 2027

During fiscal years 2025 -2027, 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. Heart Health
4. Cancer

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.

Meeting the Need

The three-year plan will allow us to focus on the prevalent and high impact issues identified via our FY2023 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, patients and patients families. 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's goal is to develop a Community-level Health Plan that will not only include the Community Benefit & Health Improvement Plan requirements, but meet the standards for 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, heart health and cancer 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 diabetes risk screenings and blood pressure 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. Focus on health equity as well as health drivers will play an important and impactful role in this plan.

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 community with The Partnership's Access to Health 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 3

Key Community Benefit Issues Implementation Strategies

#1 Mental Health

Mental health includes emotional, psychological, and social well-being. After COVID-19, there remained concerns about loss of loved ones, isolation, sustained disruption in our daily activities, income loss, and job loss that had individual and combined impact – resulting in increased stress and symptoms of anxiety and depression among many.

Approximately 19% of the 33,746 ED visits in 2023 by Carroll County residents involved a Mental Health diagnosis (CRISP Public Health Dashboard, utilizing HSCRC data). Suicide was the 9th highest cause of death in Carroll in 2021 at 13.1 per 100,000 population, higher than the Statewide rate of 9.7 (MD Vital Statistics).

Strategies

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

2. Promote availability of The Partnership's Behavioral Health Resources and Directory for the community.

3. 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, school nurses, and mental health professionals and family members of persons receiving services related to substance abuse or mental health.

4. 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.

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

6. In collaboration with CCHD, continue Peer Recovery 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. Utilize Peer Support for substance use Disorder (SUD) prevention education within PHP/IOP services.

7. Participate in community fairs to share information on mental health issues and resources.

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

9. Collaboration among Carroll Hospital, CCHD and The Partnership to use consistent messaging, including MDH messaging, to promote CARE.

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

11. Access Carroll will continue to offer integrated behavioral health services for at-risk individuals, directly addressing the provider shortage in the community.

12. Access Carroll will host a community-based behavioral health hotline to expedite access to services.

13. 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). Continue collaboration with local law enforcement with data and information sharing, alignment of processes when appropriate.

14. Continue to offer and expand outpatient psychiatry, including telepsychiatry, for behavioral health issues.

15. Actively participate in the Central Maryland Regional Crisis System (formerly GBRICS) project through appropriate workgroups and 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.

16. Multi-disciplinary Behavioral Health committee formed.

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

18. Expand navigation outreach and support services to adolescent patients who visit the hospital for behavioral health needs.

19. Expand the Peer Recovery Services to a broader Behavioral Health Program.

20. Support community access to Substance Use Disorder residential care with crisis stabilization (triage) beds, to provide care for individuals experiencing behavioral health crises (those experiencing a mental health-only crisis are able to be served on a limited basis).

21. Expand the Emergency Department to include a dedicated Behavioral Health Unit.

22. Continue working with CCPS for PHP/IOP and inpatient services.

23. Continue collaborating with partners to provide education for both hospital staff and the community.

Anticipated Outcomes

- 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

1. Total number of patients admitted for mental health diagnosis including those transferred to other facilities for admission.
2. Emergency Department visits related to mental health conditions
3. Age-adjusted suicide mortality rate per 100,000

#2 Diabetes

Diabetes was the 7th top cause of death in Carroll County in 2021 at 30.3 deaths per 100,000 population, higher than the State rate of 22.7 per 100,000 (MD Vital Statistics), and 6.2% of Carroll County adults have been diagnosed with diabetes (2022, MD BRFSS). Additionally, 30.4% of Carroll adults are considered obese (BMI of 30.0+) (2022, MD BRFSS).

With early detection and awareness, you can take steps to prevent or delay the onset of type 2 diabetes.

Strategies

1. Provide diabetes self-management education by physician order.

2. Partner with local PCP offices to establish satellite Diabetes Management programs to make diabetes education more accessible. Offer a free Diabetes Basics session for patients referred to the Diabetes Program that cannot meet their cost obligation.

3. Provide diabetes and prediabetes education throughout the community, including virtual learning opportunities, referring to local resources and programs as appropriate. Expand the Carroll Hospital Diabetes Education and Support Group reach by promoting virtual availability to senior communities through facility/residence partnerships.

4. Implement an automatic referral process to the Carroll Hospital Diabetes Program for patients admitted to Carroll Hospital with uncontrolled diabetes.

5. Continue the Stroke Smart Carroll County initiative.

6. The Partnership and Carroll Hospital collaboration with CCPL to offer monthly Cooking for Wellness™ classes including sessions directed at a variety of populations.

7. Offer nutrition education through various modalities: Carroll Hospital bimonthly nutrition/healthy recipe blog; Nutrition in Media, community presentations & health fairs.

8. Offer Jumpstart to Wellness (nutrition & physical activity related wellness program) and explore ways to reach high risk populations.

9. Recruit an endocrinologist to join Carroll Health Group in order to provide additional access to care.

10. Increase awareness of prediabetes and how to address the health issue with local resources and programs, through communications directing the public to a resource page on HealthyCarroll.org

11. The Carroll County Health Department will offer the free, evidence-based Diabetes Prevention Program.

12. The Bureau of Aging and Disabilities, The Partnership and the Carroll County Health Department will offer the Diabetes Self-Management Program.

Anticipated Outcomes

- 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

1. Percentage of adults with diabetes
2. Age-adjusted death rate due to diabetes per 100,000
3. Emergency department visit rate for diabetes (type 1 or type 2) as the primary diagnosis

#3 Heart Health

Heart disease is the leading cause of death in Carroll County, at 162.3 deaths per 100,000 population. There were also 30.5 deaths per 100,000 population due to cerebrovascular disease and stroke (2021 MD Vital Statistics). In 2022, 5.1% of Carroll County adults reported having been diagnosed with heart disease (2022, MD BRFSS). A reported 26.1% of Carroll County adults have high blood pressure and 25.4% have high cholesterol (2021, MD BRFSS).

Heart-healthy living involves understanding your risk, making healthy choices, and taking steps to reduce your chances of getting heart disease, including coronary heart disease, the most common type. By taking preventive measures, you can lower your risk of developing heart disease that could lead to a heart attack. You can also improve your overall health and well-being.

Strategies

1. Offer nutrition education through various modalities: Carroll Hospital bimonthly nutrition/healthy recipe blog; Nutrition in Media, community presentations & health fairs.

2. The Partnership and Carroll Hospital will continue to collaborate with CCPL to offer monthly Cooking for Wellness™ classes including sessions directed at a variety of populations.

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

4. Offer Jumpstart to Wellness (nutrition & physical activity related wellness program) and explore ways to reach high risk populations.

5. Offer telemonitoring services at home to patients with heart failure & HTN after hospital discharge or referral from physician or staff.

6. Offer heart health and stroke education at outreach locations including health fairs, organizations, faith communities, local events, and virtually as appropriate. Continue the Stroke Smart Carroll County initiative.

7. Promote services and increase referrals to new Carroll Hospital Heart Failure Clinic.

8. CCHD will initiate and support the maintenance of Taking Off Pounds Sensibly (TOPS) chapters in Carroll County to offer low-cost weight loss support.

9. The Partnership will lead and sustain a leadership team composed of community and subject 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

Anticipated Outcomes

- A continued downward trend in age-adjusted death rates for CVA (stroke) and heart disease.
- Increased opportunities for physical activity to reduce obesity.
- Increased utilization of diabetes program and HF clinic.

Indicators

1. Age-adjusted death rate due to CVA (stroke) per 100,000
2. Age-adjusted death rate due to heart disease per 100,000
3. Emergency department visits due to heart disease (CH)

#4 Cancer

Cancer was the 2nd leading cause of death in Carroll County in 2021 at 154.4 deaths per 100,000 population (MD Vital Statistics), higher than the Statewide rate of 136.8 per 100,000. The incidence of all cancers combined is also higher in Carroll (513.9 per 100,000 population) than Statewide (462.8 per 100,000) (2019, MD Cancer Registry). The incidence and death rates of melanoma in Carroll County are also higher than both the United States and Maryland rates.

Awareness through education is the first and best step in the prevention of some cancers. Awareness through early detection can result in a better outcome for many cancers. Everyone benefits from cancer education, prevention, and early detection via screening.

Strategies

1. Offer free, one-on-one informational consultation and clinical breast exam screenings with providers from the Center for Breast Health at Carroll Hospital.
2. Provide colon and breast cancer prevention and screening education at health fairs, organizations, faith communities and/or local events.
3. Offer free cervical cancer screens from Gynecologic Oncologist.
4. Offer skin cancer prevention education and free screenings on-site and at outreach locations.
5. Offer Embrace to Win Survivorship program to cancer survivors (all cancer types) to improve health and decrease obesity, which could impact recurrence rates.
6. Continue to provide genetic counseling and genetic testing services both on-site and virtually.
7. Provide nutritional education and counseling services to oncology patients on-site through William E. Kahlert Regional Cancer Center.
8. Explore the development of cancer screening protocols within provider practices.
9. Educate on palliative care options to improve the quality of life of patients diagnosed with cancer.
10. 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.
11. Collaborate with CCHD to connect low-income residents with Maryland Cancer Fund to offer financial support to cover the costs of cancer care.
12. Recruit providers to join the William E. Kahlert Regional Cancer Center.
13. Continue to offer nutrition education through various modalities: Carroll Hospital bimonthly nutrition/healthy recipe blog; Nutrition in Media, community presentations & health fairs.
14. Return to having cancer screenings and care in order to raise screening rates to pre-pandemic levels.
15. Continue to offer clinics with physicians focused on breast and gynecologic cancers at the William E. Kahlert Regional Cancer Center.
16. On-site research nurses available to evaluate patients for clinical trial eligibility.
17. The Partnership will offer sun safety programs to elementary schools, Head Start, community pools, Vacation Bible Schools, area colleges, Senior Centers, 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 shaded 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 will continue. The Partnership will support skin cancer awareness as it affects the aging population. Skin cancer prevention, education and identification are the focus.
18. CCHD's Breast and Cervical Cancer Program (BCCP) will continue to help women who cannot afford screening tests for these cancers. Eligible individuals can get free mammograms, Pap tests, GYN exams, and other testing and treatment if needed. CCHD also offers a patient navigation program, which provides guidance to patients as they move through the healthcare system.
19. CCHD's Colorectal Cancer Screening Program will continue to help low-income Carroll County residents 45 and over to get screening tests at no cost.

Anticipated Outcomes

- Increased awareness and education of screening guidelines and recommendations as well as prevention for skin, breast, and colon cancers

Indicators

1. Age-adjusted Mortality rate from cancer per 100,000
2. Age-adjusted melanoma incidence rate per 100,000
3. Age-adjusted colorectal cancer incidence rate per 100,000

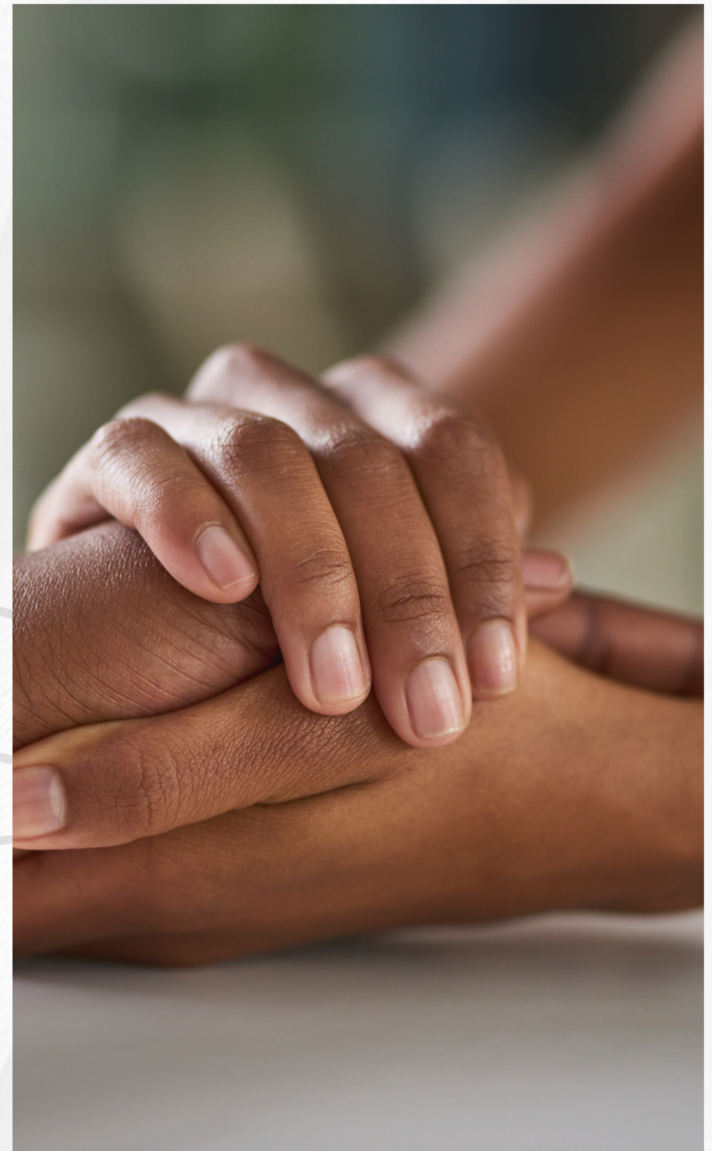
SECTION 4
Financial Assistance

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 clearly communicated by signage, the patient information sheet, uniformed summary bill and the hospital website.
- Assistance with the application process is available.
- 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.
- 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.
- The financial counselors work with numerous different entities on the patient's behalf not only to take care of the immediate need for services, but also to establish a plan for continuity of care and to remove the barriers which obstruct access.



SECTION 5
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 in to 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 community benefit narrative is reviewed by the LifeBridge Health Board, which includes representatives from each of LifeBridge's hospitals. The Partnership for a Healthier Carroll County Board also reviews the community benefit assessment and plan.

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 Hosptial boards approve the 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 6
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 to support 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 FY23, Access Carroll had 5,865 medical encounters (384 new patients), 3,237 dental encounters (384 new patients) and 6,686 behavioral health encounters (110 new patients) for a total of 15,788 encounters. Access Carroll strives to ease the use of the ED as a source of primary care for the uninsured and ensure they have access to integrated healthcare and intensive case management when they need it, so that health conditions do not worsen due to their inability to pay for services or navigate community health resources.

Since 2005, Access Carroll has been helping its patients manage chronic diseases, including diabetes, hypertension, respiratory conditions, chronic pain, substance use disorder and mental health issues. The practice features seven medical exam rooms, four dental operatories, strategic in-house partnerships with Genoa Licensed Pharmacy and LabCorp Laboratory, 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.

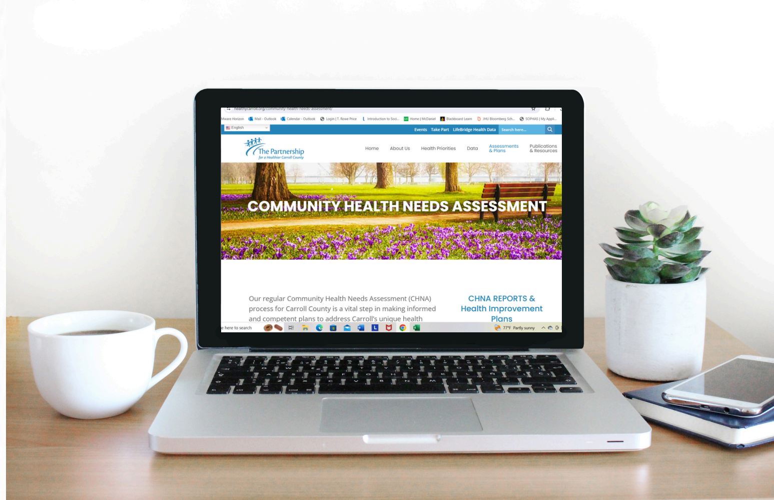
Two of the most significant benefits anticipated are better patient care and better outcomes. By providing care teams with the tool they need to develop evidence-based care plans and by connecting patients to clinical, educational and support resources, both patients and physicians will have the tools 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 7
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, 2024.

Carroll Hospital publishes the Community Benefit Report in its annual report to donors, distributed January/February each year.

The report also is made available on the hospital's website (https://publications.lifebridgehealth.org/books/vihg/).

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 8
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 15 identified needs were selected as the priorities of this Community Benefit & Health Improvement Plan based on:
  - Seriousness/Significance/Pervasiveness
  - 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.

APPENDIX

FY2022-FY2024 Community Benefit Plan

FY2019-FY2021 Community Benefit Plan

FY2017-FY2018 Community Benefit Plan

FY2014-FY2016 Community Benefit Plan

Carroll Hospital Financial Assistance Policy

Community Benefit Plan Policy

FY2024 Community Health Needs Assessment

NOTES

CARROLL HOSPITAL

A LifeBridge Health Center

CARE BRAVELY

The Partnership

for a Healthier Carroll County